

## **Highlights of Model Bill for Universal Publicly Paid Health Care in Indiana**

- The Indiana General Assembly would establish the Health Care Finance Plan that would pay providers for comprehensive health services to all residents of Indiana.

### **The Board**

- A board, with both appointed and publicly elected members, would administer the Plan with the aim of enhancing health education, primary and preventive care, provider accountability, and administrative efficiency.
- The Board would divide the state into regional health planning and policy districts whose councils would advise the Board in drawing up a comprehensive budget.
- A Board managed trust fund would be the only payer compensating claims for services covered by the plan. Private insurers and individual patients would no longer compensate doctors and hospitals.

### **The Fund**

- The Trust Fund would finance Board approved capital expenditures for participating individual and institutional providers.
- The Trust Fund would pay for training/retraining health-care sector employees who the change from a multi-payer to a single-payer system has displaced.
- The Trust Fund would use waivers to capture monies now dedicated to other public programs, such as Medicare and Medicaid.
- Employers would pay a progressive payroll tax into the Trust Fund. Individuals subject to income tax would pay a progressive income tax into the Fund. The law would set the upper and lower percentages for these taxes.
- When the law takes effect, individuals and employers would continue paying for health plans for which they have contracted until those contracts expire while also making payments to the Trust Fund, for which they would then get a tax credit.

### **Coverage**

- The Health Plan would cover participants for, among other things, preventive services, inpatient and outpatient services, services by individual practitioners, dental care, prescription drugs, mental health services, and long-term care.

- For an individual receiving health care under the Plan, there would be no co-payments and no charges beyond what the Plan pays. Patients would be free to choose their doctors and hospitals.
- The Board would negotiate fees and rates with both individual and institutional providers, any of whom would be free to choose whether to be compensated either as a fee-for-service provider or as a capitated (fee-for-client) provider.

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