

Draft Bill

Universal Publicly Paid Health Care in Indiana

1-1-1-1 The Health Care Finance Plan

There is established the Indiana Comprehensive Health Care Finance Plan. The Plan shall be the single agency to collect funds and to provide payment on behalf of all Indiana residents for all medically necessary services.

1-1-1-2 Definitions

- (a) "Plan" means the Indiana Comprehensive Health Care Finance Plan.
- (b) "Board" means the Board of Governors of the Indiana Comprehensive Health Care Finance Plan.
- (c) "Employer" means any person or organization using the service of another for pay.
- (d) "Provider" means a health care practitioner, group, or facility.
- (e) "Eligible Provider" means a Provider licensed, certified, or registered in Indiana that receives compensation for covered services solely from the Trust Fund of the Plan and receives no more than 5% of its revenue from services not covered by the Plan..
- (f) "Effective Date of this Act" means the beginning of the second fiscal year after the enactment of this Act.

1-1-2-1 The Composition of the Board for the Plan

- (a) The Indiana Comprehensive Health Care Finance Plan shall be administered by the Board.
- (b) The Board shall have 24 members selected as follows:
 - (1) Nine members shall be elected at the quadrennial general elections, one from each congressional district in Indiana. Members elected from a congressional district must be registered to vote in that district.
 - (2) Fifteen members shall be appointed from among Indiana residents by the governor with the advice and consent of the Senate of the Indiana General Assembly as follows:
 - (i) Two from hospitals;
 - (ii) Two physicians;
 - (iii) One registered nurse;
 - (iv) One from a community health center whose mission is primarily that of

- providing services to low income families and whose operation involves community participation;
- (v) One mental health care provider;
 - (vi) One whose annual income does not exceed the federal poverty level;
 - (vii) One whose annual income does not exceed twice the federal poverty level;
 - (viii) One sixty-five years of age or older;
 - (ix) One from a labor organization;
 - (x) One employer;
 - (xi) One licensed health care professional other than a physician or a nurse;
 - (xii) One trained in bioethics; and
 - (xiii) One dentist;

(c) The term of office for a Board member is four years. No member may serve more than two terms consecutively.

(1) The terms of the initial appointed members shall be staggered as follows: five shall be appointed for a term of four years, five for a term of three years, and four for a term of two years.

(2) The initial elected members shall be elected at the first quadrennial general election after the enactment of this Act.

(3) The term of office for each elected member of the board begins on the first Monday of January next following a general election.

(d) If there is a vacancy on the Board for any cause, the Governor shall fill the vacancy by appointment. A vacancy in the office of any member shall be filled for the remainder of that member's term.

(1) If the first general election occurs after January of the first fiscal year after the enactment of this Act, the elected seats would be vacant when the Board begins its activity. To avoid this situation, the Governor shall fill these seats by appointing a member to the Board from each congressional district who shall serve until a member elected from that district fills the position.

(2) A person appointed to fill a vacancy for an appointed position shall be from the same category as the Board member who is being replaced.

(e) Members of the Board shall at all times include:

(1) A sufficient representation of women and racial and ethnic minorities so that the makeup of the Board shall accurately reflect the diversity among persons eligible for coverage under the Plan; and

(2) At least two members who are defined as disabled under the Americans with Disabilities Act, P.L. 101-336.

(f) Standards and criteria shall be established by the Secretary of State to:

(1) Prevent a person from serving as an elected member of the Board who has a financial interest in any provider, practitioner or supplier doing business with the Board under this Plan.

(2) Assure that practitioners on the Board shall not have a financial interest in facilities to which they refer patients for tests, procedures, services or supplies.

(g) The Board is to be constituted and to have met by the end of January of the first fiscal year after the enactment of the Act.

1-1-2-2 Powers and Responsibilities of the Board

(a) The Board shall exercise and carry out all powers and rights needed to operate and implement the Plan.

(b) The responsibilities of the Board include, but are not limited to:

- (1) Determining Plan policies;
- (2) Establishing a balanced budget for the annual plan;
- (3) Managing the Trust Fund of the Plan;
- (4) Adopting rules for implementation and operation, including a written grievance procedure with rights of hearing and appeal;
- (5) Evaluating and auditing health services in order to promote quality and cost effectiveness;
- (6) Establishing incentives to ensure access to quality health services and emphasis on disease prevention and health promotion through health education and other activities;
- (7) Communicating with and soliciting input from the public through district advisory committees and other means, including from individuals and groups with special health service needs;
- (8) Establishing a medical science and a medical ethics advisory committee with a defined mission for each;
- (9) Employing an Executive Director and other necessary employees;
- (10) Negotiating the costs of goods and services covered by the Plan; and
- (11) Issuing revenue bonds.

(c) The board shall appoint the Executive Director of the Plan.

(1) The Executive Director shall serve as secretary to the Board and shall perform such duties in the administration of the plan as the Board may assign.

(2) The Board may delegate to the Executive Director any of its functions or duties except the issuances of rules and the determination of the Plan policies.

1-1-2-3 Annual Plan for the State

(a) The Board, in cooperation with the district advisory councils, shall develop an annual comprehensive state health care plan that would be adequate to meet the health care needs of the state's residents in an efficient, timely, and humane way.

(b) The annual plan shall include the following for the coming fiscal year:

(1) A comprehensive budget within the limits of funds made available through the measures instituted in Sections 1-1-4-3, 1-1-5-1, and 1-1-5-2. The budget shall include

specific amounts to pay for activity in the eight different areas listed in Section 1-1-4-2 according to the allocations specified there; and

(2) An evaluation of the adequacy of total funds available to the program. Any recommendation made by the Board or staff of the annual plan to the General Assembly for increases in either the Health Trust Premium taken from payrolls (1-1-5-1) or the Health Trust Surcharge (1-1-5-2-) on Indiana adjusted gross personal income shall:

- (i) Maintain the relative proportion of funding from these two sources; and
- (ii) Limit, except in emergency situations, growth in total state health care expenditures to no more than two percent above the total percentage increase in the State's gross domestic product for the previous year.

(c) The annual plan shall also include for each of the next four fiscal years:

(1) An assessment of the health care and mental health needs of each regional health care planning and policy development district and of the State as a whole, which shall include, but not be limited to, assessments of:

- (i) Local needs for medical technology and other investments in health care equipment and capital improvements;
- (ii) The extent to which state and local efforts to coordinate the activities of the health care delivery system have been effective; and
- (iii) Any other unmet local health care or mental health needs;

(2) Goals for geographic distribution of health care practioners and personnel. To achieve such goals, the plan shall include strategies for using the authority to negotiate reimbursements under Section 1-1-7-1 and for using resources for health professional education and training listed in Section 1-1-4-2;

(3) Quantitative goals for the use of health and mental health services by residents of the state;

(4) Specific goals for physical and mental health and for the quality of care rendered under the program;

(d) Prior to promulgation of the annual plan, the Board shall:

(1) Obtain recommendations from the medical science advisory committee regarding grants for medical and other health care research and development;

(2) Obtain recommendations from the medical ethics advisory committee on the ethical issues relating to the allocation of health care resources;

(3) Instruct each district advisory council to conduct at least one public hearing in its region to gather public comment on the proposed plan. The board shall provide the district advisory councils with staff assistance in the development of such hearings;

(4) Hold at least two public hearings to gather public comment on the proposed plan.

(e) The annual health plan shall, to the extent practical, seek to assure the most cost-effective delivery of health care by reflecting the following priorities:

(1) Quality of care, which will be achieved through:

- (i) Increased emphasis on health promotion and primary and preventive services;
- (ii) Accountability of practitioners to the Fund and to consumers for both the outcomes and consumer acceptability of the care they render;
- (iii) Continuity of care, to individuals and to the community, as embodied in

- coordination of services and case management; and
 - (iv) Positive efforts to improve and assure high levels of professional competence and expertise among health care practitioners; and
 - (v) Phasing in the computerizing of records and of networks for communicating them subject to strict protection of privacy rights.
- (2) Access to care through the equitable distribution of resources within the health care delivery system on the basis of community need; and
- (3) Efficient use of resources, which will be achieved through:
- (i) Health education initiatives;
 - (ii) Elimination of unnecessary administrative and overhead expense;
 - (iii) Increased emphasis on innovative and cost-effective modes of care, including, but not limited to:
 - a. Community, nonmedical or in-home services that provide alternatives to institutional long-term care;
 - b. Community health nursing;
 - c. Services provided by nurse practitioners; and
 - d. Psychiatric and other mental health services provided on an outpatient basis.

1-1-3-1 **Health Districts**

- (a) The Board shall divide the State into at least three and no more than six Regional Health Planning and Policy Development Districts of approximately equal population.
- (b) An advisory council in each District shall:
- (1) Assist the Board in the development of the plan, including without limitation the development of budgetary allocations for health care services and the assessment of health care and mental health needs;
 - (2) Assist the Board in developing operating policies and procedures for implementing the annual plan; and
 - (3) Develop a transportation plan to enable indigents, elderly persons, and persons with disabilities to have access to necessary nonemergency health care services.
- (c) Not later than thirty days after the first meeting of the Board of Governors, the Board shall submit to the Governor of Indiana a list of names of qualified persons who reside in each District. From such list, the governor shall appoint a District Advisory Council of thirteen members divided as follows:
- (1) One business person;
 - (2) One trade unionist;
 - (3) One person elected from a political subdivision within the District;
 - (4) Two physicians;
 - (5) One registered nurse;
 - (6) One licensed health care giver who is neither a physician nor a registered nurse;
 - (7) Two representatives of consumers of health care services;

- (8) One person trained in bioethics;
- (9) One dentist;
- (10) One mental health care provider, and
- (11) One hospital staff person.

(d) The terms of the initial appointees to each of the District Advisory Councils shall be as follows: five shall be appointed for a term of four years, four for a term of three years, and four for a term of two years. Thereafter all terms shall be for four years, but any member appointed to fill a vacancy in an unexpired term shall serve only for the remainder of that term. No member may be appointed to serve more than two consecutive terms.

1-1-4-1 **Health Care Trust Fund**

(a) There is hereby established the Health Care Trust Fund, hereinafter the Fund, which shall be administered and expended by the Board .

(b) The Fund shall consist of all revenue sources defined in Section 1-1-4-3.

(c) Revenues held in the Fund are not subject to appropriation or allotment by the state or any political subdivision of the state.

(d) The Board may invest the funds of the Trust Fund as permitted by law. All property and securities acquired by and through the use of monies deposited to the Fund and all interest thereon less payments therefrom to meet liabilities incurred by the Fund in the exercise of its powers shall be part of the Fund.

(e) All claims for payment for any health services eligible for coverage under the Plan shall be made to the Fund, and all payments for such services shall be disbursed from the Fund.

(f) Contracts entered into prior to the Effective Date of this Act for payment of health services eligible for coverage under the Plan with health insurers, health services organizations, health maintenance organizations, or employee governed employer/employee funds shall be exempted from both clauses of (e) of this Section.

(1) This exemption for such contracts ends one year after the Effective Date of this Act.

(2) After the Effective Date of this Act, no such contract may be renewed or signed whether by an individual or by an organization, institution, or agency on behalf of a group of individuals.

(g) The Board shall from time to time requisition for said Fund such amounts as the Board deems necessary to meet the Fund's current obligations for a reasonable future period.

1-1-4-2 **Allocations from the Trust Fund**

Amounts credited to the Fund shall be used for the following purposes:

- (1) to pay for covered benefits – whether services or goods – rendered to those eligible to participate in the Plan;
- (2) to fund capital expenditures for Eligible Providers for approved capital investments in excess of a threshold amount to be determined annually by the Executive Director;
- (3) to pay for preventive care, education, outreach, and public health risk reduction initiatives, not to exceed **5%** of Fund income in any fiscal year;
- (4) to supplement other sources of financing for education and training of the health care workforce, not to exceed **2%** of Fund income in any fiscal year;
- (5) to supplement other sources of financing for medical research and innovation, not to exceed **1%** of Fund income in any fiscal year;
- (6) to supplement other sources of financing for training and retraining programs for workers in the health care sector displaced as a result of administrative streamlining gained by moving from a multi-payer to a single payer health care system, not to exceed **2%** of Trust income in any fiscal year: provided, however, that such funding shall end June 30 of the third year following full implementation of this Act;
- (7) to fund a reserve account to finance anticipated long-term cost increases due to demographic changes, inflation or other foreseeable trends that would increase Fund liabilities, and for budgetary shortfall, epidemics, and other extraordinary events, not to exceed **1%** of Fund income in any fiscal year: provided, however, that the Trust reserve account shall at no time constitute more than **5%** of total Trust assets;
- (8) to pay the administrative costs of the Plan which, within two years of full implementation of this chapter shall not exceed **5%** of Fund income in any fiscal year.

1-1-4-3 **Sources of the Trust Fund**

(a) The Fund shall be the repository for all health care funds and related administrative funds.

(b) The sources of the Fund shall include the following:

- (1) All monies that the State and other governmental subdivisions currently appropriate to pay for health care services or health insurance premiums;
- (2) All monies collected by cities, towns and other governmental subdivisions to pay for health care services or health insurance premiums;
- (3) All monies the State receives from the federal government to pay for health care services or health insurance premiums;
- (4) All monies collected from taxes imposed on items that contribute to increased health care costs, including without limitation taxes on: alcohol, gasoline,

firearms, tobacco, and facilities operating in the State that generate air and/or water pollution.

- i. Such surtaxes are to be determined by the General Assembly, in consultation with the Executive Director of the Plan, and
 - ii. They shall be imposed on products and facilities to the extent that they can be determined to contribute to the health care costs of the State.
- (5) All monies collected from taxes described in 1-1-5-1 and 1-1-5-2.
- (6) The Fund shall retain:
- i. all charitable donations, gifts, grants or bequests made to it from whatever source consistent with State and federal law;
 - ii. payments from third party payers for covered services rendered by Eligible Providers to out of State patients but paid for by the Fund;
 - iii. income from the investment of Fund assets, consistent with state and federal law.

(c) The placement of funds described in (b) (1)-(3) is conditioned on the Fund's assumption of the responsibility for all benefits and services previously paid with these funds.

(d) The Board shall obtain all necessary waivers, exemptions, agreements, or legislation so that all current federal payments for health care shall be paid directly to the Fund.

- (1) In obtaining the waivers, exemptions, agreements, or legislation, the Executive Director shall seek from the federal government a contribution for health care services in Indiana that shall not decrease in relation to the contribution to other states as a result of the waivers, exemptions, agreements, or legislation.
- (2) If, and to the extent that, federal law and regulations, waivers, exemptions, agreements, or legislation allow the transfer of Medicaid and Medicare funding into the Fund, any premiums, deductible payments, and coinsurance for qualified Medicaid and Medicare beneficiaries shall be paid by the Fund for all individuals eligible for both the Fund and federal insurance programs.
- (3) The Board shall seek to maximize all sources of federal financial support for health care services in Indiana.

1-1-5-1 Health Trust Premium Based on Payroll

(a) All employers in Indiana shall pay a tax, called a Health Trust Premium, based on their payroll, starting with the Effective Date of this Act, as determined by the Board in consultation with the Department of Revenue of the State.

(b) Any tax imposed under this Section will be based on a progressive rate, within the following limits:

- (1) The minimum rate imposed on wages and salaries shall be **5%**;
- (2) The maximum rate imposed on wages and salaries shall be **15%**; and
- (3) The total amount imposed under this Section may not exceed **13%** of total statewide wages and salaries.

(c) The Board shall determine the rates and associated pay brackets for the tax imposed under this Section at least six months prior to the start of the fiscal year for which those rates and income brackets apply.

(d) The Health Trust Premium shall be collected and administered by the Indiana Department of Revenue.

(e) Any Employer having a contract with an insurer, health services corporation, or health maintenance organization to provide health care services or benefits for its employees which was signed before and is in effect on the Effective Date of this Act shall be entitled to a credit, for the amount contributed on and after this date by that Employer to the premium paid under that contract, against an amount equal to the Health Trust Premium otherwise due pursuant to this Section.

(f) An Employer may not reduce the wages or salary of an employee to pay all or any portion of the Health Insurance Premium.

(g) Where an employer provides health insurance for employees through a fund that is financed solely by the Employer and is governed jointly by equal representation of both employees and employer, the employer may claim a tax credit, for the amount of its contribution to this employee/employer plan that was needed to cover expenditures for health and administration during the first year after the Effective Date of the Act, against the premiums otherwise to be paid to the Health Care Trust Fund pursuant to this Section.

(h) Where a tax credit against either the Health Trust Premium tax of this Section or the Health Trust Surcharge tax of Section 1-1-5-2 exceeds one of these taxes, the excess may be carried over to apply against the tax in a later period.

1-1-5-2 Health Trust Surcharge on Income

(a) Beginning with the Effective Date of this Act, every person subject to income tax shall pay an additional tax to fund the Plan, to be called the Health Trust Surcharge.

(b) The tax shall be imposed at progressive rates applied to taxpayers' adjusted gross personal income, which rates are to be determined annually by the Board in cooperation with the Indiana Department of Revenue.

(c) The following limits apply to any tax collected under this Section:

- (1) The total amount of taxes imposed under this Section may not exceed **8%** of total statewide adjusted gross personal income;
- (2) The maximum tax that may be imposed on any taxpayer may not exceed **12%** of adjusted gross personal income;
- (3) Persons with income that is equal to or less than **100%** of the federal poverty level are not subject to tax under this Section.

(4)The maximum Health Trust Surcharge tax that any taxpayer will pay will not exceed **\$25,000**.

(d) The Board shall determine the rates and associated income brackets for the tax imposed under this Section at least six months prior to the start of the calendar year for which those rates and income brackets apply.

(e) The tax imposed under this Section shall be collected and administered by the Indiana Department of Revenue in the same manner in which other personal income taxes are collected and administered.

(f) A taxpayer who has a contract with a health insurer, a health services organization, or a health maintenance organization that was entered into prior to the Effective Date of this Act is eligible for a credit, for the amount paid on and after this date for that contract during the tax year, against the Health Trust Surcharge tax otherwise due under this Section.

(g) A taxpayer is eligible for a credit against the Health Trust Surcharge tax otherwise due under this Section for the amount of money contributed by the taxpayer on and after the Effective Date of this Act as an employee pursuant to a contract entered into by the employer of the taxpayer with a health insurer, a health services organization, or a health maintenance organization prior to the Effective Date of the Act

(h)A taxpayer may claim a credit against the taxes otherwise due under this Section, if:

- (1) The taxpayer is a retired person receiving retirement benefits from a former employer of the taxpayer, or a successor of the employer; and
- (2) All or a portion of the retirement benefits consist of health care benefits arising from a contract of health insurance entered into between the employer, or successor, and a health insurance provider; and
- (3) The contract was entered into prior to the effective date of this Act.

(i) An employer may undertake to pay all or a portion of the tax imposed under this Section on the wages and salary of an employee.

(1) The tax imposed under this section shall remain a liability of the employee until paid, unless payment of the tax is an enforceable contract obligation of the employer, in which case payment of the tax is a joint and several liability of the employer and the employee.

(2) If an employer makes a payment of the tax imposed under this section, the payment is not includable in Indiana taxable income.

1-1-6-1 Benefits for Participants

(a) The Plan shall establish a single package of covered health care services and benefits that shall include, but not be limited to, all of the following:

(1) Inpatient and outpatient Provider care, both primary and secondary;

- (2) Emergency services;
- (3) Emergency and other transportation services to covered health care services;
- (4) Rehabilitation services, including speech, occupational, and physical therapy;
- (5) Inpatient and outpatient mental health services and substance abuse treatment;
- (6) Hospice care;
- (7) Prescription drugs and prescribed medical nutrition;
- (8) Vision care, aids, and equipment;
- (9) Hearing care, hearing aids, and equipment;
- (10) Diagnostic medical tests, including laboratory tests and imaging procedures;
- (11) Medical supplies and prescribed medical equipment, both durable and nondurable;
- (12) Immunizations, preventive care, health maintenance care, and screening;
- (13) Dental care;
- (14) Home health care services;
- (15) Long term care.

(b) The Plan shall provide necessary transportation in each county to covered health care services.

(c) The Plan shall not exclude or limit coverage of its participants' pre-existing conditions.

(d) Participants in the Plan are not subject to co-payments, point-of-service charges, deductibles, or any other fee or charge, and shall not be directly billed by providers for covered services.

(e) The Board shall remove or exclude procedures and treatments, the use of equipment, and prescription drugs from the Plan's benefit package that the Board finds unsafe, experimental, of no proven value, or which add no therapeutic value.

(f) The Board shall exclude coverage for any surgical, orthodontic, or other medical procedure, or prescription drug, that the medical advisory committee determines was or will be provided primarily for cosmetic purposes, unless required to correct a congenital defect, to restore or correct disfigurements resulting from injury or disease, or that is determined to be medically necessary by a qualified, licensed provider.

1-1-6-2 Participants' and Providers' Choice

(a) Participants may receive health services compensated under the Plan from any Eligible Provider of their choice.

(b) No Provider shall be compelled to offer any particular service, provided that the provider does not discriminate among patients in providing health care services.

(c) The Plan and the providers participating in the plan shall not discriminate on the basis of race, color, national origin, gender, age, religion, sexual orientation, health status, mental or physical disability, employment status, veteran status, or occupation.

1-1-6-3 Participants in the Plan

(a) People who are eligible to participate in the Plan include:

- (1) All Indiana residents;
- (2) All non-residents who:
 - (i) work an average of 20 hours or more per week in Indiana,
 - (ii) pay the applicable Health Trust Surcharge and Health Trust Premium Taxes, and
 - (iii) have complied with requirements (i) and (ii) inclusive for at least 90 days; and
- (3) All non-resident patients requiring emergency treatment for illness or injury, provided, however, that the trust shall recoup expenses for such patients wherever possible.

(b) Payment for emergency care of Indiana residents obtained out of the State shall be compensated by the Plan at prevailing rates where the emergency occurs.

(c) Payment for non-emergency care of Indiana residents obtained out of State shall be compensated according to rates and conditions established by the Executive Director.

(d) The Board may require that a resident be transported back to Indiana when prolonged treatment of an emergency condition is necessary.

(e) Visitors to Indiana shall be billed for all services received under the Plan.

(f) The Board may establish intergovernmental arrangements with other states and countries to provide reciprocal coverage for temporary visitors.

1-1-7-1 Negotiations of Reimbursement

(a) Providers shall negotiate reimbursement with the Board. Such reimbursement may be made on a fee-for-service, capitated system, or global operating budget basis.

(b) Practitioners working on a fee-for-service basis will negotiate those fees with the Board.

(1) The Board shall negotiate annually the fee schedules with appropriate professional groups of practitioners.

(2) The appropriate professional groups shall be the professional associations chosen by election of members of each health care profession.

- (c) Providers which are groups or facilities working on a global operating budget basis shall negotiate their annual global budgets with the Board to cover their anticipated services for the next year.
- (1) The budget will be based on past utilization and projected changes in factor prices and in services delivered at primary, secondary, and tertiary care levels,
 - (2) The budget will provide for operating expenses and any capital expenses that fall below a threshold set by the Board.
 - (3) The Plan will pay such expenses on the basis of global budgets approved by the Board.
- (d) Every physician or other practitioner employed by a globally budgeted facility or group shall be paid through and in a manner determined by the facility.
- (e) Each year, capitated providers will negotiate individual enrollment fees with the Board that are sufficient to provide health services to individuals choosing an integrated health delivery system.
- (1) Such a provider shall not be paid additionally on a fee-for-service basis for covered services.
 - (2) Capitated providers shall report immediately to the Board any projected operating deficits. The Board will make an adjustment if it determines that the projected deficits reflect appropriate increases in health care needs.

1-1-8-1 **Severability**

If any portion of this Act is held to be invalid, that invalidity shall not affect other portions of this initiative that can be given effect without the invalid portion, and to this end the portions of this Act are savable. Any invalid portion shall be severed from the remainder of the Act to preserve the remaining portions.

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