



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB3780

Introduced 2/18/2025, by Rep. Barbara Hernandez

SYNOPSIS AS INTRODUCED:

New Act

Creates the Illinois Universal Health Care Act. Provides that all individuals residing in the State are covered under the Illinois Health Services Program for health insurance. Sets forth the health coverage benefits that participants are entitled to under the Program. Sets forth the qualification requirements for participating health providers. Sets forth standards for provider reimbursement. Provides that it is unlawful for private health insurers to sell health insurance coverage that duplicates the coverage of the Program. Provides that investor-ownership of health delivery facilities is unlawful. Provides that the State shall establish the Illinois Health Services Trust to provide financing for the Program. Sets forth the requirements for claims billing under the Program. Provides that the Program shall include funding for long-term care services and mental health services. Provides that the Program shall establish a single prescription drug formulary and list of approved durable medical goods and supplies. Creates the Pharmaceutical and Durable Medical Goods Committee to negotiate the prices of pharmaceuticals and durable medical goods with suppliers or manufacturers on an open bid competitive basis. Sets forth provisions concerning patients' rights. Provides that the employees of the Program shall be compensated in accordance with the current pay scale for State employees and as deemed professionally appropriate by the General Assembly.

LRB104 10252 BDA 20326 b

1 AN ACT concerning health.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 1. Short title. This Act may be cited as the
5 Illinois Universal Health Care Act.

6 Section 5. Purposes. It is the purpose of this Act to
7 provide universal access to health care for all individuals
8 within the State, to promote and improve the health of all its
9 citizens, to stress the importance of good public health
10 through treatment and prevention of diseases, and to contain
11 costs to make the delivery of this care affordable. Should
12 legislation of this kind be enacted on a federal level, it is
13 the intent of this Act to become a part of a nationwide system.

14 Section 10. Definitions. In this Act:

15 "Board" means the Illinois Health Services Governing
16 Board.

17 "Program" means the Illinois Health Services Program.

18 Section 15. Eligibility; registration. All individuals
19 residing in this State are covered under the Illinois Health
20 Services Program for health insurance and shall receive a card
21 with a unique number in the mail. An individual's social

1 security number shall not be used for purposes of registration
2 under this Section. Individuals and families shall receive an
3 Illinois Health Services Insurance Card in the mail after
4 filling out a Program application form at a health care
5 provider. Such application form shall be no more than 2 pages
6 long. Individuals who present themselves for covered services
7 from a participating provider shall be presumed to be eligible
8 for benefits under this Act, but shall complete an application
9 for benefits in order to receive an Illinois Health Services
10 Insurance Card and have payment made for such benefits.

11 Section 20. Benefits and portability.

12 (a) The health coverage benefits under this Act cover all
13 medically necessary services, including:

- 14 (1) primary care and prevention;
- 15 (2) specialty care (other than what is deemed elective
16 cosmetic);
- 17 (3) inpatient care;
- 18 (4) outpatient care;
- 19 (5) emergency care;
- 20 (6) prescription drugs;
- 21 (7) durable medical equipment;
- 22 (8) long-term care;
- 23 (9) mental health services;
- 24 (10) the full scope of dental services (other than
25 elective cosmetic dentistry);

- 1 (11) substance abuse treatment services;
2 (12) chiropractic services; and
3 (13) basic vision care and vision correction.

4 (b) Health coverage benefits under this Act are available
5 through any licensed health care provider anywhere in the
6 State that is legally qualified to provide such benefits and
7 for emergency care anywhere in the United States.

8 (c) No deductibles, copayments, coinsurance, or other cost
9 sharing shall be imposed with respect to covered benefits
10 except for those goods or services that exceed basic covered
11 benefits, as defined by the Board.

12 Section 25. Qualification of participating providers.

13 (a) Health care delivery facilities must meet regional and
14 State quality and licensing guidelines as a condition of
15 participation under the Program, including guidelines
16 regarding safe staffing and quality of care.

17 (b) A participating health care provider must be licensed
18 by the State. No health care provider whose license is under
19 suspension or has been revoked may participate in the Program

20 (c) Only non-profit health maintenance organizations that
21 actually deliver care in their own facilities and directly
22 employ clinicians may participate in the Program.

23 (d) Patients shall have free choice of participating
24 eligible providers, hospitals, and inpatient care facilities.

1 Section 30. Provider reimbursement.

2 (a) The Program shall pay all health care providers
3 according to the following standards:

4 (1) Physicians and other practitioners can choose to
5 be paid fee-for-service, salaried by institutions
6 receiving global budgets, or salaried by group practices
7 or HMOs receiving capitation payments. Investor-owned HMOs
8 and group practices shall be converted to not-for-profit
9 status. Only institutions that deliver care shall be
10 eligible for Program payments.

11 (2) The Program shall pay each hospital and providing
12 institution a monthly lump sum (global budget) to cover
13 all operating expenses. The hospital and Program shall
14 negotiate the amount of this payment annually based on
15 past budgets, clinical performance, projected changes in
16 demand for services and input costs, and proposed new
17 programs. Hospitals shall not bill patients for services
18 covered by the Program, and cannot use any of their
19 operating budgets for expansion, profit, excessive
20 executive income, marketing, or major capital purchases or
21 leases.

22 (3) The Program budget shall fund major capital
23 expenditures, including the construction of new health
24 facilities and the purchase of expensive equipment. The
25 regional health planning districts shall allocate these
26 capital funds and oversee capital projects funded from

1 private donations.

2 (b) The Program shall reimburse physicians choosing to be
3 paid fee-for-service according to a fee schedule negotiated
4 between physician representatives and the Program on at least
5 an annual basis.

6 (c) Hospitals, nursing homes, community health centers,
7 non-profit staff model HMOs, and home health care agencies
8 shall receive a global budget to cover operating expenses,
9 negotiated annually with the Program based on past
10 expenditures, past budgets, clinical performance, projected
11 changes in demand for services and input costs, and proposed
12 new programs. Expansions and other substantive capital
13 investments shall be funded separately.

14 (d) All covered prescription drugs and durable medical
15 supplies shall be paid for according to a fee schedule
16 negotiated between manufacturers and the Program on at least
17 an annual basis. Price reductions shall be achieved by bulk
18 purchasing whenever possible. Where therapeutically equivalent
19 drugs are available, the formulary shall specify the use of
20 the lowest-cost medication, with exceptions available in the
21 case of medical necessity.

22 Section 35. Prohibition against duplicating coverage;
23 investor-ownership of health delivery facilities.

24 (a) It is unlawful for a private health insurer to sell
25 health insurance coverage that duplicates the benefits

1 provided under this Act. Nothing in this Act shall be
2 construed as prohibiting the sale of health insurance coverage
3 for any additional benefits not covered by this Act.

4 (b) Investor-ownership of health delivery facilities,
5 including hospitals, health maintenance organizations, nursing
6 homes, and clinics, is unlawful. Investor-owners of health
7 delivery facilities at the time of the effective date of this
8 Act shall be compensated for the loss of their facilities, but
9 not for loss of business opportunities or for administrative
10 capacity not used by the Program.

11 Section 40. Illinois Health Services Trust.

12 (a) The State shall establish the Illinois Health Services
13 Trust (IHST), the sole purpose of which shall be to provide the
14 financing reserve for the purposes outlined in this Act.
15 Specifically, the IHST shall provide all of the following:

16 (1) The funds for the general operating budget of the
17 Program.

18 (2) Reimbursement for those benefits outlined in
19 Section 20 of this Act.

20 (3) Public health services.

21 (4) Capital expenditures for construction or
22 renovation of health care facilities or major equipment
23 purchases deemed necessary throughout the State and
24 approved by the Board.

25 (5) Re-education and job placement of persons who have

1 lost their jobs as a result of this transition, limited to
2 the first 5 years.

3 (b) The General Assembly or the Governor may provide funds
4 to the IHST, but may not remove or borrow funds from the IHST.

5 (c) The IHST shall be administered by the Board, under the
6 oversight of the General Assembly.

7 (d) Funding of the IHST shall include, but is not limited
8 to, all of the following:

9 (1) Funds appropriated as outlined by the General
10 Assembly on a yearly basis.

11 (2) A progressive set of graduated income
12 contributions: 20% paid by individuals, 20% paid by a
13 business, and 60% paid by the government.

14 (3) All federal moneys that are designated for health
15 care, including, but not limited to, all moneys designated
16 for Medicaid. The Secretary shall be authorized to
17 negotiate with the federal government for funding of
18 Medicare recipients.

19 (4) Grants and contributions, both public and private.

20 (5) Any other tax revenues designated by the General
21 Assembly.

22 (6) Any other funds specifically ear-marked for health
23 care or health care education, such as settlements from
24 litigation.

25 (e) The total overhead and administrative portion of the
26 Program budget may not exceed 12% of the total operating

1 budget of the Program for the first 2 years that the Program is
2 in operation; 8% for the following 2 years; and 5% for each
3 year thereafter.

4 (f) The Program may be divided into regional districts for
5 the purposes of local administration and oversight of programs
6 that are specific to each region's needs.

7 (g) Claims billing from all providers must be submitted
8 electronically and in compliance with current State and
9 federal privacy laws within 5 years after the effective date
10 of this Act. Electronic claims and billing must be uniform
11 across the State. The Board shall create and implement a
12 statewide uniform system of electronic medical records that is
13 in compliance with current State and federal privacy laws
14 within 7 years after the effective date of this Act. Payments
15 to providers must be made in a timely fashion as outlined under
16 current State and federal law. Providers who accept payment
17 from the Program for services rendered may not bill any
18 patient for covered services. Providers may elect either to
19 participate fully, or not at all, in the Program.

20 Section 45. Long-term care payment. The Board shall
21 establish funding for long-term care services, including
22 in-home, nursing home, and community-based care. A local
23 public agency shall be established in each community to
24 determine eligibility and coordinate home and nursing home
25 long-term care. This agency may contract with long-term care

1 providers for the full range of needed long-term care
2 services.

3 Section 50. Mental health services. The Program shall
4 provide coverage for all medically necessary mental health
5 care on the same basis as the coverage for other conditions.
6 The Program shall cover supportive residences, occupational
7 therapy, and ongoing mental health and counseling services
8 outside the hospital for patients with serious mental illness.
9 In all cases the highest quality and most effective care shall
10 be delivered, including institutional care.

11 Section 55. Payment for prescription medications, medical
12 supplies, and medically necessary assistive equipment.

13 (a) The Program shall establish a single prescription drug
14 formulary and list of approved durable medical goods and
15 supplies. The Board shall, by itself or by a committee of
16 health professionals and related individuals appointed by the
17 Board and called the Pharmaceutical and Durable Medical Goods
18 Committee, meet on a quarterly basis to discuss, reverse, add
19 to, or remove items from the formulary according to sound
20 medical practice.

21 (b) The Pharmaceutical and Durable Medical Goods Committee
22 shall negotiate the prices of pharmaceuticals and durable
23 medical goods with suppliers or manufacturers on an open bid
24 competitive basis. Prices shall be reviewed, negotiated, or

1 re-negotiated on no less than an annual basis. The
2 Pharmaceutical and Durable Medical Goods Committee shall
3 establish a process of open forum to the public for the
4 purposes of grievance and petition from suppliers, provider
5 groups, and the public regarding the formulary no less than 2
6 times a year.

7 (c) All pharmacy and durable medical goods vendors must be
8 licensed to distribute medical goods through the regulations
9 outlined by the Board.

10 (d) All decisions and determinations of the Pharmacy and
11 Durable Medical Goods Committee must be presented to and
12 approved by the Board on an annual basis.

13 Section 60. Illinois Health Services Governing Board.

14 (a) The Program shall be administered by an independent
15 agency known as the Illinois Health Services Governing Board.
16 The Board will consist of a Commissioner, a Chief Medical
17 Officer, and public State board members. The Board is
18 responsible for administration of the Program, including:

19 (1) implementation of eligibility standards and
20 Program enrollment;

21 (2) adoption of the benefits package;

22 (3) establishing formulas for setting health
23 expenditure budgets;

24 (4) administration of global budgets, capital
25 expenditure budgets, and prompt reimbursement of

1 providers;

2 (5) negotiations of service fee schedules and prices
3 for prescription drugs and durable medical supplies;

4 (6) recommending evidenced-based changes to benefits;
5 and

6 (7) quality and planning functions including criteria
7 for capital expansion and infrastructure development,
8 measurement and evaluation of health quality indicators,
9 and the establishment of regions for long-term care
10 integration.

11 (b) At least one-third of the members of the Board,
12 including all committees dedicated to benefits design, health
13 planning, quality, and long-term care, shall be consumer
14 representatives.

15 Section 65. Patients' rights. The Program shall protect
16 the rights and privacy of the patients that it serves in
17 accordance with all current State and federal statutes. With
18 the development of the electronic medical records, patients
19 shall be afforded the right and option of keeping any portion
20 of their medical records separate from the electronic medical
21 records. Patients have the right to access their medical
22 records upon demand.

23 Section 70. Compensation. The Commissioner, the Chief
24 Medical Officer, public State board members, and subsequent

1 employees of the Program shall be compensated in accordance
2 with the current pay scale for State employees and as deemed
3 professionally appropriate by the General Assembly and
4 reviewed in accordance with all other State employees.