



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB2873

Introduced 1/16/2026, by Sen. Mike Simmons

SYNOPSIS AS INTRODUCED:

New Act

Creates the Health Care for All Illinois Act. Provides that all individuals residing in this State are covered under the Illinois Health Services Program for health insurance. Sets forth requirements and qualifications of participating health care providers. Sets forth the specific 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. Requires the State to establish the Illinois Health Services Trust to provide financing for the program. Sets forth the specific requirements for claims billed under the program. Provides that the program shall include funding for long-term care services and mental health services. 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. Provides that patients in the program shall have the same rights and privacy as they are entitled to under current State and federal law. Establishes the Illinois Health Services Governing Board to administer the program. Provides that the Commissioner, the Chief Medical Officer, the public board members, and 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. Effective January 1, 2027.

LRB104 17901 BAB 31337 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 Health
5 Care for All Illinois 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 Board
16 created under this Act.

17 "IHST" means the Illinois Health Services Trust created
18 under this Act.

19 "Program" means the Illinois Health Services Program
20 created under this Act.

21 Section 15. Eligibility; registration. All individuals

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

14 Section 20. Benefits and portability.

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

- 17 (1) primary care and prevention;
- 18 (2) specialty care, other than what is deemed elective
19 cosmetic;
- 20 (3) inpatient care;
- 21 (4) outpatient care;
- 22 (5) emergency care;
- 23 (6) prescription drugs;
- 24 (7) durable medical equipment;
- 25 (8) long-term care;

- 1 (9) mental health services;
- 2 (10) the full scope of dental services, other than
- 3 elective cosmetic dentistry;
- 4 (11) substance abuse treatment services;
- 5 (12) chiropractic services; and
- 6 (13) basic vision care and vision correction.

7 (b) Health coverage benefits under this Act are available

8 through any licensed health care provider anywhere in the

9 State that is legally qualified to provide such benefits and

10 for emergency care anywhere in the United States.

11 (c) No deductibles, copayments, coinsurance, or other cost

12 sharing shall be imposed with respect to covered benefits,

13 except for those goods or services that exceed basic covered

14 benefits, as defined by the Board.

15 Section 25. Qualification of participating providers.

16 (a) Health care delivery facilities must meet regional and

17 State quality and licensing guidelines as a condition of

18 participation under the program, including guidelines

19 regarding safe staffing and quality of care.

20 (b) A participating health care provider must be licensed

21 by the State. No health care provider whose license is under

22 suspension or has been revoked may participate in the program.

23 (c) Only nonprofit health maintenance organizations that

24 actually deliver care in their own facilities and directly

25 employ clinicians may participate in the program.

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

3 Section 30. Provider reimbursement.

4 (a) The program shall pay all health care providers
5 according to the following standards:

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

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

25 (3) The program budget shall fund major capital

1 expenditures, including the construction of new health
2 facilities and the purchase of expensive equipment. The
3 regional health planning districts shall allocate these
4 capital funds and oversee capital projects funded from
5 private donations.

6 (b) The program shall reimburse physicians choosing to be
7 paid fee-for-service according to a fee schedule negotiated
8 between physician representatives and the program on at least
9 an annual basis.

10 (c) Hospitals, nursing homes, community health centers,
11 nonprofit staff model health maintenance organizations, and
12 home health care agencies shall receive a global budget to
13 cover operating expenses, negotiated annually with the program
14 based on past expenditures, past budgets, clinical
15 performance, projected changes in demand for services and
16 input costs, and proposed new programs. Expansions and other
17 substantive capital investments shall be funded separately.

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

1 Section 35. Prohibition against duplicating coverage;
2 investor-ownership of health delivery facilities.

3 (a) It is unlawful for a private health insurer to sell
4 health insurance coverage that duplicates the benefits
5 provided under this Act. Nothing in this Act shall be
6 construed as prohibiting the sale of health insurance coverage
7 for any additional benefits not covered by this Act.

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

15 Section 40. Illinois Health Services Trust.

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

20 (1) The funds for the general operating budget of the
21 program.

22 (2) Reimbursement for those benefits outlined in
23 Section 20 of this Act.

24 (3) Public health services.

25 (4) Capital expenditures for construction or

1 renovation of health care facilities or major equipment
2 purchases deemed necessary throughout the State and
3 approved by the Board.

4 (5) Re-education and job placement of persons who have
5 lost their jobs as a result of this transition, limited to
6 the first 5 years after the effective date of this Act.

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

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

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

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

15 (2) A progressive set of graduated income
16 contributions; 20% paid by individuals, 20% paid by
17 businesses, and 60% paid by the government.

18 (3) All federal moneys that are designated for health
19 care, including, but not limited to, all moneys designated
20 for Medicaid. The Secretary of Human Services shall be
21 authorized to negotiate with the federal government for
22 funding of Medicare recipients.

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

24 (5) Any other tax revenues designated by the General
25 Assembly.

26 (6) Any other funds specifically earmarked for health

1 care or health care education, such as settlements from
2 litigation.

3 (e) The total overhead and administrative portion of the
4 program budget may not exceed 12% of the total operating
5 budget of the program for the first 2 years that the program is
6 in operation; 8% for the following 2 years; and 5% for each
7 year thereafter.

8 (f) The program may be divided into regional districts for
9 the purposes of local administration and oversight of programs
10 that are specific to each region's needs.

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

24 Section 45. Long-term care payment. The Board shall
25 establish funding for long-term care services, including

1 in-home, nursing home, and community-based care. A local
2 public agency shall be established in each community to
3 determine eligibility and coordinate home and nursing home
4 long-term care. This agency may contract with long-term care
5 providers for the full range of needed long-term care
6 services.

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

15 Section 55. Payment for prescription medications, medical
16 supplies, and medically necessary assistive equipment.

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

1 (b) The Pharmaceutical and Durable Medical Goods Committee
2 shall negotiate the prices of pharmaceuticals and durable
3 medical goods with suppliers or manufacturers on an open bid
4 competitive basis. Prices shall be reviewed, negotiated, or
5 renegotiated on no less than an annual basis. The
6 Pharmaceutical and Durable Medical Goods Committee shall
7 establish a process of open forum to the public for the
8 purposes of grievance and petition from suppliers, provider
9 groups, and the public regarding the formulary no less than 2
10 times a year.

11 (c) All pharmacy and durable medical goods vendors must be
12 licensed to distribute medical goods through the regulations
13 outlined by the Board.

14 (d) All decisions and determinations of the Pharmaceutical
15 and Durable Medical Goods Committee must be presented to and
16 approved by the Board on an annual basis.

17 Section 60. Illinois Health Services Governing Board.

18 (a) The program shall be administered by an independent
19 agency known as the Illinois Health Services Governing Board.
20 The Board shall consist of a Commissioner, a Chief Medical
21 Officer, and 15 other public board members as follows:

22 (1) five members appointed by the Governor, two being
23 consumer representatives, one being the Commissioner of
24 the Board, and one being the Chief Medical Officer;

25 (2) five members appointed by the Lieutenant Governor,

1 two of which shall be consumer representatives;

2 (3) five members elected in statewide elections by the
3 People of Illinois, one of which shall be a consumer
4 representative;

5 (4) one member appointed by the Speaker of the House;
6 and

7 (5) one member appointed by the President of the
8 Senate.

9 (b) The Board is responsible for administration of the
10 program, including:

11 (1) implementation of eligibility standards and
12 program enrollment;

13 (2) adoption of the benefits package;

14 (3) establishing formulas for setting health
15 expenditure budgets;

16 (4) administration of global budgets, capital
17 expenditure budgets, and prompt reimbursement of
18 providers;

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

21 (6) recommending evidence-based changes to benefits;
22 and

23 (7) quality and planning functions, including criteria
24 for capital expansion and infrastructure development,
25 measurement and evaluation of health quality indicators,
26 and the establishment of regions for long-term care

1 integration.

2 Section 65. Patients' rights. The program shall protect
3 the rights and privacy of the patients that it serves in
4 accordance with all current State and federal statutes. With
5 the development of the electronic medical records, patients
6 shall be afforded the right and option of keeping any portion
7 of their medical records separate from the electronic medical
8 records. Patients have the right to access their medical
9 records upon demand.

10 Section 70. Compensation. The Commissioner, the Chief
11 Medical Officer, public board members, and employees of the
12 program shall be compensated in accordance with the current
13 pay scale for State employees and as deemed professionally
14 appropriate by the General Assembly and reviewed in accordance
15 with all other State employees.

16 Section 99. Effective date. This Act takes effect January
17 1, 2027.