



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB5111

Introduced 2/10/2026, by Rep. Kam Buckner

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5H-1
305 ILCS 5/5H-3
305 ILCS 5/5H-7

Amends the Managed Care Organization Provider Assessment Article of the Illinois Public Aid Code. In provisions concerning tiered managed care assessment rates, provides that beginning July 1, 2026, the Department of Healthcare and Family Services may implement a tax that is based on uniform rates, determined at a level not to exceed limitations imposed by the federal Centers for Medicare and Medicaid Services, that may be set at either a percentage of premium revenue or on a per member per month basis. Removes a provision requiring any upward adjustment to the Tier 3 rate to be the minimum necessary to meet federal statistical tests. In the definition of "member months", removes language exempting enrollment in a Limited Health Services Organization, a Medicare Supplement Plan, or a Federal Employee Health Benefits Plan from the calculation of member months. Expands the definition of "managed care organization" to include an entity that operates as a preferred provider organization. Effective July 1, 2026.

LRB104 20230 KTG 33681 b

1 AN ACT concerning public aid.

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

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Sections 5H-1, 5H-3, and 5H-7 as follows:

6 (305 ILCS 5/5H-1)

7 Sec. 5H-1. Definitions. As used in this Article:

8 "Base year" means the 12-month period from January 1, 2023
9 to December 31, 2023.

10 "Department" means the Department of Healthcare and Family
11 Services.

12 "Federal employee health benefit" means the program of
13 health benefits plans, as defined in 5 U.S.C. 8901, available
14 to federal employees under 5 U.S.C. 8901 to 8914.

15 "Fund" means the Healthcare Provider Relief Fund.

16 "Managed care organization" means an entity operating
17 under a certificate of authority issued pursuant to the Health
18 Maintenance Organization Act or as a Managed Care Community
19 Network pursuant to Section 5-11 of this Code, or as a
20 preferred provider organization.

21 "Medicaid managed care organization" means a managed care
22 organization under contract with the Department to provide
23 services to recipients of benefits in the medical assistance

1 program pursuant to Article V of this Code, the Children's
2 Health Insurance Program Act, or the Covering ALL KIDS Health
3 Insurance Act. It does not include contracts the same entity
4 or an affiliated entity has for other business.

5 "Medicare" means the federal Medicare program established
6 under Title XVIII of the federal Social Security Act.

7 "Member months" means the aggregate total number of months
8 all individuals are enrolled for coverage in a Managed Care
9 Organization during the base year. Member months are
10 determined by the Department for Medicaid Managed Care
11 Organizations based on enrollment data in its Medicaid
12 Management Information System and by the Department of
13 Insurance for other Managed Care Organizations based on
14 required filings with the Department of Insurance. Member
15 months do not include months individuals are enrolled in ~~a~~
16 ~~Limited Health Services Organization, including stand alone~~
17 ~~dental or vision plans, a Medicare Advantage Plan, a Medicare~~
18 ~~Supplement Plan, or a Federal Employee Health Benefits Plan.~~

19 (Source: P.A. 103-593, eff. 6-7-24; 104-2, eff. 6-16-25.)

20 (305 ILCS 5/5H-3)

21 Sec. 5H-3. Managed care assessment.

22 (a) There is imposed upon managed care organization member
23 months an assessment, calculated on base year data, as set
24 forth below for the appropriate tier:

25 (1) Tier 1: \$78.90 per member month.

1 (2) Tier 2: \$1.40 per member month.

2 (3) Tier 3: \$2.40 per member month.

3 (b) The tiers are established as follows:

4 (1) Tier 1 includes the first 4,195,000 member months
5 in a Medicaid managed care organization for the base year;

6 (2) Tier 2 includes member months over 4,195,000 in a
7 Medicaid managed care organization during the base year;
8 and

9 (3) Tier 3 includes member months during the base year
10 in a managed care organization that is not a Medicaid
11 managed care organization.

12 (c) For State fiscal year 2020, and for each State fiscal
13 year thereafter, the Department may adjust rates or tier
14 parameters or both in order to maximize the revenue generated
15 by the assessment consistent with federal regulations and to
16 meet federal statistical tests necessary for federal financial
17 participation. Beginning July 1, 2026, the Department may
18 implement a tax that is based on uniform rates, determined at a
19 level not to exceed limitations imposed by the federal Centers
20 for Medicare and Medicaid Services, that may be set at either a
21 percentage of premium revenue or on a per member per month
22 basis. Any upward adjustment to the Tier 3 rate shall be the
23 minimum necessary to meet federal statistical tests.

24 (Source: P.A. 103-593, eff. 6-7-24.)

25 (305 ILCS 5/5H-7)

1 Sec. 5H-7. Rulemaking. The Department may by rule modify
2 or make adjustments to any methodology, assessment amount,
3 assessment tier, or other similar provision specified in this
4 Article, including broadening the tax base in subsection (a)
5 of Section 5H-3, to the extent necessary to meet the
6 requirements of federal law or regulations, obtain federal
7 approval, or to ensure federal financial participation is
8 available. ~~However, upward adjustments to Tier 3 rates shall~~
9 ~~be the minimum necessary to meet federal statistical tests to~~
10 ~~receive federal financial participation.~~ The Department shall
11 adopt rules to implement this Article under the Illinois
12 Administrative Procedure Act.

13 (Source: P.A. 101-9, eff. 6-5-19.)

14 Section 99. Effective date. This Act takes effect July 1,
15 2026.