HB5517

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103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB5517

Introduced 2/9/2024, by Rep. Jenn Ladisch Douglass

SYNOPSIS AS INTRODUCED:

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Creates the Protection Against Unnecessary Health Care Costs Act. Requires the State Comptroller to establish the Drug Discount Card Program to be made available for all residents of this State. Requires the Department of Insurance to report to the General Assembly and to the Governor recommendations for establishing an outreach and education program to inform licensed physicians on when a drug patent will expire and become available in generic form, and when generic alternatives exist for drugs whose patent recently expired. Provides that on and after October 1, 2025, a pharmaceutical manufacturer that employs an individual to perform the duties of a pharmaceutical sales representative shall register annually with the Department of Financial and Professional Regulation as a pharmaceutical marketing firm. Provides that each pharmaceutical marketing firm shall provide to the Department a list of all individuals employed by the pharmaceutical marketing firm as a pharmaceutical sales representative. Sets forth provisions concerning registration; registration fees; discipline of pharmaceutical marketing firms; the Department posting a list of all individuals employed by the pharmaceutical marketing firm as a pharmaceutical sales representative; and reports by pharmaceutical marketing firms to the Department. Requires the Department of Public Health to report to the General Assembly and the Governor, an analysis of pharmacy benefit managers' practices of prescription drug distribution. Requires the Department of Public Health to prepare a list of not more than 10 outpatient prescription drugs that the Director of Public Health, in the Director's discretion, determines are provided at substantial cost to the State or critical to public health. Requires the pharmaceutical manufacturer of an outpatient prescription drug included on that list to provide specified information to the Department of Public Health. Sets forth provisions concerning hearings; violations of the Act by health care facilities; civil penalties; and a report of the utilization management and provider payment practices of Medicare Advantage plans. Makes other changes. Amends the Illinois Health Facilities Planning Act. Requires a health care facility to post notice of its intent to file an application for a certificate of need. Effective immediately.

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A BILL FOR

AN ACT concerning regulation.

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

Section 1. Short title. This Act may be cited as the Protection Against Unnecessary Health Care Costs Act.

Section 5. Drug Discount Card Program.

(a) In this Section, "volume discount contracting" means a negotiated purchase of a prescription drug in a large quantity for a decreased cost.

(b) The State Comptroller shall establish the Drug Discount Card Program to be made available for all residents of this State. To further the purpose of the program, the State Comptroller may cooperate with other states and territories of the United States, or regional consortia to pool prescription drug purchasing power to (1) lower prescription drug costs, (2) negotiate discounts with prescription drug manufacturers, (3) centralize the purchasing of prescription drugs, and (4) establish volume discount contracting.

(c) The State Comptroller shall study the feasibility of centralizing statewide contracts to consolidate the purchasing of prescription and physician-administered drugs by State agencies, State hospitals, State-operated community mental health centers, and other public entities, as necessary. The

study shall include an evaluation of (1) the potential cost savings, administrative feasibility, and other benefits and risks of centralizing and consolidating contracts, and (2) any additional staff and resources required by the State Comptroller to centrally procure and administer those contracts. Not later than November 1, 2026, each State agency, State hospital, community mental health center, and other public entity, as necessary, that procures prescription or physician-administered drugs shall provide information regarding the types, amount, and cost of those drugs to the State Comptroller, in a form and manner prescribed by the State Comptroller. Not later than February 1, 2027, the State Comptroller shall submit a report regarding the findings of the study to the Governor and the General Assembly.

Section 10. Physician outreach and education on drug patents. Not later than January 1, 2026, the Department of Insurance, in consultation with the Consumer Protection Division of the Office of the Attorney General, shall report to the General Assembly and to the Governor recommendations for establishing an outreach and education program to inform licensed physicians on: (1) when a drug patent will expire and become available in generic form; and (2) when generic alternatives exist for drugs whose patent recently expired.

Section 15. Definitions. For the purposes of this Section

through the Section immediately preceding Section 35:

"Contact" means any communication to promote or provide information relating to a legend drug that is transmitted in person or by telephone, email, text message, or other electronic means between a pharmaceutical representative and a prescribing practitioner or pharmacist.

"Department" means the Department of Financial and Professional Regulation.

"Legend drug" has the meaning given to that term in Section 3.23 of the Illinois Food, Drug and Cosmetic Act.

"Pharmaceutical manufacturer" means: (1) a person, whether within or outside the boundaries of the State, that produces, prepares, cultivates, grows, propagates, compounds, converts, or processes a drug, device, or cosmetic, directly or indirectly, by extraction from substances of natural origin, by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or that packages, repackages, labels, or relabels a container under the manufacturer's own trademark or label or any other trademark or label, or a drug, device, or cosmetic for the purpose of selling the drug, device, or cosmetic, or (2) a sterile compounding pharmacy.

"Pharmaceutical manufacturer" includes a virtual manufacturer.

"Pharmaceutical marketing firm" means a pharmaceutical manufacturer that employs pharmaceutical representatives.

"Pharmaceutical representative" means any person, including, but not limited to, a sales representative, who markets, promotes, or provides information regarding a legend drug for human use to a prescribing practitioner and is employed or compensated by a pharmaceutical manufacturer.

"Pharmacist" means an individual licensed to engage in the practice of pharmacy under the Pharmacy Practice Act or licensed to engage in the practice of pharmacy in another state.

"Prescribing practitioner" means an individual authorized by law to prescribe the usage of certain drugs for medical purposes.

"Secretary" means the Secretary of Financial and Professional Regulation.

"Tagline" means a short statement written in a non-English language that indicates the availability of language assistance services free of charge.

Section 20. Pharmaceutical marketing firm registration.

(a) On and after October 1, 2025, a pharmaceutical manufacturer that employs an individual to perform the duties of a pharmaceutical sales representative shall register annually with the Department of Financial and Professional Regulation as a pharmaceutical marketing firm, in a form and manner prescribed by the Department. No pharmaceutical manufacturer shall authorize an individual to perform such

duties on the manufacturer's behalf unless the manufacturer has obtained a registration from the Department pursuant to this Section. Registrations issued pursuant to this Section shall expire annually on June 30.

(b) The nonrefundable fee for registration as a pharmaceutical marketing firm and for annual renewal of that registration is $150. Any pharmaceutical marketing firm that fails to renew its registration on or before June 30 shall pay a late fee of $100 for each year that the pharmaceutical marketing firm did not renew, in addition to the annual renewal fee required under this Section.

(c) On the date of its initial registration, and annually thereafter, each pharmaceutical marketing firm shall provide to the Department a list of all individuals employed by the pharmaceutical marketing firm as a pharmaceutical sales representative. Each pharmaceutical marketing firm shall notify the Department, in a form and manner prescribed by the Department, of each individual who is no longer employed as a pharmaceutical sales representative or who was hired after the date on which the pharmaceutical marketing firm provided the annual list, not later than 2 weeks after the individual left employment or was hired.

(d) The Department shall prominently post on its website the most recent list provided by each pharmaceutical marketing firm pursuant to subsection (c) of this Section.

(e) Any person who is not identified to the Department

pursuant to subsection (c) of this Section shall not perform the duties of a pharmaceutical sales representative on behalf of the pharmaceutical marketing firm for any prescribing practitioner in this State.

(f) Not later than July 1, 2025, and annually thereafter, each pharmaceutical marketing firm shall provide the Secretary with the following information regarding the performance for the previous calendar year of each of its pharmaceutical sales representatives identified to the Department pursuant to subsection (c) of this Section at any time during the previous calendar year, in a form and manner prescribed by the Department:

(1) the aggregate number of contacts the pharmaceutical sales representative had with prescribing practitioners and pharmacists;

(2) the specialty of each prescribing practitioner and pharmacist with whom the pharmaceutical sales representative made contact;

(3) whether product samples, materials, or gifts of any value were provided to a prescribing practitioner or the practitioner's staff in a prescribing practitioner's office or to a pharmacist; and

(4) an aggregate report of all free samples, by drug name and strength, in a form and manner prescribed by the Department.

(g) The Department shall annually analyze the information

submitted pursuant to this Section and compile a report on the activities and pharmaceutical representatives in the State. Not later than December 1, 2026, and annually thereafter, the Department shall post the report on its website and submit the report to the Governor and the General Assembly.

Section 25. Legend drug marketing. Each pharmaceutical representative engaged in legend drug marketing in this State shall disclose, in writing, to a prescribing practitioner or pharmacist, at the time of each contact with the prescribing practitioner or pharmacist, the following:

(1) the list price of a legend drug when the pharmaceutical representative provides information concerning the legend drug to the prescribing practitioner or pharmacist based on the dose and quantity of the legend drug as described in the medication package insert; and

(2) information on the variation efficacy of the legend drug marketed to different racial and ethnic groups, if that information is available.

Section 30. Discipline of pharmaceutical marketing firms.

(a) The Department may: (1) refuse to authorize the issuance or renewal of a registration to operate as a pharmaceutical marketing firm; (2) revoke, suspend, or place conditions on a registration to operate as a pharmaceutical marketing firm; and (3) assess a penalty of up to $1,000 for

each violation of any provision of Section 20 or 25, or take other action permitted by law, if the applicant or holder of the registration fails to comply with the requirements set forth in Section 20 or 25.

(b) The Department may adopt rules as necessary to implement this Section.

Section 35. Report of pharmacy benefit managers' practices. Not later than January 1, 2026, the Department of Public Health, in consultation with the Department of Insurance, shall report to the General Assembly and the Governor, its analysis of pharmacy benefit managers' practices of prescription drug distribution, including, but not limited to, spread pricing arrangements, manufacturing rebates and transparency, fees charged, financial incentives for adding drugs to health plan formularies and an evaluation of prescription drug distribution practices conducted by pharmacy benefit managers in other states. The report shall provide recommendations (1) to reduce prescription drug costs for consumers, and (2) for the regulation of pharmacy benefit managers in this State.

Section 40. List of outpatient prescription drugs.

(a) On or before January 1, 2025, and annually thereafter, the Director of Public Health, in consultation with the State Comptroller and the Department of Insurance, shall prepare a

list of not more than 10 outpatient prescription drugs that the Director of Public Health, in the Director of Public Health's discretion, determines are (A) provided at substantial cost to the State, considering the net cost of such drugs, or (B) critical to public health. The list shall include outpatient prescription drugs from different therapeutic classes of outpatient prescription drugs and not less than one generic outpatient prescription drug.

(b) Prior to publishing the annual list pursuant to subsection (a) of this Section, the Director of Public Health shall prepare a preliminary list that includes outpatient prescription drugs that the Director of Public Health plans to include on the annual list. The Director of Public Health shall make the preliminary list available for public comment for not less than 30 days. During the public comment period, any manufacturer of an outpatient prescription drug included on the preliminary list may produce documentation, as permitted by federal law, to the Director of Public Health to establish that the wholesale acquisition cost of such drug, less all rebates paid to the State for that outpatient prescription drug during the immediately preceding calendar year, does not exceed the limits established in subsection (c) of this Section. If the documentation establishes, to the satisfaction of the Director of Public Health, that the wholesale acquisition cost of the drug, less all rebates paid to the State for that drug during the immediately preceding

calendar year, does not exceed the limits established in subsection (c) of this Section, the Director of Public Health shall, not later than 15 days after the closing of public comment, remove that drug from the preliminary list before publishing the annual list pursuant to subsection (a) of this Section.

(c) The Director of Public Health shall not list any outpatient prescription drugs under subsection (a) or (b) of this Section unless the wholesale acquisition cost of that outpatient prescription drug (A) increased by not less than 16% cumulatively during the immediately preceding 2 calendar years, and (B) was not less than $40 for a course of treatment.

(d)(1) The pharmaceutical manufacturer of an outpatient prescription drug included on a list prepared by the Director of Public Health pursuant to subsection (a) of this Section shall provide to the Department of Public Health, in a form and manner specified by the Director of Public Health, (i) a written, narrative description, suitable for public release, of all factors that caused the increase in the wholesale acquisition cost of the listed outpatient prescription drug, and (ii) aggregate, company-level research and development costs and such other capital expenditures that the Director of Public Health, in the Director of Public Health's discretion, deems relevant for the most recent year for which final audited data are available.

(2) The quality and types of information and data that a

pharmaceutical manufacturer submits to the office under this subsection shall be consistent with the quality and types of information and data that the pharmaceutical manufacturer includes in (i) the pharmaceutical manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K, or (ii) any other public disclosure.

(e) The Department of Public Health shall establish a standardized form for reporting information and data pursuant to this Section after consulting with pharmaceutical manufacturers. The form shall be designed to minimize the administrative burden and cost of reporting on the office and pharmaceutical manufacturers.

Section 45. Hospital facility fees.

(a) As used in this Section:

"Affiliated provider" means a provider that is: (1) employed by a hospital or health system; (2) under a professional services agreement with a hospital or health system that permits the hospital or health system to bill on behalf of such provider; or (3) a clinical faculty member of a medical school that is affiliated with a hospital or health system in a manner that permits the hospital or health system to bill on behalf of the clinical faculty member.

"Campus" means: (1) the physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are

located within 250 yards of the main buildings; or (2) any other area that has been determined on an individual case basis by the Department of Public Health, the Department of Human Services, or other State agency to be a part of a hospital's campus.

"Facility fee" means any fee charged or billed by a hospital or health system for outpatient services provided in a hospital-based facility that is: (1) intended to compensate the hospital or health system for the operational expenses of the hospital or health system; and (2) separate and distinct from a professional fee.

"Health care provider" means an individual, entity, corporation, person or organization, whether for-profit or not-for-profit, that furnishes bills or is paid for health care service delivery in the normal course of business, including, but not limited to, a health system, a hospital, a hospital-based facility, a freestanding emergency department and an urgent care center.

"Health system" means: (1) a parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership, or other means; or (2) a hospital and any entity affiliated with the hospital through ownership, governance, membership, or other means.

"Hospital" means an institution, place, building, or agency located in this State that is licensed as a general

acute hospital by the Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

"Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided.

"Medicaid" means the federal medical assistance program established under Title XIX of the Social Security Act.

"Observation" means services furnished by a hospital on the hospital's campus, regardless of the length of stay, including use of a bed and periodic monitoring by the hospital's nursing or other staff to evaluate an outpatient's condition or determine the need for admission to the hospital as an inpatient.

"Payer mix" means the proportion of different sources of payment received by a hospital or health system, including, but not limited to, Medicare, Medicaid, other government-provided insurance, private insurance, and self-pay patients.

"Professional fee" means any fee charged or billed by a provider for professional medical services provided in a hospital-based facility.

"Provider" means an individual, entity, corporation, or health care provider, whether for profit or not-for-profit, whose primary purpose is to provide professional medical

services.

(b) If a hospital or health system charges a facility fee using a current procedural terminology evaluation (CPT E/M) code or assessment and management (CPT A/M) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) that the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that is in addition to and separate from the professional fee charged by the provider;

(2)(A) the amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the

patient, (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility, and (D) a telephone number the patient may call for additional information regarding the patient's potential financial liability, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services; and

(3) that a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(c) If a hospital or health system charges a facility fee without using a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility, located outside of the hospital campus, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) that the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that may be in addition to and separate from the professional fee charged by a provider:

(2)(A) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, (B) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility was not hospital-based, and (C) a telephone number the patient may call for additional information regarding the patient's potential financial liability, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services; and

(3) that a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(d) Each initial billing statement that includes a facility fee shall: (1) clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider; (2) provide the corresponding Medicare facility fee reimbursement rate for the same service as a comparison or, if there is no corresponding Medicare facility fee for such service, (A) the approximate amount Medicare would have paid the hospital for the facility fee on the billing statement, or (B) the percentage of the hospital's charges that Medicare would have paid the hospital

for the facility fee; (3) include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses; (4) inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and (5) include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction without regard to whether such patient qualifies for, or is likely to be granted, any reduction. Not later than January 1, 2025, and annually thereafter, each hospital, health system, and hospital-based facility shall submit to the Department of Public Health a sample of a billing statement issued by the hospital, health system, or hospital-based facility that complies with this subsection and that represents the format of billing statements received by patients. The billing statement shall not contain patient identifying information.

(e) The written notice described in subsections (b), (c), (d), (h), (i), and (j) of this Section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges. On and after January 1, 2025, the written notices shall include taglines in at least the top 15 languages spoken in the State indicating that the notice is available in each of those languages.

(f)(1) For nonemergency care, if a patient's appointment is scheduled to occur 10 or more days after the appointment is made, written notice shall be sent to the patient by first-class mail, encrypted email, or a secure patient Internet portal not less than 3 days after the appointment is made. If an appointment is scheduled to occur less than 10 days after the appointment is made or if the patient arrives without an appointment, notice shall be hand-delivered to the patient when the patient arrives at the hospital-based facility.

(2) For emergency care, written notice shall be provided to the patient as soon as practicable after the patient is stabilized in accordance with the federal Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd, or is determined not to have an emergency medical condition and before the patient leaves the hospital-based facility. If the patient is unconscious, under great duress, or for any other reason unable to read the notice and understand and act on the patient's rights, the notice shall be provided to the patient's representative as soon as practicable.

(g) Subsections (b), (c), (d), (e), (f), and (l) of this Section do not apply if a patient is insured by Medicare or Medicaid.

(h) A hospital-based facility shall prominently display written notice in locations that are readily accessible to and visible by patients, including patient waiting or appointment

check-in areas, stating: (1) that the hospital-based facility is part of a hospital or health system; (2) the name of the hospital or health system; and (3) that if the hospital-based facility charges a facility fee, the patient may incur a financial liability greater than the patient would incur if the hospital-based facility was not hospital-based. On and after January 1, 2025, such notices shall include tag lines in at least the top 15 languages spoken in the State indicating that the notice is available in each of those top 15 languages. Not later than January 1, 2025, and annually thereafter, each hospital-based facility shall submit a copy of the written notice required by this subsection to the Department of Public Health.

(i) A hospital-based facility shall clearly hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage, marketing materials, websites, and stationery.

(j) A hospital-based facility shall, when scheduling services for which a facility fee may be charged, inform the patient: (1) that the hospital-based facility is part of a hospital or health system; (2) of the name of the hospital or health system; (3) that the hospital or health system may charge a facility fee in addition to and separate from the professional fee charged by the provider; and (4) of the telephone number the patient may call for additional

information regarding such patient's potential financial liability.

(k)(1) If any business transaction results in the establishment of a hospital-based facility at which facility fees may be billed, where such a hospital-based facility did not previously exist, the purchaser in such transaction shall, not later than 30 days after such transaction, provide written notice, by first-class mail, of the transaction to each patient served within the 3 years preceding the date of the transaction by the health care facility that has been purchased as part of the transaction.

(2) Such notice shall include the following information:

(A) A statement that the health care facility is now a hospital-based facility and is part of a hospital or health system, the health care facility's full legal and business name and the date of such facility's acquisition by a hospital or health system.

(B) The name, business address, and phone number of the hospital or health system that is the purchaser of the health care facility.

(C) A statement that the hospital-based facility bills, or is likely to bill, patients a facility fee that may be in addition to, and separate from, any professional fee billed by a health care provider at the hospital-based facility.

(D) A statement that the patient's actual financial

liability will depend on the professional medical services actually provided to the patient, and an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility.

(E) The estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility fee billed at the hospital-based facility for the most common services provided at the hospital-based facility.

(F) A statement that, prior to seeking services at the hospital-based facility, a patient covered by a health insurance policy should contact the patient's health insurer for additional information regarding the hospital-based facility fees, including the patient's potential and financial liability, if any, for those hospital-based facility fees.

(3) A copy of the written notice provided to patients in accordance with this subsection shall be filed with the Department of Insurance. A link to copies of these written notices shall be conspicuously available on the Department's website.

(4) A hospital, health system or hospital-based facility shall not collect a facility fee for services provided at a hospital-based facility that is subject to this subsection from the date of transaction until at least 30 days after the

written notice required pursuant to this subsection is mailed to the patient or a copy of such notice is filed with the Department of Public Health, whichever is later. A violation of this subsection is a deceptive business practice under the Consumer Fraud and Deceptive Business Practices Act.

(5) Not later than July 1, 2025, and annually thereafter, each hospital-based facility that was the subject of a transaction, as described in paragraph (1) of this subsection, during the preceding calendar year shall report to the Department of Insurance the number of patients served by the hospital-based facility in the preceding 3 years.

(l)(1) Notwithstanding any other provision of this Section, no hospital, health system, or hospital-based facility shall collect a facility fee for (A) outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) code or assessment and management (CPT A/M) code and are provided at a hospital-based facility located off-site from a hospital campus, or (B) outpatient health care services provided at a hospital-based facility located off-site from a hospital campus received by a patient who is uninsured of more than the Medicare rate.

(2) Notwithstanding any other provision of this Section, on and after July 1, 2025, no hospital or health system shall collect a facility fee for outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) code or assessment and management (CPT

A/M) code and are provided on the hospital campus. The provisions of this paragraph do not apply to (A) an emergency department located on a hospital campus, or (B) observation stays on a hospital campus and (CPT E/M) and (CPT A/M) codes when billed for the following services: (i) wound care, (ii) orthopedics, (iii) anticoagulation, (iv) oncology, (v) obstetrics, and (vi) solid organ transplant.

(3) Notwithstanding the provisions of paragraphs (1) and (2) of this subsection, in circumstances when an insurance contract that was in effect on or after July 1, 2025, provides reimbursement for facility fees prohibited under the provisions of paragraph (1) of this subsection, and in circumstances when an insurance contract that is in effect on July 1, 2025, provides reimbursement for facility fees prohibited under the provisions of paragraph (2) of this subsection, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the applicable date of expiration, renewal, or amendment of such contract, whichever date is earliest.

(4) The provisions of this subsection do not apply to a freestanding emergency department. As used in this paragraph, "freestanding emergency department" means a freestanding facility that (A) is structurally separate and distinct from a hospital, (B) provides emergency care, (C) is a department of a hospital licensed under Hospital Licensing Act, and (D) has

been issued a certificate of need to operate as a freestanding emergency department by the Health Facilities and Services Review Board by showing the need for such a department in the geographic area where the facility is situated.

(5)(A) On and after July 1, 2025, if the Director of Public Health receives information and has a reasonable belief, after evaluating such information, that any hospital, health system, or hospital-based facility charged facility fees, other than through isolated clerical or electronic billing errors, in violation of any provision of this Section, or rule adopted thereunder, such hospital, health system, or hospital-based facility shall be subject to a civil penalty of up to $1,000. The Director of Public Health may issue a notice of violation and civil penalty by first-class mail or personal service. Such notice shall include: (i) a reference to the Section of the statutes, rule, or Section of the rules alleged to have been violated; (ii) a short and plain language statement of the matters asserted or charged; (iii) a description of the activity to cease; (iv) a statement of the amount of the civil penalty or penalties that may be imposed; (v) a statement concerning the right to a hearing; and (vi) a statement that the hospital, health system, or hospital-based facility may, not later than 10 business days after receipt of the notice, make a request for a hearing on the matters asserted.

(B) The hospital, health system, or hospital-based facility to whom notice is provided pursuant to subparagraph

(A) of this paragraph (5) may, not later than 10 business days after receipt of such notice, make written application to the Department of Public Health to request a hearing to demonstrate that such violation did not occur. The failure to make a timely request for a hearing shall result in the issuance of a cease and desist order or civil penalty. All hearings held under this subsection shall be conducted in accordance with Illinois Administrative Procedure Act.

(C) Following any hearing pursuant to this paragraph, if the Department of Public Health finds, by a preponderance of the evidence, that the hospital, health system, or hospital-based facility violated or is violating any provision of this subsection, any rule adopted thereunder, or any order issued by the Department of Public Health, the Department of Public Health shall issue a final cease and desist order in addition to any civil penalty the Department of Public Health imposes.

(m)(1) Each hospital and health system shall report not later than November 1, 2025, and thereafter not later than July 1, 2026, and annually thereafter, to the Director of Public Health, on a form prescribed by the Department of Public Health, concerning facility fees charged or billed during the preceding calendar year. The report shall include, but need not be limited to: (A) the name and address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or

billed, and an indication as to whether each facility is located on or outside of the hospital or health system campus; (B) the number of patient visits at each such facility for which a facility fee was charged or billed; (C) the number, total amount, and range of allowable facility fees paid at each such facility disaggregated by payer mix; (D) for each facility, the total amount of facility fees charged and the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of facility fees charged and the total amount of revenue received by the hospital or health system from all facilities derived from facility fees; (F) a description of the 10 procedures or services that generated the greatest amount of facility fee gross revenue, disaggregated by current procedural terminology category (CPT) code for each such procedure or service and, for each such procedure or service, patient volume and the total amount of gross and net revenue received by the hospital or health system derived from facility fees, disaggregated by on-campus and off-campus; and (G) the top 10 procedures or services for which facility fees are charged based on patient volume and the gross and net revenue received by the hospital or health system for each such procedure or service, disaggregated by on-campus and off-campus. For purposes of this subsection, "facility" means a hospital-based facility that is located on a hospital campus or outside a hospital campus.

(2) The Department of Public Health shall publish the information reported pursuant to paragraph (1) of this subsection or post a link to such information on the Department of Public Health's website.

Section 50. Hearings.

(a) The Director of Public Health, or any agent authorized by the Director of Public Health to conduct any inquiry, investigation, or hearing under this Act, has the power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the Department of Public Health, the Director of Public Health, or an agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers, and documents pertinent to the inquiry. If any person disobeys the process or refuses to answer any pertinent question put to that person by the Director of Public Health or the Director of Public Health's authorized agent or to produce any records and papers so requested, the Director of Public Health or Director of Public Health's authorized agent may apply to the Circuit Court for the district wherein such person resides or where the business has been conducted, setting forth the disobedience to the process or refusal to answer, and said court shall order such person to appear before that court and to answer the questions or produce the records requested.

(b) If the Director of Public Health or the Director of Public Health's agent has received information and has a reasonable belief that any person, health care facility, or other institution has violated or is violating any provision of this Act, or any rule or order of the Department of Public Health, the Director of Public Health or the Director of Public Health's agent may issue a notice pursuant to this Section. The Department of Public Health shall notify the person, health care facility, or institution against whom such order is issued by first-class mail or personal service. The notice shall include: (1) a reference to the Section of the statutes, rule, or Section of the rules believed to have been violated; (2) a short and plain language statement of the matters asserted or charged; (3) a description of the activity alleged to have violated a statute or rule pursuant to paragraph (1) of this subsection; (4) a statement concerning the right to a hearing of such person, health care facility, or institution; and (5) a statement that the person, health care facility, or institution may, not later than 10 business days after receipt of the notice, make a written request for a hearing on the matters asserted, to be sent to the executive director of the health care facility or institution or the agent of the executive director.

(c) The person, health care facility, or institution to whom notice is provided under subsection (b) of this Section may, not later than 10 business days after receipt of the

notice, make written application to the unit to request a hearing to demonstrate that such violation has not occurred, or present other defenses applicable. A failure to make a timely request for a hearing shall result in the Department issuing a cease and desist order. Each hearing held under this subsection shall be conducted and contested pursuant to Illinois Administrative Procedure Act.

(d) If the Department finds, by a preponderance of the evidence, following a hearing held under subsection (c) of this Section that a person, health care facility, or institution has violated or is violating any provision of this Act, or any rule or order of the Department, the Department shall issue a cease and desist order to such person, health care facility, or institution that shall be considered a final decision subject to appeal to the Circuit Court in accordance with the Administrative Review Law of the Code of Civil Procedure.

(e) Any cease and desist order issued under this Section may be enforced by the Attorney General.

Section 55. Report of the utilization management and provider payment practices of Medicare Advantage plans.

(a) Not later than January 1, 2026, the Department of Insurance, in consultation with the Department of Public Health, shall report to the Governor and to the General Assembly an analysis of the utilization management and

provider payment practices of Medicare Advantage plans, including, but not limited to, (1) the impact of such practices on the delivery of hospital outpatient and inpatient services, including patient placement, discharges, transfers, and other clinical plans, (2) the costs to hospitals and plan members associated with such practices, (3) the effect of such practices on commercial, non-Medicare payment rates and access to services, including behavioral health services, and (4) a comparison of claims denials, modifications, and reversals on appeal among Medicare Advantage plans and with traditional Medicare, Medicaid, and commercial non-Medicare product lines. To the extent information and data are not available to support specified areas of such analysis, such unavailability shall be noted in the report.

(b) Based on the findings of the analysis such report shall provide recommendations on (1) improving quality of and access to care, (2) improving the timely delivery of care, (3) reducing provider administrative costs associated with utilization management, (4) addressing payment practices that inappropriately reduce provider payments, (5) improving any practices identified in the study contributing to unwarranted changes to clinical care plans, (6) considering quarterly monitoring of prior authorization requests, service denials and payment denials by Medicare Advantage plans and comparing such data with commercial plans and Medicaid, (7) addressing the broad effect of Medicare Advantage plan practices on the

health care delivery system, including costs borne by non-Medicare Advantage consumers and plan sponsors, (8) reducing costs for consumers, and (9) the extent to which states have the authority to regulate Medicare Advantage plans. To the extent the analysis does not support recommendations in any of the specified areas, that outcome should be noted in the report.

(c) The Department of Insurance may engage the services of third-party professionals and specialists the Director of Insurance deems necessary to assist the Director of Insurance in fulfilling the requirements of this Section. The costs and services shall be paid from the General Revenue Fund, subject to appropriation.

Section 90. The Illinois Health Facilities Planning Act is amended by adding Section 6.5 as follows:

(20 ILCS 3960/6.5 new)

Sec. 6.5. Notice of intent to file an application. Any health care facility that intends to file an application for a certificate of need with the Board shall, in advance of filing such an application, post notice of the health care facility's intent to file in a conspicuous location on its website, if such a website exists. After filing an application for a certificate of need, the health care facility shall post, in a conspicuous location on its website, a notice of the

application having been filed and a digital copy of the application.

Section 99. Effective date. This Act takes effect upon becoming law.

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Statutes amended in order of appearance