SB3976

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104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB3976

Introduced 2/6/2026, by Sen. Omar Aquino

SYNOPSIS AS INTRODUCED:

210 ILCS 88/5
210 ILCS 88/10
210 ILCS 88/16
210 ILCS 88/25
210 ILCS 88/27
210 ILCS 88/30
210 ILCS 88/35
210 ILCS 88/40
210 ILCS 88/45
210 ILCS 88/70
210 ILCS 89/5
210 ILCS 89/10
210 ILCS 89/15

Amends the Fair Patient Billing Act. Makes changes to findings and defined terms provisions. Provides that a hospital shall not deny any protection or benefit of the Act on the basis of a patient's citizenship or immigration status or assets or prospective assets. Provides that a patient who inquires about a denial of financial assistance in whole or in part must be permitted to appeal the decision within at least 90 days. Requires a hospital to use only a uniform financial assistance form developed and provided by the Attorney General no later than December 31, 2026. Provides that every hospital bill and every collection notice must notify the patient, in the patient's preferred language, of the availability of hospital financial assistance and charity care. Establishes further provisions concerning hospitals pursuing collection actions; outsourced health care services; patient responsibilities; and applicability of the Act. Amends the Hospital Uninsured Patient Discount Act. Sets forth provisions concerning uninsured patient discounts for specified income levels. Prohibits hospitals from making the availability of a discount under the Act contingent upon the uninsured patient first applying for coverage under public health insurance programs. Provides that patients may not be denied a discount under the Act on the basis of citizenship or immigration status or assets or prospective assets. Makes other changes concerning uninsured patient discounts, outsourcing health care services, and patient responsibilities. 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 5. The Fair Patient Billing Act is amended by changing Sections 5, 10, 16, 25, 27, 30, 35, 40, 45, and 70 as follows:

(210 ILCS 88/5)

Sec. 5. Purpose; findings.

(a) The purpose of this Act is to advance the prompt and accurate payment of health care services through fair and reasonable billing and collection practices of hospitals.

(b) The General Assembly finds that:

(1) Medical debts are the cause of an increasing number of bankruptcies in Illinois and are typically associated with severe financial hardship incurred by bankrupt persons and their families.

(2) Patients, hospitals, and government bodies alike will benefit from clearly articulated standards regarding fair billing and collection practices for all Illinois hospitals.

(3) Hospitals should employ responsible standards when collecting debt from their patients.

(4) Patients should be provided sufficient billing

information from hospitals to determine the accuracy of the bills for which they may be financially responsible.

(5) Patients should be given a fair and reasonable opportunity to discuss and assess the accuracy of their bill.

(6) Hospitals should provide patients with timely and meaningful access to any financial assistance available through the hospital and any public health insurance programs for which patients may be eligible to prevent patients from ending up with avoidable medical debt. Hospitals should assist patients who need financial assistance to access it. Patients who are deemed eligible for hospital financial assistance or public health insurance programs should not be improperly billed, steered into payment plans, or sent to collections.

(7) Hospitals should offer patients the opportunity to enter into a reasonable payment plan for their hospital care.

(8) Patients have an obligation to pay for the hospital services they receive subject to any discounts or free care for which they are eligible under Illinois law.

(9) Hospitals have an obligation to screen uninsured patients before pursuing collection action. To promote the general welfare and to mitigate the negative impact that medical debt has on accessing and using needed health care, hospitals should not attempt to collect a debt from

an uninsured patient without first adequately screening the patient for public health insurance programs and financial assistance available to the patient and assisting the patient in obtaining the hospital financial assistance for which they are eligible.

(10) Hospitals are increasingly outsourcing on-site health care services to third-party individuals or entities. When a hospital outsources care, the hospital must ensure the screening, billing, and collection action protections continue to be afforded to hospital patients under this Act.

(Source: P.A. 103-323, eff. 1-1-24.)

(210 ILCS 88/10)

Sec. 10. Definitions. As used in this Act:

"Collection action" means any referral of a bill to a collection agency or law firm to collect payment for services from a patient or a patient's guarantor for hospital services.

"Health care plan" means a health insurance company, health maintenance organization, preferred provider arrangement, or third party administrator authorized in this State to issue policies or subscriber contracts or administer those policies and contracts that reimburse for inpatient and outpatient services provided in a hospital. Health care plan, however, does not include any government-funded program such as Medicare or Medicaid, workers' compensation, and accident

liability insurers.

"Insured patient" means a patient who is insured by a health care plan.

"Medical debt" means a debt arising from the receipt of health care services, products, or devices.

"Outsource" or "outsourcing" means to contract with a person or entity not employed by the hospital or otherwise not on the hospital staff. "Outsourced" or "outsourcing" is distinct from an in-network or out-of-network contracted relationship with an insurer described in Section 50.

"Patient" means the individual receiving services from the hospital and any individual who is the guarantor of the payment for such services.

"Public health insurance program" means Medicare; Medicaid; medical assistance under the Non-Citizen Victims of Trafficking, Torture and Other Serious Crimes program; Health Benefit for Immigrant Adults; Health Benefit for Immigrant Seniors; All Kids; or other medical assistance programs offered by the Department of Healthcare and Family Services.

"Reasonable payment plan" means a plan to pay a hospital bill that is offered to the patient or the patient's legal representative and takes into account the patient's available income ~~and assets~~, the amount owed, and any prior payments.

"Screen" or "screening" means a process whereby a hospital engages with a patient to review and assess the patient's potential eligibility for any financial assistance offered by

the hospital, public health insurance program, or other discounted care known to the hospital; informs the patient of the hospital's assessment; documents in the patient's record the circumstances of the screening; and assists with the application for hospital financial assistance.

"Uninsured patient" means a patient who is not insured by a health care plan and is not a beneficiary under a government-funded program, workers' compensation, or accident liability insurance.

(Source: P.A. 103-323, eff. 1-1-24.)

(210 ILCS 88/16)

Sec. 16. Screening patients for health insurance and financial assistance.

(a) All hospitals shall screen each uninsured patient, upon the uninsured patient's agreement, at the earliest reasonable moment for potential eligibility for both:

(1) public health insurance programs; and

(2) any financial assistance offered by the hospital.

(b) All screening activities, including initial screenings and all follow-up assistance, must be provided in compliance with the Language Assistance Services Act.

(c) If a patient declines or fails to respond to the screening described in subsection (a), the hospital shall document in the patient's record the patient's decision to decline or failure to respond to the screening, confirming the

date and method by which the patient declined or failed to respond.

(d) If a patient does not decline the screening described in subsection (a), a hospital should screen an uninsured patient during registration unless it would cause a delay of care to the patient, otherwise a hospital must screen an uninsured patient at the earliest reasonable moment.

(e) If a patient does not submit screening, financial assistance application, or reasonable payment plan documentation within 30 days after a request as required under Section 45, the hospital shall document the lack of received documentation, confirming the date that the screening took place and that the 30-day timeline for responding to the hospital's request has lapsed, but may be reopened within 90 days after the date of discharge, date of service, or completion of the screening.

(f) If the screening indicates that the patient may be eligible for a public health insurance program, the hospital shall provide information to the patient about how the patient can apply for the public health insurance program, including, but not limited to, referral to health care navigators who provide free and unbiased eligibility and enrollment assistance, including health care navigators at federally qualified health centers; local, State, or federal government agencies; or any other resources that Illinois recognizes as designed to assist uninsured individuals in obtaining health

coverage.

(g) If the uninsured patient's application for a public health insurance program is approved, the hospital shall bill the insuring entity and shall not pursue the patient for any aspect of the bill, except for any required copayment, coinsurance, or other similar payment for which the patient is responsible under the insurance. If the uninsured patient's application for public health insurance is denied, the hospital shall again offer to screen the uninsured patient for hospital financial assistance and the timeline for applying for financial assistance under the Hospital Uninsured Patient Discount Act shall begin again.

(h) A hospital shall offer to screen an insured patient for hospital financial assistance under this Section if the patient requests financial assistance screening, if the hospital is contacted in response to a bill, if the hospital learns information that suggests an inability to pay, or if the circumstances otherwise suggest the patient's inability to pay.

(i) Any hospital that submits an annual hospital community benefits plan report to the Attorney General shall include in that report the number of uninsured patients who have declined or failed to respond to screening under subsection (a) of Section 16 and the 5 most frequent reasons for declining.

(j) A hospital shall not deny any protection or benefit of this Act on the basis of a patient's citizenship or

immigration status or assets or prospective assets.

(Source: P.A. 103-323, eff. 1-1-24.)

(210 ILCS 88/25)

Sec. 25. Bill inquiries.

(a) A hospital must implement a process for patients to inquire about or dispute a bill. Such process must include a telephone number for billing inquiries and disputes and may include any of the following options:

(1) a toll-free telephone number that the patient may call;

(2) an address to which he or she may write;

(3) a department or identified individual within the hospital he or she may call or write, with appropriate contact information; or

(4) a website or e-mail address.

(b) All hospital bills and collection notices must provide a telephone number allowing the patient to inquire about or dispute a bill.

(c) The hospital must return calls made by patients as promptly as possible, but no later than 2 business days after the call is made. If the hospital's billing inquiry process involves correspondence from the patient, the hospital must respond within 10 business days of receipt of the patient correspondence. For purposes of this Section, "business day" means a day on which the hospital's billing office is open for

regular business.

(d) A patient who inquires about a denial of financial assistance in whole or in part must be permitted to appeal the decision within at least 90 days from the denial. The hospital must advise the patient about the availability of seeking assistance in resolving the billing dispute or denial of financial assistance from the Health Care Bureau of the Office of the Attorney General and must provide contact information for the Health Care Bureau in the patient's preferred language.

(Source: P.A. 94-885, eff. 1-1-07.)

(210 ILCS 88/27)

Sec. 27. Application Procedures for Financial Assistance.

(a) Applications. A hospital must use only a uniform financial assistance form developed and provided by the Attorney General no later than December 31, 2026. In developing this form, the Attorney General shall consult with advocates for communities with limited access to affordable health care coverage and other health care consumer advocates, representatives of the hospital industry, and local public health officials. The Attorney General must consult with organizations and consumers by September 1, 2026. A hospital may not request information regarding a patient's assets when a patient applies for financial assistance. Eligibility for financial assistance is determined solely on household income.

Approval of eligibility for financial assistance is valid for 12 months after the first service date for which the patient submitted a financial assistance application. ~~The Attorney General shall, by rule, adopt standard provisions to be included in all applications for financial assistance no later than June 30, 2013. On or before January 1, 2013, a statewide association representing a majority of hospitals may submit to the Attorney General recommendations concerning standard provisions to be used in an application for financial assistance, and the Attorney General shall take those recommendations into account when adopting rules under this subsection.~~

(b) Presumptive Eligibility. The Attorney General shall, by rule, adopt appropriate methodologies for the determination of presumptive eligibility no later than June 30, 2013. On or before January 1, 2013, a statewide association representing a majority of hospitals may submit to the Attorney General recommendations concerning those methodologies, and the Attorney General shall take those recommendations into account when adopting rules under this subsection.

(Source: P.A. 97-690, eff. 6-14-12.)

(210 ILCS 88/30)

Sec. 30. Pursuing collection action.

(a) Hospitals and their agents may pursue collection action against an uninsured patient only if the following

conditions are met:

(1) The hospital has complied with the screening requirements set forth in Section 16 and applied and exhausted any discount available to a patient under Section 10 of the Hospital Uninsured Patient Discount Act.

(2) The hospital has given the uninsured patient the opportunity to:

(A) assess the accuracy of the bill;

(B) apply for financial assistance under the hospital's financial assistance policy; and

(C) avail themselves of a reasonable payment plan for which the hospital must collect any amount charged in monthly installments such that a patient is not paying more than 4% of the patient's monthly household income. After a cumulative 36 months of payments, a hospital must consider the patient's bill paid in full and permanently cease any and all collection activities on any balance that remains unpaid. The availability of a capped 4%-of-income reasonable payment plan shall be included in the hospital's financial assistance policy and in information provided to uninsured patients.

(3) If the uninsured patient has indicated an inability to pay the full amount of the debt in one payment, the hospital has offered the patient a reasonable payment plan. The hospital may require the uninsured

patient to provide reasonable verification of his or her inability to pay the full amount of the debt in one payment.

(4) To the extent the hospital provides financial assistance and the circumstances of the uninsured patient suggest the potential for eligibility for charity care, the uninsured patient has been given at least 90 days following the date of discharge or receipt of outpatient care to submit an application for financial assistance and shall be provided assistance with the application in compliance with subsection (a) of Section 16 and Section 27.

(5) If the uninsured patient has agreed to a reasonable payment plan with the hospital, and the patient has failed to make payments in accordance with that reasonable payment plan.

(6) If the uninsured patient informs the hospital that he or she has applied for health care coverage under a public health insurance program (and there is a reasonable basis to believe that the patient will qualify for such program) but the patient's application is denied.

(a-5) A hospital shall proactively offer information on charity care options available to uninsured patients, regardless of their immigration status or residency. <u>Every hospital bill and every collection notice must notify the patient, in the patient's preferred language, of the</u>

availability of hospital financial assistance and charity care.

(b) A hospital may not refer a bill, or portion thereof, to a collection agency or attorney for collection action against the insured patient, without first ensuring compliance with Section 16 and offering the patient the opportunity to request a reasonable payment plan for the amount personally owed by the patient. Such an opportunity shall be made available for the 90 days following the date of the initial bill. If the insured patient requests a reasonable payment plan, but fails to agree to a plan within 90 days of the request, the hospital may proceed with collection action against the patient.

(c) No collection agency, law firm, or individual may initiate legal action for non-payment of a hospital bill against a patient without the written approval of an authorized hospital employee who reasonably believes that the conditions for pursuing collection action under this Section have been met.

(d) Nothing in this Section prohibits a hospital from engaging an outside third party agency, firm, or individual to manage the process of implementing the hospital's financial assistance and reasonable payment plan programs and policies so long as such agency, firm, or individual is contractually bound to comply with the terms of this Act.

(Source: P.A. 102-504, eff. 12-1-21; 103-323, eff. 1-1-24.)

(210 ILCS 88/35)

Sec. 35. Collection limitations.

(a) The hospital shall not pursue legal action for non-payment of a hospital bill against uninsured patients who have clearly demonstrated that they have neither sufficient income ~~nor assets~~ to meet their financial obligations provided the patient has complied with Section 45 of this Act.

(b) A hospital may not bill an uninsured patient who requires health care services, as defined in Section 5 of the Hospital Uninsured Patient Discount Act, if it determines, through its financial assistance screening process, that the patient has a household income that qualifies the person for free care under the Hospital Uninsured Patient Discount Act. If the patient is deemed eligible for public health insurance or any other insurance product certified by the Department of Insurance, the hospital shall provide information to the patient about how the patient can apply for the insurance program under subsection (f) of Section 16.

(c) Any action on a medical debt by a hospital must be commenced within 3 years after treatment.

(Source: P.A. 103-901, eff. 1-1-25; 104-417, eff. 8-15-25.)

(210 ILCS 88/40)

Sec. 40. Hospital agents; outsourced health care services on-site.

(a) The hospital must ensure that any external collection

agency, law firm, or individual engaged by the hospital to obtain payment of outstanding bills for hospital services agrees in writing to comply with the collections provisions of this Act.

(b) The hospital's obligation to patients under this Act covers all health care services, including, but not limited to, any outsourced health care service provided in a hospital building or facility by a hospital contractor.

(c) If the hospital outsources health care services within the hospital facility or on the hospital site, the hospital must ensure that the individual or entity contracted to provide health care services abides by the hospital's financial assistance policy or a substantially similar financial assistance policy, screening obligations, collections provisions, and any other provisions of this Act.

(d) The hospital is responsible for ensuring a provider of outsourced health care services complies with this Act.

(Source: P.A. 94-885, eff. 1-1-07.)

(210 ILCS 88/45)

Sec. 45. Patient responsibilities.

(a) To receive the protection and benefits of this Act, a patient responsible for paying a hospital bill must act reasonably and cooperate in good faith with the hospital in the screening process by providing the hospital with all of the reasonably requested financial and other relevant

information and documentation needed to determine the patient's potential eligibility for coverage under a public health insurance program, under the hospital's financial assistance policy, or for a reasonable payment plan within 30 days of a request for such information. A hospital must not require a patient to provide any information regarding citizenship, immigration, assets, or prospective assets, even for the purpose of determining eligibility for a public health insurance program.

(b) To receive the protection and benefits of this Act, a patient responsible for paying a hospital bill shall communicate to the hospital any material change in the patient's financial situation that may affect the patient's ability to abide by the provisions of an agreed upon reasonable payment plan or qualification for financial assistance within 30 days of the change.

(Source: P.A. 103-323, eff. 1-1-24.)

(210 ILCS 88/70)

Sec. 70. Application.

(a)(1) This Act applies to all hospitals licensed under the Hospital Licensing Act or the University of Illinois Hospital Act. This Act does not apply to a hospital that does not charge for its services.

(2) This Act applies to all outpatient clinics or facilities affiliated with a hospital or operating under the

license of a hospital as described in paragraph (1).

(3) This Act applies to any licensed practice that provides outpatient medical, behavioral, optical, radiological, laboratory, dental, or other health care services with revenues of at least $20,000,000 annually, even if not affiliated with a hospital.

(b) The obligations of hospitals under this Act shall take effect for services provided on or after the first day of the month that begins 180 days after the effective date of this Act.

(c) The obligations of hospitals under this amendatory Act of the 103rd General Assembly shall apply to services provided on or after the first day of the month that begins 180 days after the effective date of this amendatory Act of the 103rd General Assembly.

(Source: P.A. 103-323, eff. 1-1-24.)

Section 10. The Hospital Uninsured Patient Discount Act is amended by changing Sections 5, 10, and 15 as follows:

(210 ILCS 89/5)

Sec. 5. Definitions. As used in this Act:

"Community health center" means a federally qualified health center as defined in Section 1905(l)(2)(B) of the federal Social Security Act or a federally qualified health center look-alike.

"Cost to charge ratio" means the ratio of a hospital's costs to its charges taken from its most recently filed Medicare cost report (CMS 2552-96 Worksheet C, Part I, PPS Inpatient Ratios).

"Critical Access Hospital" means a hospital that is designated as such under the federal Medicare Rural Hospital Flexibility Program.

"Family income" means the sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support.

"Federal poverty income guidelines" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

"Financial assistance" means a discount provided to a patient under the terms and conditions a hospital offers to qualified patients or as required by law.

"Free and charitable clinic" means a 501(c)(3) tax-exempt health care organization providing health services to low-income uninsured or underinsured individuals that is recognized by either the Illinois Association of Free and Charitable Clinics or the National Association of Free and Charitable Clinics.

"Guaranteed income program" means a publicly or privately funded program that provides one-time or recurring unconditional cash transfers or payments, or gifts to

individuals or households, for a defined number of months or years for the purposes of reducing poverty, promoting economic mobility, or increasing the financial stability of Illinois residents.

"Health care services" means any medically necessary inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient.

"Hospital" means any facility or institution required to be licensed pursuant to the Hospital Licensing Act or operated under the University of Illinois Hospital Act and includes outpatient clinics or facilities affiliated with a hospital or operating under the license of a hospital.

"Illinois resident" means any person who lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this Act.

"Medically necessary" means any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A "medically necessary" service does not include any of the following:

(1) Non-medical services such as social and vocational

services.

(2) Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.

"Outsource" or "outsourcing" means to contract with a person or entity not employed by the hospital, or otherwise not on the hospital staff.

"Rural hospital" means a hospital that is located outside a metropolitan statistical area.

"Uninsured discount" means a hospital's charges multiplied by the uninsured discount factor.

"Uninsured discount factor" means 1.0 less the product of a hospital's cost to charge ratio multiplied by 1.35.

"Uninsured patient" means an Illinois resident who is a patient of a hospital and is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability.

(Source: P.A. 102-581, eff. 1-1-22; 103-492, eff. 1-1-24.)

(210 ILCS 89/10)

Sec. 10. Uninsured patient discounts.

(a) Eligibility.

(1) A hospital, other than a rural hospital or

Critical Access Hospital, shall provide a discount from its charges to any uninsured patient who applies for a discount and has family income of not more than 600% of the federal poverty income guidelines for all medically necessary health care services exceeding $150 in any one inpatient admission or outpatient encounter.

(2) A hospital, other than a rural hospital or Critical Access Hospital, shall provide a charitable discount of 100% of its charges for all medically necessary health care services exceeding $150 in any one inpatient admission or outpatient encounter to any uninsured patient who applies for a discount and has family income of not more than 300% ~~200%~~ of the federal poverty income guidelines.

(3) A rural hospital or Critical Access Hospital shall provide a discount from its charges to any uninsured patient who applies for a discount and has annual family income of not more than 300% of the federal poverty income guidelines for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter.

(4) A rural hospital or Critical Access Hospital shall provide a charitable discount of 100% of its charges for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter to any uninsured patient who applies for a

discount and has family income of not more than 200% ~~125%~~ of the federal poverty income guidelines. A patient or a rural hospital or Critical Access Hospital with household income of 201-400% of the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) shall be charged pursuant to paragraph (6).

(5) In determining eligibility under this Act, a hospital subject to this Act shall exclude from consideration any unconditional cash transfers, payments, or gifts received under a guaranteed income program if:

(A) such cash transfers, payments, or gifts are excluded from consideration for determining eligibility under public health insurance programs administered by the State in which the State has the authority to waive guaranteed income; and

(B) the guaranteed income program is a program for a defined number of months or years designed to reduce poverty, promote social mobility, or increase financial stability for program participants and if there is an explicit plan to collect data.

This paragraph is inoperative on and after July 1, 2026.

(6) Patients with household income of 301-400% of the poverty guidelines updated periodically in the Federal

Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) shall be charged no more than the amount calculated in the following manner:

(A) recalculate the patient's bill using the Medicare reimbursement rate applicable on the date of service; and

(B) the patient shall be charged no more than 25% of this recalculated bill.

(7) Patients with household income of 401-600% of the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) shall receive the same discounts as patients with household income of 301-400% of the poverty guidelines if the patient and the patient's household have incurred medical expenses from the hospital's bill and all other medical bills for medically necessary health care services received during the previous 12 months that, in total, exceed 5% of the household's annual income.

(8) In addition to other financial assistance provided under this Act, no patient with household income at or below 400% of the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) shall be required to pay more than $2,300 in

cumulative medical bills to large health care facilities per year. Upon patient request and documentation, any health care services that have been delivered by one or more hospitals after the $2,400 limit has been met must be provided as free care.

(9) A patient's assets may not be considered when reviewing eligibility under this Act. Eligibility for an uninsured patient discount is determined solely on family income.

(10) Hospitals may not make the availability of a discount under this Act contingent upon the uninsured patient first applying for coverage under public health insurance programs.

(11) Patients may not be denied a discount under this Act on the basis of citizenship or immigration status or assets or prospective assets.

(b) Discount. For all health care services exceeding $300 in any one inpatient admission or outpatient encounter, a hospital shall not collect from an uninsured patient, deemed eligible under subsection (a), more than its charges less the amount of the uninsured discount.

(c) Maximum Collectible Amount.

(1) The maximum amount that may be collected in a 12-month period for health care services provided by the hospital from a patient determined by that hospital to be eligible under subsection (a) is 20% of the patient's

family income, and is subject to the patient's continued eligibility under this Act.

(2) The 12-month period to which the maximum amount applies shall begin on the first date, after the effective date of this Act, an uninsured patient receives health care services that are determined to be eligible for the uninsured discount at that hospital.

(3) To be eligible to have this maximum amount applied to subsequent charges, the uninsured patient shall inform the hospital in subsequent inpatient admissions or outpatient encounters that the patient has previously received health care services from that hospital and was determined to be entitled to the uninsured discount. The availability of the maximum collectible amount shall be included in the hospital's financial assistance information provided to uninsured patients.

(4) (Blank). ~~Hospitals may adopt policies to exclude an uninsured patient from the application of subdivision (c)(1) when the patient owns assets having a value in excess of 600% of the federal poverty level for hospitals in a metropolitan statistical area or owns assets having a value in excess of 300% of the federal poverty level for Critical Access Hospitals or hospitals outside a metropolitan statistical area, not counting the following assets: the uninsured patient's primary residence; personal property exempt from judgment under Section~~

~~12-1001 of the Code of Civil Procedure; or any amounts held in a pension or retirement plan, provided, however, that distributions and payments from pension or retirement plans may be included as income for the purposes of this Act.~~

(d) Each hospital bill, invoice, or other summary of charges to an uninsured patient shall include with it, or on it, a prominent statement that an uninsured patient who meets certain income requirements may qualify for an uninsured discount and information regarding how an uninsured patient may apply for consideration under the hospital's financial assistance policy. The hospital's financial assistance application shall include language that directs the uninsured patient to contact the hospital's financial counseling department with questions or concerns, along with contact information for the financial counseling department, and shall state: "Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General.". A website, phone number, or both provided by the Attorney General shall be included with this statement.

(e) If the hospital outsources health care services within the hospital facility or otherwise on the hospital site, the hospital must ensure that the individual or entity providing the outsourced health services abides by the hospital's

uninsured patient discount obligations under this Act or substantially similar financial assistance policies. The hospital shall include charges from any outsourced health service provider within the hospital facility or on the hospital site when calculating the charge, discount, or collectible amount applicable under this Act.

(f) The hospital's obligation to patients under this Act covers all health care services, including, but not limited to, outsourced on-site health care services provided by a nonhospital entity.

(g) If the hospital outsources health care services within the hospital facility or on the hospital site, the hospital must ensure any provider of outsourced health care services complies with this Act.

(Source: P.A. 102-581, eff. 1-1-22; 103-492, eff. 1-1-24.)

(210 ILCS 89/15)

Sec. 15. Patient responsibility.

(a) (Blank). ~~Hospitals may make the availability of a discount and the maximum collectible amount under this Act contingent upon the uninsured patient first applying for coverage under public health insurance programs, such as Medicare, Medicaid, AllKids, the State Children's Health Insurance Program, the Health Benefits for Immigrants program, or any other program, if there is a reasonable basis to believe that the uninsured patient may be eligible for such program.~~

~~If the patient declines to apply for a public health insurance program on the basis of concern for immigration-related consequences, the hospital may refer the patient to a free, unbiased resource, such as an Immigrant Family Resource Program, to address the patient's immigration related concerns and assist in enrolling the patient in a public health insurance program. The hospital may still screen the patient for eligibility under its financial assistance policy.~~

(b) Hospitals shall permit an uninsured patient to apply for a discount within 90 days of the date of discharge, date of service, completion of the screening under the Fair Patient Billing Act, or denial of an application for a public health insurance program.

Hospitals shall offer uninsured patients who receive community-based primary care provided by a community health center or a free and charitable clinic, are referred by such an entity to the hospital, and seek access to nonemergency hospital-based health care services with an opportunity to be screened for and assistance with applying for public health insurance programs if there is a reasonable basis to believe that the uninsured patient may be eligible for a public health insurance program. An uninsured patient who receives community-based primary care provided by a community health center or free and charitable clinic and is referred by such an entity to the hospital for whom there is not a reasonable basis to believe that the uninsured patient may be eligible for a

public health insurance program shall be given the opportunity to apply for hospital financial assistance when hospital services are scheduled. An uninsured patient who subsequently becomes eligible for insurance, a public health insurance program, or charity care shall be given the opportunity to apply for hospital financial assistance for any outstanding bill.

(1) Income verification. Hospitals may require an uninsured patient who is requesting an uninsured discount to provide documentation of family income. Acceptable family income documentation shall include any one of the following:

(A) a copy of the most recent tax return;

(B) a copy of the most recent W-2 form and 1099 forms;

(C) copies of the 2 most recent pay stubs;

(D) written income verification from an employer if paid in cash; or

(E) one other reasonable form of third-party income verification deemed acceptable to the hospital.

(2) (Blank). ~~Asset verification. Hospitals may require an uninsured patient who is requesting an uninsured discount to certify the existence or absence of assets owned by the patient and to provide documentation of the value of such assets, except for those assets referenced in paragraph (4) of subsection (c) of Section 10.~~

~~Acceptable documentation may include statements from financial institutions or some other third-party verification of an asset's value. If no third-party verification exists, then the patient shall certify as to the estimated value of the asset.~~

(3) Illinois resident verification. Hospitals may require an uninsured patient who is requesting an uninsured discount to verify Illinois residency. Acceptable verification of Illinois residency shall include any one of the following:

(A) any of the documents listed in paragraph (1);

(B) a valid state-issued identification card;

(C) a recent residential utility bill;

(D) a lease agreement;

(E) a vehicle registration card;

(F) a voter registration card;

(G) mail addressed to the uninsured patient at an Illinois address from a government or other credible source;

(H) a statement from a family member of the uninsured patient who resides at the same address and presents verification of residency;

(I) a letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility; or

(J) a temporary visitor's drivers license.

(c) Hospital obligations toward an individual uninsured patient under this Act shall cease if that patient unreasonably fails or refuses to provide the hospital with information or documentation requested under subsection (b) ~~or to apply for coverage under public programs when requested under subsection (a)~~ within 30 days of the hospital's request.

(d) In order for a hospital to determine the 12 month maximum amount that can be collected from a patient deemed eligible under Section 10, an uninsured patient shall inform the hospital in subsequent inpatient admissions or outpatient encounters that the patient has previously received health care services from that hospital and was determined to be entitled to the uninsured discount.

(e) Hospitals may require patients to certify that all of the information provided in the application is true. The application may state that if any of the information is untrue, any discount granted to the patient is forfeited and the patient is responsible for payment of the hospital's full charges.

(f) Hospitals shall ask for an applicant's race, ethnicity, sex, and preferred language on the financial assistance application. However, the questions shall be clearly marked as optional responses for the patient and shall note that responses or nonresponses by the patient will not have any impact on the outcome of the application.

(Source: P.A. 102-581, eff. 1-1-22; 103-323, eff. 1-1-24;

103-492, eff. 1-1-24; 103-605, eff. 7-1-24.)

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