HB2719

LRB10327682AWJ54059b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB2719

Introduced 2/16/2023, by Rep. Dagmara Avelar

SYNOPSIS AS INTRODUCED:

210 ILCS 88/5
210 ILCS 88/10
210 ILCS 88/16 new
210 ILCS 88/17 new
210 ILCS 88/30
210 ILCS 88/34 new
210 ILCS 89/15

Amends the Fair Patient Billing Act. Provides that a hospital shall screen each uninsured patient for eligibility in State and federal health insurance programs, financial assistance offered by the hospital, and other public programs that may assist with health care costs and provide information about those programs. For an insured patient, requires the hospital to screen the patient for discounted care in specified circumstances. Provides that the screenings and all follow-up assistance must be culturally competent, in the patient's primary language, in plain language, and in an accessible format. Requires a hospital to implement an operational plan and trainings relating to screenings. Prohibits hospitals from pursuing collection actions against uninsured patients if they have not completed the screening requirements. Includes a prohibition on the sale of medical debt, limitations on collection actions, penalties for violating the Act's provisions, and defenses against collection actions pursued in violation of the provisions. Makes other changes. Amends the Hospital Uninsured Patient Discount Act. Provides that a patient declining to apply for a public health insurance program on the basis of concern for immigration-related consequences shall not be grounds for denying financial assistance under a hospital's financial assistance policy.

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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, and 30 and by adding Sections 16, 17, and 34 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 the hospital's financial assistance options to prevent patients from ending up with avoidable medical debt. Hospitals should assist patients who need financial assistance to access it in a culturally competent manner. Patients who are eligible for hospital financial assistance or public health insurance coverage should not be improperly billed, steered into payment plans, or sent to collections ~~Patients should be provided information regarding the hospital's policies regarding financial assistance options the hospital may offer to qualified patients~~.

(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 unless they are eligible for free or discounted care under Illinois law.

(9) Hospitals have financial assistance obligations to uninsured patients. To promote the general welfare, 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.

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

(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.

"Culturally competent" means providing services, supports, or other assistance in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of individuals who are receiving services and in a manner that has the greatest likelihood of ensuring their maximum participation in a screening.

"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.

"Patient" means the individual receiving services from the hospital and any individual who is the guarantor of the payment for such 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 the patient's circumstances related to eligibility criteria and assesses whether the patient may qualify for any financial assistance offered by the hospital or known to the hospital, public health insurance, or discounted care; informs the patient of the hospital's assessment; documents in the patient's file the circumstances of the screening; and either assists with the application or provides information to the patient about how the patient can enroll or otherwise apply for the 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. 94-885, eff. 1-1-07.)

(210 ILCS 88/16 new)

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

(a) A hospital shall screen each uninsured patient for eligibility for the following programs: (1) all available public health insurance programs, including, but not limited to, Medicare; Medicaid; Medical Benefits for Non-Citizen Victims of Trafficking, Torture or Other Serious Crimes; Health Benefit for Immigrant Adults; Health Benefit for Immigrant Seniors; All Kids; or any other program if there is a reasonable basis to believe that the uninsured patient may be eligible for such a program; (2) any financial assistance offered by the hospital; and (3) any other public programs that may assist with health care costs.

(b) All screening activities, including initial screenings and all follow-up assistance, must be culturally competent. All information provided must be in the patient's primary language, in plain language, and in an accessible format. Information provided verbally may include using a professional interpretation service. Information provided in writing shall be in the uninsured patient's or patient's legal representative's primary language.

(c) If a patient declines the screening described in subsection (a), the hospital shall document the patient's

informed consent to decline the screening in writing, confirming the date and method by which the patient declined. A patient's decision to decline the screening is a defense to a claim brought by a patient under Section 34, so long as contemporaneous hospital documentation shows that the decision to decline was an informed decision and in the patient's primary language.

(d) A hospital must screen an uninsured patient or insured patient under subsection (h) at the earliest reasonable moment, which in all circumstances means before issuing a bill. After screening, the hospital shall inform the patient of the hospital's assessment.

(e) If the screening indicates that the patient may be eligible for financial assistance, the hospital shall assist the patient with the application required under Section 27.

(f) If the screening indicates that the patient may be eligible for health coverage, the hospital shall provide information to the patient about how the patient can enroll in the health coverage for which the patient may be eligible, including, but not limited to, referral to healthcare navigators who provide free and unbiased eligibility and enrollment assistance, including health navigators at federally qualified health centers, the Immigrant Family Resource Program, or any other resources that Illinois recognizes as designed to assist uninsured individuals in obtaining coverage.

(g) Undertaking screening activities or having an eligibility decision pending regarding any public health insurance program, including those listed in paragraph (1) of subsection (a), tolls the timeline for filing for hospital financial assistance under the Hospital Uninsured Patient Discount Act. If the uninsured patient's application for public health insurance 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 under the insurance. If the uninsured patient's application for public health insurance is denied, the hospital shall again 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) For an insured patient, a hospital shall screen an insured patient for discounted care pursuant to this Section if the hospital is contacted in response to a bill, if requested by the patient, if the patient provides information that suggests an inability to pay, or if the hospital learns information that suggests an inability to pay, or if the circumstances otherwise suggest the patient's inability to pay.

(210 ILCS 88/17 new)

Sec. 17. Training.

(a) A hospital shall develop an operational plan for implementing the screening provisions of Section 16. The operational plan shall describe activities the hospital is undertaking to adopt and actively implement policies and trainings to ensure compliance with Section 16, including, but not limited to, training on:

(1) the screening requirements;

(2) interacting with uninsured patients with cultural competency; and

(3) addressing implicit bias when interacting with uninsured patients.

(b) The operational plan shall establish the parameters for these trainings, including the staff that shall be required to attend, the frequency of these trainings, and checks on compliance. All relevant employees shall be provided the training at least once per year.

(210 ILCS 88/30)

Sec. 30. Pursuing collection action.

(a) Hospitals and their agents may pursue collection action against an uninsured patient only if they have complied with the screening requirements set forth in Section 16 of this Act and the following conditions are met:

(1) 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.

(2) If the uninsured patient has indicated, during the screening required under Section 16 of this Act or otherwise, an inability to pay the full amount of the debt in one payment, the hospital has offered the patient a reasonable payment plan. A hospital and its agent, including any third-party entity engaging in any billing activity on behalf of a hospital, shall not offer a payment plan to a patient without first exhausting any discount available to a patient under Section 10 of the Hospital Uninsured Patient Discount Act and shall not enter into any payment plan for any bill that is subject to a discount of 100% under Section 10 of the Hospital Uninsured Patient Discount Act. A payment plan is unreasonable per se if it requires payment of funds that should be written off or discounted under Section 10 of the Hospital Uninsured Patient Discount Act ~~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~~.

(3) 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 ~~60~~ 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 (e) of Section 16 and Section 27.

(4) 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.

(5) If the uninsured patient informs the hospital that he or she has applied for health care coverage under Medicaid, ~~Kidcare,~~ or other government-sponsored health care program (and there is a reasonable basis to believe that the patient will qualify for such program) but the patient's application is denied. The hospital must first offer any financial assistance under Section 10 of the Hospital Uninsured Patient Discount Act.

(a-5) A hospital shall proactively offer information on charity care options available to uninsured patients, regardless of their immigration status or residency.

(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 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 ~~30~~ 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 ~~30~~ 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.)

(210 ILCS 88/34 new)

Sec. 34. Sale of medical debt; collection actions; private enforcement; affirmative defenses.

(a) No hospital shall sell its medical debt.

(b) Before assigning a patient debt to a third-party biller or collection agency, and before pursuing, either directly or indirectly, any collection action, a hospital shall meet the screening requirements in Section 16. Patients

may apply for financial assistance at any time during the collection process, including after the commencement of a medical debt court action or upon the plaintiff obtaining a default judgment. A hospital may not collect a debt that was incurred after the effective date of this amendatory Act of the 103rd General Assembly by an uninsured patient who was not screened in compliance with Section 16. A hospital violates this subsection when it pursues a collection action against an uninsured patient but does not prove compliance with Section 16. A hospital may prove compliance by submitting an affidavit of the hospital's chief financial officer or the officer's designee affirming that the patient does not meet the criteria for financial assistance and specifying the criteria that were not met (for example, income or residency). Upon request, a hospital that has violated this subsection shall execute and file a release and satisfaction of judgment for the underlying medical debt within 30 days.

(c) A hospital that fails to comply with the requirements of this Section is strictly liable without regard to fault to a patient in an amount of $4,000 or actual damages, whichever is greater. Notwithstanding any other law or the provisions of Section 45, the following are not defenses to an action brought under this Section: ignorance or mistake of law; misplaced documentation; contributory or comparative negligence; or any claim that a hospital or collection agency was unaware that it did not meet the screening requirements or

was otherwise engaged in the conduct described.

(d) Any person aggrieved by a violation of this section shall have a right of action in a court and shall recover damages as provided in subsection (c) plus attorney's fees, costs, expenses, and other relief, including an injunction, as the court deems appropriate. Any person aggrieved by a violation of this Section has a complete defense to an action to collect the debt. Failure to screen a patient shall constitute a meritorious claim or defense in a petition for relief from judgment under Section 2-1401 of the Code of Civil Procedure.

(e) Any waiver of the right to sue, defend, or countersue under this Section is void as against public policy and is unenforceable in any court.

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

(210 ILCS 89/15)

Sec. 15. Patient responsibility.

(a) 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, All Kids ~~AllKids~~, the State Children's Health Insurance Program, or any other program, if there is a reasonable basis to believe

that the uninsured patient may be eligible for such program unless the patient declines to apply for a public health insurance program on the basis of concern for immigration-related consequences, which shall not be grounds for denying financial assistance under the hospital's financial assistance policy.

(b) Hospitals shall permit an uninsured patient to apply for a discount within 90 days of the date of discharge or date of service.

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.

(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) 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.)