AN ACT concerning regulation.

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

Section 5. The Community Benefits Act is amended by changing Section 22 as follows:

(210 ILCS 76/22)

Sec. 22. Public reports.

(a) In order to increase transparency and accessibility of charity care and financial assistance data, a hospital shall make the annual hospital community benefits plan report submitted to the Attorney General under Section 20 available to the public by publishing the information on the hospital's website in the same location where annual reports are posted or on a prominent location on the homepage of the hospital's website. A hospital is not required to post its audited financial statements. Information made available to the public shall include, but shall not be limited to, the following:

(1) The reporting period.

(2) Charity care costs consistent with the reporting requirements in paragraph (3) of subsection (a) of Section 20. Charity care costs associated with services provided in a hospital's emergency department shall be reported as a subset of total charity care costs.

(3) Total net patient revenue, reported separately by hospital if the reporting health system includes more than one hospital.

(4) Total community benefits spending. If a hospital is owned or operated by a health system, total community benefits spending may be reported as a health system.

(5) Data on financial assistance applications consistent with the reporting requirements in paragraph (3) of subsection (a) of Section 20, including:

(A) the number of applications submitted to the hospital, both complete and incomplete;

(B) the number of applications approved; ~~and~~

(C) the number of applications denied and the 5 most frequent reasons for denial; and~~.~~

(D) the number of uninsured patients who have declined or failed to respond to the screening described in subsection (a) of Section 16 of the Fair Patient Billing Act and the 5 most frequent reasons for declining.

(6) To the extent that race, ethnicity, sex, or preferred language is collected and available for financial assistance applications, the data outlined in paragraph (5) shall be reported by race, ethnicity, sex, and preferred language. If this data is not provided by the patient, the hospital shall indicate this in its reports. Public reporting of this information shall begin

with the community benefit report filed on or after July 1, 2022. A hospital that files a report without having a full year of demographic data as required by this Act may indicate this in its report.

(b) The Attorney General shall provide notice on the Attorney General's website informing the public that, upon request, the Attorney General will provide the annual reports filed with the Attorney General under Section 20. The notice shall include the contact information to submit a request.

(Source: P.A. 102-581, eff. 1-1-22.)

Section 10. The Fair Patient Billing Act is amended by changing Sections 5, 10, 30, 45, and 70 and by adding Section 16 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 ~~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 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.

(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.

"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.

"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. 94-885, eff. 1-1-07.)

(210 ILCS 88/16 new)

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 and other applicable federal and State laws and regulations. Nothing in this Section is intended to extend the enforcement authority of the Office of the Attorney General beyond any authority not otherwise granted.

(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.

(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) ~~(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.

(3) ~~(2)~~ 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) ~~(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 (a) of Section 16 and Section 27.

(5) ~~(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.

(6) ~~(5)~~ If the uninsured patient informs the hospital that he or she has applied for health care coverage under a public health insurance program ~~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.

(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 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 ~~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 88/45)

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 ~~and~~ reasonable payment plan ~~options to qualified patients~~ within 30 days of a request for such information.

(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. 94-885, eff. 1-1-07.)

(210 ILCS 88/70)

Sec. 70. Application.

(a) 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.

(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. 94-885, eff. 1-1-07.)

Section 15. 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, 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. 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, ~~or~~ 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.

(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.)