



Rep. Dagmara Avelar

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10300HB2719ham001

LRB103 27682 BMS 59754 a

1 AMENDMENT TO HOUSE BILL 2719

2 AMENDMENT NO. _____. Amend House Bill 2719 by replacing
3 everything after the enacting clause with the following:

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

6 (210 ILCS 76/22)

7 Sec. 22. Public reports.

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

1 shall include, but shall not be limited to, the following:

2 (1) The reporting period.

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

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

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

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

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

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

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

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

1 (6) To the extent that race, ethnicity, sex, or
2 preferred language is collected and available for
3 financial assistance applications, the data outlined in
4 paragraph (5) shall be reported by race, ethnicity, sex,
5 and preferred language. If this data is not provided by
6 the patient, the hospital shall indicate this in its
7 reports. Public reporting of this information shall begin
8 with the community benefit report filed on or after July
9 1, 2022. A hospital that files a report without having a
10 full year of demographic data as required by this Act may
11 indicate this in its report.

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

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

18 Section 10. The Fair Patient Billing Act is amended by
19 changing Sections 5, 10, 30, 45, and 70 and by adding Section
20 16 as follows:

21 (210 ILCS 88/5)

22 Sec. 5. Purpose; findings.

23 (a) The purpose of this Act is to advance the prompt and
24 accurate payment of health care services through fair and

1 reasonable billing and collection practices of hospitals.

2 (b) The General Assembly finds that:

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

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

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

13 (4) Patients should be provided sufficient billing
14 information from hospitals to determine the accuracy of
15 the bills for which they may be financially responsible.

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

19 (6) Hospitals should provide patients with timely and
20 meaningful access to any financial assistance available
21 through the hospital and any public health insurance
22 programs for which patients may be eligible to prevent
23 patients from ending up with avoidable medical debt.
24 Hospitals should assist patients who need financial
25 assistance to access it. Patients who are deemed eligible
26 for hospital financial assistance or public health

1 insurance programs should not be improperly billed,
2 steered into payment plans, or sent to collections
3 ~~Patients should be provided information regarding the~~
4 ~~hospital's policies regarding financial assistance options~~
5 ~~the hospital may offer to qualified patients.~~

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

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

12 (9) Hospitals have an obligation to screen uninsured
13 patients before pursuing collection action. To promote the
14 general welfare and to mitigate the negative impact that
15 medical debt has on accessing and using needed health
16 care, hospitals should not attempt to collect a debt from
17 an uninsured patient without first adequately screening
18 the patient for public health insurance programs and
19 financial assistance available to the patient and
20 assisting the patient in obtaining the hospital financial
21 assistance for which they are eligible.

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

23 (210 ILCS 88/10)

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

25 "Collection action" means any referral of a bill to a

1 collection agency or law firm to collect payment for services
2 from a patient or a patient's guarantor for hospital services.

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

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

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

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

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

25 "Reasonable payment plan" means a plan to pay a hospital
26 bill that is offered to the patient or the patient's legal

1 representative and takes into account the patient's available
2 income and assets, the amount owed, and any prior payments.

3 "Screen" or "screening" means a process whereby a hospital
4 engages with a patient to review and assess the patient's
5 potential eligibility for any financial assistance offered by
6 the hospital, public health insurance program, or other
7 discounted care known to the hospital; informs the patient of
8 the hospital's assessment; documents in the patient's record
9 the circumstances of the screening; and assists with the
10 application for hospital financial assistance.

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

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

16 (210 ILCS 88/16 new)

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

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

22 (1) public health insurance programs; and

23 (2) any financial assistance offered by the hospital.

24 (b) All screening activities, including initial screenings
25 and all follow-up assistance, must be provided in compliance

1 with the Language Assistance Services Act and other applicable
2 federal and State laws and regulations. Nothing in this
3 Section is intended to extend the enforcement authority of the
4 Office of the Attorney General beyond any authority not
5 otherwise granted.

6 (c) If a patient declines or fails to respond to the
7 screening described in subsection (a), the hospital shall
8 document in the patient's record the patient's decision to
9 decline or failure to respond to the screening, confirming the
10 date and method by which the patient declined or failed to
11 respond.

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

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

26 (f) If the screening indicates that the patient may be

1 eligible for a public health insurance program, the hospital
2 shall provide information to the patient about how the patient
3 can apply for the public health insurance program, including,
4 but not limited to, referral to health care navigators who
5 provide free and unbiased eligibility and enrollment
6 assistance, including health care navigators at federally
7 qualified health centers; local, State, or federal government
8 agencies; or any other resources that Illinois recognizes as
9 designed to assist uninsured individuals in obtaining health
10 coverage.

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

22 (h) A hospital shall offer to screen an insured patient
23 for hospital financial assistance under this Section if the
24 patient requests financial assistance screening, if the
25 hospital is contacted in response to a bill, if the hospital
26 learns information that suggests an inability to pay, or if

1 the circumstances otherwise suggest the patient's inability to
2 pay.

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

8 (210 ILCS 88/30)

9 Sec. 30. Pursuing collection action.

10 (a) Hospitals and their agents may pursue collection
11 action against an uninsured patient only if the following
12 conditions are met:

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

17 (2) ~~(1)~~ The hospital has given the uninsured patient
18 the opportunity to:

19 (A) assess the accuracy of the bill;

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

22 (C) avail themselves of a reasonable payment plan.

23 (3) ~~(2)~~ If the uninsured patient has indicated an
24 inability to pay the full amount of the debt in one
25 payment, the hospital has offered the patient a reasonable

1 payment plan. The hospital may require the uninsured
2 patient to provide reasonable verification of his or her
3 inability to pay the full amount of the debt in one
4 payment.

5 (4) ~~(3)~~ To the extent the hospital provides financial
6 assistance and the circumstances of the uninsured patient
7 suggest the potential for eligibility for charity care,
8 the uninsured patient has been given at least 90 ~~60~~ days
9 following the date of discharge or receipt of outpatient
10 care to submit an application for financial assistance and
11 shall be provided assistance with the application in
12 compliance with subsection (a) of Section 16 and Section
13 27.

14 (5) ~~(4)~~ If the uninsured patient has agreed to a
15 reasonable payment plan with the hospital, and the patient
16 has failed to make payments in accordance with that
17 reasonable payment plan.

18 (6) ~~(5)~~ If the uninsured patient informs the hospital
19 that he or she has applied for health care coverage under a
20 public health insurance program ~~Medicaid, Kidcare, or~~
21 ~~other government-sponsored health care program~~ (and there
22 is a reasonable basis to believe that the patient will
23 qualify for such program) but the patient's application is
24 denied.

25 (a-5) A hospital shall proactively offer information on
26 charity care options available to uninsured patients,

1 regardless of their immigration status or residency.

2 (b) A hospital may not refer a bill, or portion thereof, to
3 a collection agency or attorney for collection action against
4 the insured patient, without first ensuring compliance with
5 Section 16 and offering the patient the opportunity to request
6 a reasonable payment plan for the amount personally owed by
7 the patient. Such an opportunity shall be made available for
8 the 90 ~~30~~ days following the date of the initial bill. If the
9 insured patient requests a reasonable payment plan, but fails
10 to agree to a plan within 90 ~~30~~ days of the request, the
11 hospital may proceed with collection action against the
12 patient.

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

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

25 (Source: P.A. 102-504, eff. 12-1-21.)

1 (210 ILCS 88/45)

2 Sec. 45. Patient responsibilities.

3 (a) To receive the protection and benefits of this Act, a
4 patient responsible for paying a hospital bill must act
5 reasonably and cooperate in good faith with the hospital in
6 the screening process by providing the hospital with all of
7 the reasonably requested financial and other relevant
8 information and documentation needed to determine the
9 patient's potential eligibility for coverage under a public
10 health insurance program, under the hospital's financial
11 assistance policy, or for a ~~and~~ reasonable payment plan
12 ~~options to qualified patients~~ within 30 days of a request for
13 such information.

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

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

22 (210 ILCS 88/70)

23 Sec. 70. Application.

24 (a) This Act applies to all hospitals licensed under the
25 Hospital Licensing Act or the University of Illinois Hospital

1 Act. This Act does not apply to a hospital that does not charge
2 for its services.

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

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

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

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

15 (210 ILCS 89/15)

16 Sec. 15. Patient responsibility.

17 (a) Hospitals may make the availability of a discount and
18 the maximum collectible amount under this Act contingent upon
19 the uninsured patient first applying for coverage under public
20 health insurance programs, such as Medicare, Medicaid,
21 AllKids, the State Children's Health Insurance Program, or any
22 other program, if there is a reasonable basis to believe that
23 the uninsured patient may be eligible for such program. If the
24 patient declines to apply for a public health insurance

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

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

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

1 to apply for hospital financial assistance when hospital
2 services are scheduled.

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

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

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

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

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

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

16 (2) Asset verification. Hospitals may require an
17 uninsured patient who is requesting an uninsured discount
18 to certify the existence or absence of assets owned by the
19 patient and to provide documentation of the value of such
20 assets, except for those assets referenced in paragraph
21 (4) of subsection (c) of Section 10. Acceptable
22 documentation may include statements from financial
23 institutions or some other third party verification of an
24 asset's value. If no third party verification exists, then
25 the patient shall certify as to the estimated value of the
26 asset.

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

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

7 (B) a valid state-issued identification card;

8 (C) a recent residential utility bill;

9 (D) a lease agreement;

10 (E) a vehicle registration card;

11 (F) a voter registration card;

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

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

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

21 (J) a temporary visitor's drivers license.

22 (c) Hospital obligations toward an individual uninsured
23 patient under this Act shall cease if that patient
24 unreasonably fails or refuses to provide the hospital with
25 information or documentation requested under subsection (b) or
26 to apply for coverage under public programs when requested

1 under subsection (a) within 30 days of the hospital's request.

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

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

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

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