Sen. Iris Y. Martinez

Filed: 3/27/2012

AMENDMENT TO SENATE BILL 1881

AMENDMENT NO. _____. Amend Senate Bill 1881, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Hospital Fair Care Act.

Section 5. Purpose. The purpose of this Act is to improve access to basic, affordable health care services for all Illinois residents, especially poor and low-income uninsured residents, through the regulation of non-profit hospitals, which play an important role in the health care safety-net. Access to necessary, quality health services is vital to the health, safety, and welfare of all individuals living in this State and should not be based upon one's ability to pay.

Section 10. Findings. The General Assembly finds the

following:

(1) Rising health care costs have pushed private health insurance beyond financial reach for many poor and low-income working families, thereby increasing the number of the uninsured. Since 1999, average health insurance premiums for family coverage have increased 119% according to the 2008 Kaiser Family Foundation's Employer Health Benefits Survey.

(2) According to 2009 Kaiser Family Foundation State Health data, 1.74 million individuals living in Illinois are uninsured. While the majority of the uninsured are working, many do not earn enough to afford private health coverage. Fully 35% of the uninsured living in this State earn just $25,000 a year or less according to the 2009 Gilead report on Illinois' uninsured.

(3) Minorities in particular have been disproportionately affected by rising health care costs. The Gilead study reports that the majority of the uninsured in this State are minorities; 27% are Latino, 20% are African-American, 4% are "other or multiethnic", and 49% are white.

(4) When the uninsured are struck by serious illness or injury, financial devastation is common as medical bills mount. The Kaiser Family Foundation reports that nearly half (46%) of low-income families (those making $30,000 or less a year) experience problems paying medical bills. In 2007, overwhelming medical bills forced an estimated 20,349 Illinois residents to file for bankruptcy. The Hospital Uninsured

Patient Discount Act is a step toward protecting uninsured residents from financial devastation, but it does not go far enough.

(5) The federal Patient Protection and Affordable Care Act, along with the federal Health Care and Education Affordability Reconciliation Act of 2010, reform the health care system to improve coverage through the expansion of Medicaid and regulations placed on the health insurance industry. While an estimated 32 million residents will gain coverage across the country, it is predicted that over 700,000 Illinoisans will remain uninsured, and many more will be underinsured, relying on the health safety net for care. While federal health reform sets forth new requirements for non-profit hospitals, including the development and publication of financial assistance policies and the regulation of billing and collection procedures, it does not set a standard for charity care provision.

(6) Hospital behavior toward the uninsured plays a direct role in access to health care and health outcomes. Many studies have found that exorbitant hospital charges combined with aggressive billing and collection practices discourage low-income, uninsured individuals from seeking medical care when it is needed. Accordingly, the uninsured often wait and become increasingly ill before seeking medical care, which results in more expensive care.

(7) The local health care safety-net includes many

different types of health care delivery organizations that deliver health care services to State residents with barriers to accessing health care. Such barriers include, but are not limited to, lack of insurance, no or low income, and ethnic and cultural characteristics.

(8) This Act focuses on the role of non-profit hospitals in providing affordable, necessary medical care to poor and low-income uninsured Illinois residents because hospitals are typically where people go when they experience a traumatic injury or illness.

(9) In March 2010, the Illinois Supreme Court ruled in Provena Covenant Medical Center v. Department of Revenue that non-profit hospitals must provide "charity care", defined as free or discounted care, in order to receive State property tax exemptions and that the "community benefits" standard is not the applicable test. The Court stated that the charitable activities of a non-profit hospital must reduce the burdens of local government for local property tax purposes. The Court did not set a standard for how much charity care a non-profit hospital must provide in exchange for local property tax exemption. Such standard is evaluated on a case-by-case basis, applying the 1968 Methodist Old Peoples Home v. Korzen factors.

(10) This Act holds non-profit hospitals accountable for the property tax exemptions they receive by ensuring the provision of charity care and fairly distributing the burden of uninsured patient care among all non-profit hospitals in this

State.

(11) While public hospitals are intended to play a far greater role than private hospitals in caring for the uninsured, private hospitals are expected to play a vital role. However, numerous reports have concluded that many private hospitals do not do a good job of providing hospital care that is affordable to poor and low-income uninsured individuals, thereby effectively acting as a barrier to medical treatment when it is needed.

(12) Access to affordable quality health care, hospital care in particular, and ensuring that all State residents, rather than just those with the ability to pay, get the appropriate medical care when it is necessary are in the public interest of this State. This Act seeks to provide a regulatory framework to protect access to care for the most vulnerable State residents by encouraging private non-profit general hospitals to provide affordable health care services to this population and discouraging hospital behavior that acts as an effective barrier to access to care. In addition, this Act will assist the State with its cost of caring for low-income, uninsured residents for whom private general hospitals either cannot or will not provide care.

Section 15. Definitions. In this Act:

"Bad debt" means an account receivable for services furnished to an individual that: (i) is regarded as

uncollectible following reasonable collection action, (ii) is charged as a credit loss, and (iii) is not the obligation of any federal, State, or local governmental unit. Bad debt does not constitute financial assistance, that is, charity care, as defined by the Illinois Supreme Court in Provena Covenant Medical Center v. Department of Revenue for tax purposes.

"Charge" means the price set by a hospital for a specific service or supply provided by that hospital.

"Charitable benefits" means medical services going directly to free or discounted services provided pursuant to a hospital's, hospital affiliate's, or hospitals system's financial assistance policy, measured at cost and subsidies (unreimbursed costs) attributable to the following: providing without charge, paying for, or subsidizing goods, activities, or services for the purpose of addressing the health of low-income individuals by providing financial support to community clinics or programs that serve low-income individuals; paying or subsidizing health care professionals who care for low-income individuals at free or discounted rates, including care provided as follow-up to emergency room visits; providing or subsidizing outreach services to low-income individuals for disease management and prevention; providing free or subsidized goods, supplies, or services needed by low-income individuals because of their diagnosed medical condition; and providing prenatal childbirth outreach to at-risk and low-income persons.

"Collection action" means any activity by which a hospital, a designated agent, or an assignee of a hospital or a purchaser of a patient account receivable requests payment for services from a patient or a patient's family. "Collection action" include, without limitation, pre-admission or pre-treatment deposits, billing statements, letters, electronic mail, telephone, and personal contacts related to hospital bills, court summonses and complaints, and any other activity related to collecting a hospital bill.

"Cost" means the actual expense a hospital incurs to provide each service or supply.

"Effective date of eligibility" means the later of the date on which medical services are rendered or the date of discharge from a hospital.

"Eligible individual" means an individual (i) who does not have public or private health insurance and whose family income is at or below 400% of the federal poverty guidelines or (ii) who has an insurance plan but the total out-of-pocket hospital charges exceed 10% of the patient's family income in a 12-month period.

"Family" means, for an individual 18 years of age and older, the individual's spouse or domestic partner and dependent children under age 21, whether living at home or not. For an individual under 18 years of age, "family" means parents or caretaker relatives.

"Federal poverty 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" includes "charity care", as defined by the Illinois Supreme Court's decision in Provena Covenant Medical Center v. Illinois Department of Revenue and means inpatient or outpatient medical services provided free-of-charge or at reduced charges to an eligible individual, and must be rendered with no expectation of payment from the patient or such patient's family. Financial assistance shall be measured at the cost of the medical services provided based on the total cost-to-charge ratio derived from the hospital's Medicare Cost Report (CMS 2552-96 Worksheet C, Part 1 PPS Inpatient Ratios). Financial assistance shall not be recorded as revenue, an account receivable or bad debt. Financial assistance shall include only full financial assistance and partial financial assistance as defined in this Act.

"General hospital" means any institution required to be licensed by this State pursuant to the Hospital Licensing Act or the University of Illinois Licensing Act and holds a General license pursuant to Title 77, paragraph (1) subsection (g) of Section 250.120 of the Illinois Administrative Code. "General hospital" does not include hospitals that hold a specialized license.

"Non-profit hospital" means any general hospital that receives a State income, sales, and property tax exemption

through the Illinois Department of Revenue for being charitable.

"Income" means a family's annual gross earnings and cash benefits from all sources before taxes, less payments for child support.

"Medical services" means services, whether inpatient or outpatient services, or supplies that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure a condition that endangers life, causes suffering or pain, causes physical deformity or malfunction, threatens to cause or aggravate a handicap, or results in illness or infirmity. "Medical services" includes any inpatient or outpatient hospital services mandated under Title XIX of the federal Social Security Act and emergency care mandates. "Medical services" also includes plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity. "Medical services" includes only services deemed medically necessary.

"Non-safety-net hospital" means any freestanding general hospital that did not qualify for Medicaid Disproportionate Share Hospital (DSH) payment adjustments, pursuant to Title 89, Section 148.120(a) of the Illinois Administrative Code, for the most recent year that such payments were made.

"Operating margin" means the ratio of operating income to operating revenues as each are reported in a hospital's audited financial statements. The operating margin shall be measured on

a separate hospital basis rather than a system-wide or hospital network basis.

"Safety-net hospital" means a freestanding general hospital that qualified for Medicaid Disproportionate Share Hospital (DSH) payment adjustments, pursuant to Title 89, Section 148.120(a) of the Illinois Administrative Code, for the most recent year that such payments were made.

"Subsidies" means unreimbursed costs attributable to the following: providing without charge, paying for, or subsidizing goods, activities, or services for the purpose of addressing the health of low-income individuals by providing financial support to community clinics or programs that serve low-income individuals; paying or subsidizing health care professionals who care for low-income individuals at free or discounted rates, including care provided as follow-up to emergency room visits; providing or subsidizing outreach services to low-income individuals for disease management and prevention; providing free or subsidized goods, supplies, or services needed by low-income individuals because of their diagnosed medical condition; and providing prenatal childbirth outreach to at-risk and low-income persons.

Section 20. Financial assistance requirements.

(a) Each general hospital operating in this State must provide financial assistance in accordance with Section 25 to eligible individuals on a yearly basis in a total amount at

least equal to the thresholds set in this Act.

(b) Financial assistance and eligibility are defined as follows:

(1) For the purpose of this Section, "full financial assistance" means the provision of medical services provided to an eligible individual free-of-charge to the individual. At a minimum, a general hospital must provide full financial assistance to an eligible individual who applies for financial assistance and whose annual income is equal to or less than 200% of the federal poverty guidelines. A general hospital must not take any collection action, including but not limited to, the issuance of a bill or invoice, against any individual or such individual's family who has applied, and qualifies for full financial assistance under this Act with respect to the medical services for which the individual receives financial assistance.

(2) for the purpose of this Section, "partial financial assistance" means the provision of medical services provided to an eligible individual at partially discounted charges, which shall not exceed 25% of the individual's income. A general hospital must limit any bill or invoice sent to an eligible individual or the individual's family who applies and qualifies for financial assistance to the following amounts:

(A) At a minimum, for an eligible individual whose

annual income is more than 200% of the federal poverty guidelines but equal to or less than 300% of the federal poverty guidelines, the amount billed to such individual or such individual's family shall not exceed the lesser of 20% of the general hospital's cost of providing the medical services or 25% of the individual's income. At a minimum, for an eligible individual whose annual income is more than 300% of the federal poverty guidelines but equal to or less than 400% of the federal poverty guidelines, the amount billed to such individual or such individual's family shall not exceed the lesser of 30% of the general hospital's cost of providing the medical services or 25% of the individual's income.

(B) If an individual applies and qualifies for partial financial assistance but indicates an inability to pay the full amount of a bill or invoice for such financial assistance in one payment, a general hospital must offer such individual or his or her family a reasonable payment plan without interest. The hospital may require such individual or his or her family to provide reasonable verification of his or her inability to pay the full amount of the bill or invoice in one payment.

(3) This Section is not intended to interfere or conflict with any duty established by the Hospital

Uninsured Patient Discount Act upon hospitals to provide discounts to uninsured patients.

(c) Non-profit general hospitals must provide charitable benefits, as defined in Section 15 of this Act, for hospital fiscal year 2012 and beyond at a threshold level equal to at least 6% of the hospital's total revenue. At least 5% must go to medical services as defined in Section 15 of this Act and 1% may go to subsidies as defined in Section 15 of this Act.

Working with representatives of hospitals and of patients in need of charitable benefits, the Department of Revenue shall develop a standard application for free or discounted medical services and a system of presumptive eligibility for use by all non-profit hospitals. The Department of Revenue shall adopt the standard application and system of presumptive eligibility by rule issued no later than 120 days after the effective date of this Act.

(d) Application procedures for financial assistance are as follows:

(1) Screening requirements are as follows:

(A) General hospitals must screen each individual, on or prior to the effective date of eligibility, to determine whether such individual is uninsured. If an individual is determined to be uninsured, he or she, or the individual's representative, shall be provided an application for financial assistance no later than the effective date of eligibility.

(B) Individuals who believe they are underinsured will be expected to self-identify to the financial assistance staff at the hospitals to determine eligibility for charity care.

(C) General hospitals must refrain from issuing any bill or invoice to an individual who is uninsured, or his or her family, until at least 90 days after the effective date of eligibility and, if the individual files a financial assistance application before the end of the 90-day period, must further refrain from issuing any bill or invoice until the hospital determines the individual's eligibility for financial assistance pursuant to this Act.

(2) An individual or individual's representative may submit a financial assistance application to a general hospital within 90 days after the effective date of eligibility.

(3) Each general hospital must deliver written notice of a financial assistance determination to an individual or such individual's representative who has applied for financial assistance within 14 days after receipt of a completed financial assistance application. A general hospital must not deny or delay an individual's medical care while his or her application for financial assistance is pending.

(4) Until a standard application and presumptive

eligibility system are adopted by rule by the Department of Revenue, general hospitals may use their own financial assistance application forms to determine eligibility for financial assistance in compliance with this Act. The application form must state eligibility criteria for full and partial financial assistance as set forth in this Section. The application form must be easy to understand and must request only information that is reasonably necessary to determine eligibility.

(5) Each general hospital must translate and distribute its financial assistance application form in accordance with the Language Assistance Services Act and must also translate the application form into the non-English languages most frequently used in the service area of the hospital and make those translations of the form readily available.

(e) General hospitals must provide notification of the availability of financial assistance as follows:

(1) Each general hospital must post signs in the inpatient, outpatient, emergency, admissions, and registration areas of the facility and in the business office areas that are customarily used by patients that conspicuously inform patients of the availability of full and partial financial assistance, as defined in this Act, and the location within the hospital at which to apply for financial assistance. Signs must be in English and in the

languages other than English that are most frequently spoken in the hospital's service area as well as in the languages required under the Language Assistance Services Act.

(2) Each general hospital must post a notice in a prominent place on its website that financial assistance is available at the facility. The notice must include a brief description of the financial assistance application process, qualifications for financial assistance, and a copy of the application form. The notice must be in the same language as the signs that are required pursuant to this Section.

(3) Each general hospital must provide individual notice, in the appropriate language, of the availability of full or partial financial assistance, as defined in this Act, to any patient who is identified as uninsured.

(4) Each general hospital must provide notice, or ensure that notice is provided, of the availability of full or partial financial assistance in any patient bill, invoice, or collection action issued by the hospital or by a collection agent, assignee, or account purchaser the hospital retains or with which the hospital has contracted.

(5) Each general hospital must, on a quarterly basis, publish notice in a newspaper of general circulation in the hospital's service area indicating that financial assistance is available at the facility. The notice must

include a brief description of the financial assistance application process. Each general hospital must provide a similar notice to all community medical centers located in its service area. These notices must be provided in the same languages as the signs that are required in this Section.

(f) Patient rights and responsibilities are as follows:

(1) General hospitals must distribute to every patient, on or before the effective date of eligibility, a written statement regarding financial assistance. This statement must include the following:

(A) the availability of full or partial financial assistance as provided in this Section;

(B) a patient's right to apply for financial assistance within 90 days after the effective date of eligibility;

(C) a determination of eligibility for full or partial financial assistance must be made, in writing, within 14 days after a completed application is made; and

(D) a patient has the right to enter into a payment plan pursuant to this Section if he or she is determined eligible for partial financial assistance.

(2) If a patient qualifies for financial assistance pursuant to this Act, then the general hospital shall provide the patient assistance in filling out the

application and determining what types of documentation are necessary.

(3) Individuals applying for or receiving financial assistance from any general hospital must do all of the following:

(A) Cooperate with the hospital to provide the information and documentation necessary to apply for other public or private existing programs or resources that may be available to pay for health care, including, without limitation, Medicare, Medicaid, or the Children's Health Insurance Program.

(B) Promptly provide the hospital with accurate and complete documentation and information.

(C) Promptly notify the hospital of any significant change in financial status that is likely to adversely affect eligibility for financial assistance.

(D) Upon qualifying for partial financial assistance, cooperate with the hospital to establish a reasonable payment plan that takes into account available income and assets, the amount of the discounted bill or bills, and any prior payments and must make a good faith effort to comply with this payment plan. The patient is responsible for promptly communicating to the hospital any change in financial situation that may impact his or her ability to pay the

discounted hospital bills or to honor the provisions of the payment plan.

Section 25. Fair Care fee. To ensure that low-income, uninsured individuals living in the State have access to basic, affordable health care and to fairly distribute the cost of caring for uninsured patients that other hospitals either cannot or will not care for, each hospital that does not meet the applicable threshold level of financial assistance set forth in Section 20 of this Act shall pay a fee to the State Fair Care Trust equal to the difference between the cost of the charitable benefits provided for the year and the applicable threshold for the year. The fee shall be calculated annually on a stand-alone hospital basis as follows:

(1) For purposes of calculating the fee, the amount of a general hospital's total revenue shall be determined by the hospital's most recent audited financial statements. If a hospital is part of an affiliated or consolidated group that files audited financial statements on a group basis rather than individually, then the total expenses for the stand-alone hospital shall be determined from the consolidating statements in the affiliated or consolidated audited financial statements.

(2) If the financial assistance provided by a hospital for the year in accordance with Section 20 of this Act as reported in the financial assistance statement required in

Section 20 is less than the threshold set forth in Section 20, a fee shall be paid to the State in an amount equal to the difference between the cost of the financial assistance provided and applicable threshold. Any fee due under this Act shall be paid to the State Treasurer within 90 days after receipt of notice of any fee due.

(3) Non-profit general hospitals that cannot meet the threshold as defined in Section 20 due to financial hardship may apply for a hardship waiver from the Department of Revenue to determine an exemption from this requirement for a one-year period.

Section 30. Date of determination of any Fair Care fee. The Fair Care fee for a general hospital shall be calculated by the Department of Revenue no later than October 1st of each year, using the most recent audited financial statements of each hospital and the most recently filed hospital financial assistance statement, both of which are required to be filed with the State pursuant to Section 35 of this Act. The Fair Care fee shall be calculated annually for each non-profit general hospital located within the State.

Section 35. Fair Care Trust Fund.

(a) There is hereby created the Fair Care Trust Fund as a special fund in the State Treasury. All Fair Care Fees and penalties paid under this Act shall be deposited into the Fair

Care Trust Fund. Subject to appropriation, money in the Fair Care Trust Fund shall be expended exclusively for uncompensated indigent care to those non-profit general hospitals that exceed the required threshold as set forth in Section 20 of this Act. No Fair Care fees or penalties paid pursuant to this Act may be transferred to the General Revenue Fund.

(b) Fair Care Trust Fund funds shall be distributed annually to the Illinois non-profit and public hospitals that exceed the 6% standard for charitable benefits, with the funds divided among such hospitals in proportion to the dollar amount of excess charitable benefits each hospital provided.

Section 40. Charitable benefits reporting. Not later than March 31st of each calendar year, each general non-profit hospital operating in this State must submit the following to the State Attorney General:

(1) Charitable benefits statement. A statement that identifies the dollar amount of charitable benefits, showing an aggregate amount for medical services and an aggregate amount for subsidies, as defined in Section 15 of this Act, furnished by the hospital in its most recently completed fiscal year for which the data is available, in accordance with this Act, to be reported at the actual cost of the services provided based on the total cost-to-charge ratio derived from the hospital's most recently settled Medicare Cost Report. If a hospital is required to file

Form AG-CBP-1, Annual Non Profit Hospital Community Benefits Plan Report with the Attorney General, then a copy of this form shall be sufficient as long as the financial assistance reported was provided in accordance with Section 20 of this Act. Alternatively, a hospital may also submit a copy of its profile compiled by the Department of Public Health based on that Department's Annual Hospital Questionnaire for purposes of reporting the amount of financial assistance provided for the most recent fiscal year as long as the assistance was provided in accordance with Section 20 of this Act.

(2) Most recent annual audited financial statements. The hospital's most recent annual audited financial statements, including consolidating statements if the hospital is part of a group or network that files consolidated or affiliated financial statements.

(3) Medicaid Disproportionate Share Hospital Statement. A statement identifying whether the hospital received Medicaid Disproportionate Share Hospital Payments in the most recent year that such payments were made by the State.

(4) Other necessary information. Hospitals must report any other information the Attorney General deems necessary to ensure compliance with the provisions of this Act.

Section 45. Implementation and enforcement.

(a) The Department of Revenue shall be responsible for calculating each general non-profit hospital's Fair Care fee due pursuant to Section 25 of this Act. The Department of Revenue has the authority to issue any rules necessary to carry out this Act.

(b) The Director of Revenue shall appoint a Fair Care Officer within the Department of Revenue. The Officer shall be responsible for ensuring that each general non-profit hospital in the State is in compliance with Section 20 of this Act. If the Officer determines a general non-profit hospital is not in compliance with any of the provisions of this Act, then the Officer shall notify the hospital of the assessment of the appropriate penalty or penalties provided for in Section 45 of this Act. The Fair Care Officer has the authority to adopt any rules necessary to carry out this Act.

(c) Enforcement of the provisions of this Act shall occur as follows:

(1) A general non-profit hospital that fails to post any notice or provide any notification required under this Act is subject to a civil penalty of $1,000 per day for each day the required notice is not posted or notification is not provided.

(2) A general non-profit hospital that fails to provide information to the public as required under this Act is subject to a civil penalty of $1,000 per violation.

(3) A general hospital that violates any provision of

this Act other than the provisions of subsection (b) of Section 20 and Section 25 is subject to a civil penalty of $1,000 per violation.

(4) All fees and penalties provided for in this Act shall constitute a debt to the State. The State's Attorney is authorized to institute a civil suit in the name of the State to recover the amount of any such unpaid fee or penalty.

(5) If a general non-profit hospital fails to provide the 6% in charitable benefits and fails to pay a Fair Care fee as required in Section 20, the State Department of Revenue shall revoke that hospital's tax-exempt status, including the State property, sales, and income tax exemptions.

Section 55. Renewal. This Act shall be reviewed and revised by July 1, 2019 after the full implementation of the Affordable Care Act.

Section 90. The State Finance Act is amended by adding Section 5.811 as follows:

(30 ILCS 105/5.811 new)

Sec. 5.811. The Fair Care Trust Fund.

Section 99. Effective date. This Act takes effect January

1, 2013.".