SB2080

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB2080

Introduced 2/9/2023, by Sen. Robert Peters

SYNOPSIS AS INTRODUCED:

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

Amends the Fair Patient Billing Act. Requires hospitals to screen patients for health insurance and financial assistance. Prohibits the sale of a patient's medical debt by a hospital. Prohibits hospitals from offering a payment plan to an uninsured patient without first exhausting any discount available to the uninsured patient under the Hospital Uninsured Patient Discount Act and from entering into a payment plan for a bill that is eligible to be discounted by 100% under the Hospital Uninsured Patient Discount Act. Makes other changes. Amends the Hospital Uninsured Patient Discount Act. Provides that hospital may not make the availability of a discount and maximum collectible amount contingent upon an uninsured patient's eligibility for specified programs if the patient declines to apply for a public health insurance program on the basis of concern for immigration-related consequences to the patient, which shall not be grounds for the hospital to deny financial assistance under the hospital's financial assistance policy.

LRB103 27565 CPF 53941 b

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 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) 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.

(9) Hospitals should provide patients with timely and meaningful access to the hospital's financial assistance options to prevent patients from incurring avoidable medical debt. Hospitals should assist patients who need financial assistance in accessing financial assistance in a culturally competent manner. Patients should not be improperly billed, steered into payment plans, or collected upon if they are eligible for hospital financial assistance or public health insurance coverage.

(10) Hospitals have an obligation to provide financial assistance to uninsured patients. To promote the general welfare, hospitals should not attempt to collect a debt from an uninsured patient without first (i) adequately

screening the patient for eligibility to enroll in public health insurance programs and financial assistance and (ii) assisting the patient in obtaining the financial assistance for which the patient is 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" or "cultural competency" means providing services, support, or other assistance in a manner that has the greatest likelihood of ensuring maximum participation and is responsive to the beliefs, interpersonal styles, attitudes, languages, and behaviors of individuals who receive 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.

"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. "Reasonable payment plan" does not include a payment plan that requires a patient to pay moneys that the hospital knows or should know are eligible for a discount under the Hospital Uninsured Patient Discount Act.

"Screen" or "screening" means a process whereby a hospital engages with an uninsured patient to review whether the patient's circumstances are conducive with eligibility criteria for financial assistance that is offered by the hospital or known to the hospital, public health insurance, or discounted care. "Screen" or "screening" includes, but is not limited to, informing the patient of the hospital's assessment, documenting the circumstances of the screening in the patient's file, and either assisting with the application's completion or providing information to the patient about how he or she can enroll or otherwise apply for

1 the assistance.
2 "Uninsured patient" means a patient who is not insured by
3 a health care plan and is not a beneficiary under a
4 government-funded program, workers' compensation, or accident
5 liability insurance.
6 (Source: P.A. 94-885, eff. 1-1-07.)

7 (210 ILCS 88/16 new)
8 Sec. 16. Screening for health insurance and financial
9 assistance; sale of medical debt; enforcement.
10 (a) A hospital shall screen each uninsured patient for
11 eligibility in:
12 (1) all available public health insurance programs,
13 including, but not limited to:
14 (A) Medicare;
15 (B) Medicaid;
16 (C) the following programs offered by the
17 Department of Human Services:
18 (i) medical benefits for noncitizen victims of
19 trafficking, torture, or other serious crimes;
20 (ii) health benefits for immigrant adults; and
21 (iii) health benefits for immigrant seniors;
22 (D) the Illinois All Kids program managed by the
23 U.S. Department of Health and Human Services; and
24 (E) any other program if there is a reasonable
25 basis to believe that the uninsured patient may be

1 eligible for it;
2 (2) any financial assistance offered by the hospital;
3 and
4 (3) any other public programs that may assist with the
5 patient's health care costs.
6 (b) All screening activities taken under this Act,
7 including, but not limited to, initial screenings and follow
8 up activities, must be culturally competent. All information
9 provided to an uninsured patient for a screening must be in the
10 uninsured patient's primary language, worded in a way that is
11 easy to understand, and in an accessible format. Information
12 from a screening that is provided to an uninsured patient
13 verbally may include use of a professional interpretation
14 service. Information from a screening that is provided to an
15 uninsured patient in writing shall be in the uninsured
16 patient's or the uninsured patient's legal representative's
17 primary language, if applicable.
18 (c) If an uninsured patient declines the screening
19 described in subsection (a), the hospital shall document the
20 uninsured patient's informed written consent to decline the
21 screening and the date and method by which the uninsured
22 patient declined it. An uninsured patient's decision to
23 decline a screening is a defense to a claim brought by an
24 uninsured patient under this Section if contemporaneous
25 hospital documentation shows that the decision to decline the
26 screening was an informed decision and presented in the

1 uninsured patient's primary language.
2 (d) A hospital must screen an uninsured patient at the
3 earliest reasonable moment, which in all circumstances means
4 before issuing a bill to the uninsured patient. After the
5 screening, the hospital shall inform the uninsured patient of
6 the hospital's assessment of his or her circumstances.
7 (e) If a screening indicates that the uninsured patient
8 may be eligible for financial assistance, the hospital shall
9 assist the uninsured patient with applying for financial
10 assistance in accordance with Section 27.
11 (f) If a screening indicates that the uninsured patient
12 may be eligible for financial assistance, the hospital shall
13 provide information to the uninsured patient detailing how the
14 uninsured patient can enroll in the financial assistance,
15 including, but not limited to, referring the uninsured patient
16 to health care navigators who provide free and unbiased
17 eligibility and enrollment assistance such as Federally
18 Qualified Health Centers (FQHCs), programs offered by the
19 Department of Human Services, or any other resource that is
20 recognized by the State as being designed to assist uninsured
21 individuals in obtaining health care coverage.
22 (g) The date that an uninsured patient's screening takes
23 place, or the date on which a decision regarding the uninsured
24 patient's eligibility for financial assistance described under
25 subsection (a) is pending, whichever is applicable, is the
26 starting date of any deadline for the uninsured patient to

1 file an application with the hospital for financial
2 assistance. If the uninsured patient's application is
3 approved, the hospital shall bill the entity providing the
4 financial assistance and shall not pursue a collection action
5 against the uninsured patient. If the uninsured patient's
6 application is denied, the hospital shall screen the uninsured
7 patient again, and the deadline to file an application for
8 financial assistance shall begin anew.
9 (h) If a hospital is contacted by an insured patient in
10 response to a bill issued by the hospital to the insured
11 patient, the hospital shall screen the insured patient for
12 discounted care at the earliest reasonable moment if (i) the
13 insured patient requests the screening, (ii) the insured
14 patient provides information suggesting his or her inability
15 to pay the bill, (iii) the hospital obtains information
16 suggesting the insured patient's inability to pay, or (iv)
17 circumstances suggest the insured patient's inability to pay
18 the bill.
19 (i) A hospital shall develop an operational plan for
20 implementing the screening requirements under this Section.
21 The operational plan shall describe hospital activities to
22 adopt and actively implement policies and training to ensure
23 compliance with this Section, including, but not limited to,
24 training on:
25 (1) screening requirements;
26 (2) interacting with uninsured patients in a

1 culturally competent way; and
2 (3) addressing implicit bias when interacting with
3 uninsured patients.
4 The operational plan shall establish the parameters for
5 training required under this subsection, including, but not
6 limited to, staff required to receive the training and
7 ensuring compliance with this Section. Each hospital employee
8 shall receive the training, as applicable, required for that
9 employee's position at least once each year.
10 (j) An uninsured patient may apply for financial
11 assistance at any time before, during, or after a hospital has
12 initiated any legal process to collect the uninsured patient's
13 medical debt.
14 (k) A hospital shall not sell an obligation due to the
15 hospital as an uninsured patient's medical debt.
16 (l) A hospital may demonstrate compliance with this
17 Section by submitting the hospital's chief financial
18 officer's, or the chief financial officer's designee's, sworn
19 affidavit affirming that the uninsured patient does not meet
20 the required criteria for financial assistance and listing the
21 specific criteria that were not met.
22 (m) Notwithstanding any other provision of law:
23 (1) a hospital that violates this Section shall
24 execute and file a release, a satisfaction of judgment, or
25 both, as applicable, for any medical debt at issue arising
26 from the violation within 30 days after the violation

occurs;

(2) a hospital's failure to screen an uninsured patient in compliance with this Section is a complete defense for an uninsured patient against any legal action by the hospital to collect the uninsured patient's medical debt incurred because of that failure and constitutes a meritorious claim or defense in the uninsured patient's petition for relief from judgment under Section 2-1401 of the Code of Civil Procedure;

(3) a hospital that fails to comply with the requirements of this Section is strictly liable, without regard to fault, to an uninsured patient or any other person aggrieved by the violation:

(A) in an amount equal to $4,000 or the uninsured patient's or person's actual damages, whichever is greater; and

(B) attorney's fees, costs, and expenses, and such other relief, including an injunction, as the court may deem appropriate;

(4) the following defenses are not available to a hospital in any legal action brought under this Section:

(A) ignorance or mistake of law;

(B) misplaced documentation;

(C) contributory or comparative negligence; or

(D) a claim that the hospital or the hospital's agent was unaware that the hospital (i) did not meet

the requirements under this Section or (ii) was otherwise engaged in the hospital's conduct described in the legal action;

(5) any person aggrieved by a violation of this Section shall have a right of action in any court of competent jurisdiction and shall recover damages equal to the sum of $4,000 or actual damages; and

(6) any waiver of an uninsured patient's or aggrieved person's right to sue, defend, or countersue under this Section is against public policy, is void, and shall not be enforceable in any court.

(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 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 an inability to pay the full amount of the debt in one payment during the screening required under Section 16, the

hospital has offered the patient a reasonable payment plan. A payment plan is not reasonable if it requires payment of moneys required to be written off or discounted under the Hospital Uninsured Patient Discount Act. The hospital and its agents, including, but not limited to, third-party entities acting as hospital agents, shall not offer a payment plan to an uninsured patient without first exhausting any discount available to the uninsured patient under the Hospital Uninsured Patient Discount Act and shall not at any point enter into a payment plan for a bill that is eligible to be discounted by 100% under 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 has been assisted in completing the application in accordance with Sections 16 and 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

1 reasonable payment plan.
2 (5) If the uninsured patient informs the hospital that
3 he or she has applied for health care coverage under
4 Medicaid, Kidcare, or other government-sponsored health
5 care program (and there is a reasonable basis to believe
6 that the patient will qualify for such program) but the
7 patient's application is denied.
8 <u>(6) The hospital has offered to provide the uninsured</u>
9 <u>patient with all financial assistance available to the</u>
10 <u>uninsured patient under the Hospital Uninsured Patient</u>
11 <u>Discount Act.</u>
12 <u>(7) The hospital has screened the uninsured patient</u>
13 <u>under Section 16 and is in full compliance with that</u>
14 <u>Section.</u>
15 (a-5) A hospital shall proactively offer information on
16 charity care options available to uninsured patients,
17 regardless of their immigration status or residency.
18 (b) A hospital may not refer a bill, or portion thereof, to
19 a collection agency or attorney for collection action against
20 the insured patient, without first offering the patient the
21 opportunity to request a reasonable payment plan for the
22 amount personally owed by the patient. Such an opportunity
23 shall be made available for the 30 days following the date of
24 the initial bill. If the insured patient requests a reasonable
25 payment plan, but fails to agree to a plan within 30 days of
26 the request, the hospital may proceed with collection action

1 against the patient.
2 (c) No collection agency, law firm, or individual may
3 initiate legal action for non-payment of a hospital bill
4 against a patient without the written approval of an
5 authorized hospital employee who reasonably believes that the
6 conditions for pursuing collection action under this Section
7 have been met.
8 (d) Nothing in this Section prohibits a hospital from
9 engaging an outside third party agency, firm, or individual to
10 manage the process of implementing the hospital's financial
11 assistance and reasonable payment plan programs and policies
12 so long as such agency, firm, or individual is contractually
13 bound to comply with the terms of this Act.
14 (Source: P.A. 102-504, eff. 12-1-21.)

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

17 (210 ILCS 89/15)
18 Sec. 15. Patient responsibility.
19 (a) Hospitals may make the availability of a discount and
20 the maximum collectible amount under this Act contingent upon
21 the uninsured patient first applying for coverage under public
22 health insurance programs, such as Medicare, Medicaid,
23 AllKids, the State Children's Health Insurance Program, or any
24 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 to the patient, which shall not be grounds for the hospital to deny 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

1 eligible under Section 10, an uninsured patient shall inform
2 the hospital in subsequent inpatient admissions or outpatient
3 encounters that the patient has previously received health
4 care services from that hospital and was determined to be
5 entitled to the uninsured discount.

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

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

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