SB1881

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

SB1881

Introduced 2/10/2011, by Sen. Iris Y. Martinez

SYNOPSIS AS INTRODUCED:

New Act
30 ILCS 105/5.786 new

Creates the Hospital Fair Care Act. Provides that each general hospital operating in the State must provide certain financial assistance to eligible individuals on a yearly basis in a total amount at least equal to the thresholds set in the Act. Sets forth provisions concerning financial assistance and eligibility. Provides that non-profit general hospitals must provide financial assistance for hospital fiscal year 2012 and beyond at a threshold level equal to at least 3.5% of the hospital's total revenue. Sets forth provisions concerning application for financial assistance, notification of the availability of financial assistance, and patient rights and responsibilities. Provides that each hospital that does not meet the applicable threshold level of financial assistance shall pay a fee that is deposited into the State Fair Care Trust Fund. Provides that the Department of Revenue shall be responsible for calculating each general non-profit hospital's Fair Care fee. Sets forth provisions concerning the position of Fair Care Officer to be established within the Department of Revenue. Amends the State Finance Act to create the Fair Care Trust Fund. Makes other changes. Effective on January 1, 2012.

LRB097 06589 RPM 46674 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning health.

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

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

1 estimated 32 million residents will gain coverage across the
2 country, it is predicted that over 700,000 Illinoisans will
3 remain uninsured, and many more will be underinsured, relying
4 on the health safety net for care. While federal health reform
5 sets forth new requirements for non-profit hospitals,
6 including the development and publication of financial
7 assistance policies and the regulation of billing and
8 collection procedures, it does not set a standard for charity
9 care provision.

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

18 (7) The local health care safety-net includes many
19 different types of health care delivery organizations that
20 deliver health care services to State residents with barriers
21 to accessing health care. Such barriers include, but are not
22 limited to, lack of insurance, no or low income, and ethnic and
23 cultural characteristics.

24 (8) This Act focuses on the role of non-profit hospitals in
25 providing affordable, necessary medical care to poor and
26 low-income uninsured Illinois residents because hospitals are

1 typically where people go when they experience a traumatic
2 injury or illness.
3 (9) In March 2010, the Illinois Supreme Court ruled in
4 Provena Covenant Medical Center v. Department of Revenue that
5 non-profit hospitals must provide "charity care", defined as
6 free or discounted care, in order to receive State property tax
7 exemptions and that the "community benefits" standard is not
8 the applicable test. The Court stated that the charitable
9 activities of a non-profit hospital must reduce the burdens of
10 local government for local property tax purposes. The Court did
11 not set a standard for how much charity care a non-profit
12 hospital must provide in exchange for local property tax
13 exemption. Such standard is evaluated on a case-by-case basis,
14 applying the 1968 Methodist Old Peoples Home v. Korzen factors.
15 (10) This Act holds non-profit hospitals accountable for
16 the property tax exemptions they receive by ensuring the
17 provision of charity care and fairly distributing the burden of
18 uninsured patient care among all non-profit hospitals in this
19 State.
20 (11) While public hospitals are intended to play a far
21 greater role than private hospitals in caring for the
22 uninsured, private hospitals are expected to play a vital role.
23 However, numerous reports have concluded that many private
24 hospitals do not do a good job of providing hospital care that
25 is affordable to poor and low-income uninsured individuals,
26 thereby effectively acting as a barrier to medical treatment

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

15 Section 15. Definitions. In this Act:
16 "Bad debt" means an account receivable for services
17 furnished to an individual that: (i) is regarded as
18 uncollectible following reasonable collection action, (ii) is
19 charged as a credit loss, and (iii) is not the obligation of
20 any federal, State, or local governmental unit. Bad debt does
21 not constitute financial assistance, that is, charity care, as
22 defined by the Illinois Supreme Court in Provena Covenant
23 Medical Center v. Department of Revenue for tax purposes.
24 "Charge" means the price set by a hospital for a specific
25 service or supply provided by that hospital.

1 "Collection action" means any activity by which a hospital,
2 a designated agent, or an assignee of a hospital or a purchaser
3 of a patient account receivable requests payment for services
4 from a patient or a patient's family. "Collection action"
5 include, without limitation, pre-admission or pre-treatment
6 deposits, billing statements, letters, electronic mail,
7 telephone, and personal contacts related to hospital bills,
8 court summonses and complaints, and any other activity related
9 to collecting a hospital bill.
10 "Cost" means the actual expense a hospital incurs to
11 provide each service or supply.
12 "Effective date of eligibility" means the later of the date
13 on which medical services are rendered or the date of discharge
14 from a hospital.
15 "Eligible individual" means an individual (i) who does not
16 have public or private health insurance and whose family income
17 is at or below 400% of the federal poverty guidelines or (ii)
18 who has an insurance plan but the total out-of-pocket hospital
19 charges exceed 10% of the patient's family income in a 12-month
20 period.
21 "Family" means, for an individual 18 years of age and
22 older, the individual's spouse or domestic partner and
23 dependent children under age 21, whether living at home or not.
24 For an individual under 18 years of age, "family" means parents
25 or caretaker relatives.
26 "Federal poverty guidelines" means the poverty guidelines

1 updated periodically in the Federal Register by the United
2 States Department of Health and Human Services under authority
3 of 42 U.S.C. 9902(2).

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

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

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

1 through the Illinois Department of Revenue for being
2 charitable.
3 "Income" means a family's annual gross earnings and cash
4 benefits from all sources before taxes, less payments for child
5 support.
6 "Medical services" means services, whether inpatient or
7 outpatient services, or supplies that are reasonably expected
8 to prevent, diagnose, prevent the worsening of, alleviate,
9 correct, or cure a condition that endangers life, causes
10 suffering or pain, causes physical deformity or malfunction,
11 threatens to cause or aggravate a handicap, or results in
12 illness or infirmity. "Medical services" includes any
13 inpatient or outpatient hospital services mandated under Title
14 XIX of the federal Social Security Act and emergency care
15 mandates. "Medical services" also includes plastic surgery
16 designed to correct disfigurement caused by injury, illness, or
17 congenital defect or deformity. "Medical services" includes
18 only services deemed medically necessary.
19 "Non-safety-net hospital" means any freestanding general
20 hospital that did not qualify for Medicaid Disproportionate
21 Share Hospital (DSH) payment adjustments, pursuant to Title 89,
22 Section 148.120(a) of the Illinois Administrative Code, for the
23 most recent year that such payments were made.
24 "Operating margin" means the ratio of operating income to
25 operating revenues as each are reported in a hospital's audited
26 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.

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 financial assistance as defined in this Section for hospital fiscal year 2012 and beyond at a threshold level equal to at least 3.5% of the hospital's total revenue.

(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) 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

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

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

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

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

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

1 include a brief description of the financial assistance
2 application process. Each general hospital must provide a
3 similar notice to all community medical centers located in
4 its service area. These notices must be provided in the
5 same languages as the signs that are required in this
6 Section.
7 (f) Patient rights and responsibilities are as follows:
8 (1) General hospitals must distribute to every
9 patient, on or before the effective date of eligibility, a
10 written statement regarding financial assistance. This
11 statement must include the following:
12 (A) the availability of full or partial financial
13 assistance as provided in this Section;
14 (B) a patient's right to apply for financial
15 assistance within 90 days after the effective date of
16 eligibility;
17 (C) a determination of eligibility for full or
18 partial financial assistance must be made, in writing,
19 within 14 days after a completed application is made;
20 and
21 (D) a patient has the right to enter into a payment
22 plan pursuant to this Section if he or she is
23 determined eligible for partial financial assistance.
24 (2) If a patient qualifies for financial assistance
25 pursuant to this Act, then the general hospital shall
26 provide the patient assistance in filling out the

1 application and determining what types of documentation
2 are necessary.
3 (3) Individuals applying for or receiving financial
4 assistance from any general hospital must do all of the
5 following:
6 (A) Cooperate with the hospital to provide the
7 information and documentation necessary to apply for
8 other public or private existing programs or resources
9 that may be available to pay for health care,
10 including, without limitation, Medicare, Medicaid, or
11 the Children's Health Insurance Program.
12 (B) Promptly provide the hospital with accurate
13 and complete documentation and information.
14 (C) Promptly notify the hospital of any
15 significant change in financial status that is likely
16 to adversely affect eligibility for financial
17 assistance.
18 (D) Upon qualifying for partial financial
19 assistance, cooperate with the hospital to establish a
20 reasonable payment plan that takes into account
21 available income and assets, the amount of the
22 discounted bill or bills, and any prior payments and
23 must make a good faith effort to comply with this
24 payment plan. The patient is responsible for promptly
25 communicating to the hospital any change in financial
26 situation that may impact his or her ability to pay the

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

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

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

23 (2) If the financial assistance provided by a hospital
24 for the year in accordance with Section 20 of this Act as
25 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) Rules shall define the distribution of the Fair Care Trust Fund funds so that those hospitals that exceed the threshold set forth in Section 20 shall be given priority for receiving available funds.

Section 40. Financial assistance 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) Financial assistance statement. A statement that identifies the aggregate dollar amount of financial assistance 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

1 assistance reported was provided in accordance with
2 Section 20 of this Act. Alternatively, a hospital may also
3 submit a copy of its profile compiled by the Department of
4 Public Health based on that Department's Annual Hospital
5 Questionnaire for purposes of reporting the amount of
6 financial assistance provided for the most recent fiscal
7 year as long as the assistance was provided in accordance
8 with Section 20 of this Act.

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

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

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

22 Section 45. Implementation and enforcement.

23 (a) The Department of Revenue shall be responsible for
24 calculating each general non-profit hospital's Fair Care fee
25 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.

1 (4) All fees and penalties provided for in this Act
2 shall constitute a debt to the State. The State's Attorney
3 is authorized to institute a civil suit in the name of the
4 State to recover the amount of any such unpaid fee or
5 penalty.
6 (5) If a general non-profit hospital refuses to pay a
7 Fair Care fee as required in Section 20, the State
8 Department of Revenue may revoke that hospital's property
9 tax exemption for that year.

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

13 Section 90. The State Finance Act is amended by adding
14 Section 5.786 as follows:

15 (30 ILCS 105/5.786 new)
16 <u>Sec. 5.786. The Fair Care Trust Fund.</u>

17 Section 99. Effective date. This Act takes effect January
18 1, 2012.