



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB5390

Introduced 2/10/2026, by Rep. Dagmara Avelar

SYNOPSIS AS INTRODUCED:

210 ILCS 88/5
210 ILCS 88/10
210 ILCS 88/16
210 ILCS 88/25
210 ILCS 88/27
210 ILCS 88/30
210 ILCS 88/35
210 ILCS 88/40
210 ILCS 88/45
210 ILCS 88/70
210 ILCS 89/5
210 ILCS 89/10
210 ILCS 89/15

Amends the Fair Patient Billing Act. Makes changes to findings and defined terms provisions. Provides that a hospital shall not deny any protection or benefit of the Act on the basis of a patient's citizenship or immigration status or assets or prospective assets. Provides that a patient who inquires about a denial of financial assistance in whole or in part must be permitted to appeal the decision within at least 90 days. Requires a hospital to use only a uniform financial assistance form developed and provided by the Attorney General no later than December 31, 2026. Provides that every hospital bill and every collection notice must notify the patient, in the patient's preferred language, of the availability of hospital financial assistance and charity care. Establishes further provisions concerning hospitals pursuing collection actions; outsourced health care services; patient responsibilities; and applicability of the Act. Amends the Hospital Uninsured Patient Discount Act. Sets forth provisions concerning uninsured patient discounts for specified income levels. Prohibits hospitals from making the availability of a discount under the Act contingent upon the uninsured patient first applying for coverage under public health insurance programs. Provides that patients may not be denied a discount under the Act on the basis of citizenship or immigration status or assets or prospective assets. Makes other changes concerning uninsured patient discounts, outsourcing health care services, and patient responsibilities. Effective immediately.

LRB104 18752 BAB 32195 b

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Fair Patient Billing Act is amended by
5 changing Sections 5, 10, 16, 25, 27, 30, 35, 40, 45, and 70 as
6 follows:

7 (210 ILCS 88/5)

8 Sec. 5. Purpose; findings.

9 (a) The purpose of this Act is to advance the prompt and
10 accurate payment of health care services through fair and
11 reasonable billing and collection practices of hospitals.

12 (b) The General Assembly finds that:

13 (1) Medical debts are the cause of an increasing
14 number of bankruptcies in Illinois and are typically
15 associated with severe financial hardship incurred by
16 bankrupt persons and their families.

17 (2) Patients, hospitals, and government bodies alike
18 will benefit from clearly articulated standards regarding
19 fair billing and collection practices for all Illinois
20 hospitals.

21 (3) Hospitals should employ responsible standards when
22 collecting debt from their patients.

23 (4) Patients should be provided sufficient billing

1 information from hospitals to determine the accuracy of
2 the bills for which they may be financially responsible.

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

6 (6) Hospitals should provide patients with timely and
7 meaningful access to any financial assistance available
8 through the hospital and any public health insurance
9 programs for which patients may be eligible to prevent
10 patients from ending up with avoidable medical debt.
11 Hospitals should assist patients who need financial
12 assistance to access it. Patients who are deemed eligible
13 for hospital financial assistance or public health
14 insurance programs should not be improperly billed,
15 steered into payment plans, or sent to collections.

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

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

22 (9) Hospitals have an obligation to screen uninsured
23 patients before pursuing collection action. To promote the
24 general welfare and to mitigate the negative impact that
25 medical debt has on accessing and using needed health
26 care, hospitals should not attempt to collect a debt from

1 an uninsured patient without first adequately screening
2 the patient for public health insurance programs and
3 financial assistance available to the patient and
4 assisting the patient in obtaining the hospital financial
5 assistance for which they are eligible.

6 (10) Hospitals are increasingly outsourcing on-site
7 health care services to third-party individuals or
8 entities. When a hospital outsources care, the hospital
9 must ensure the screening, billing, and collection action
10 protections continue to be afforded to hospital patients
11 under this Act.

12 (Source: P.A. 103-323, eff. 1-1-24.)

13 (210 ILCS 88/10)

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

15 "Collection action" means any referral of a bill to a
16 collection agency or law firm to collect payment for services
17 from a patient or a patient's guarantor for hospital services.

18 "Health care plan" means a health insurance company,
19 health maintenance organization, preferred provider
20 arrangement, or third party administrator authorized in this
21 State to issue policies or subscriber contracts or administer
22 those policies and contracts that reimburse for inpatient and
23 outpatient services provided in a hospital. Health care plan,
24 however, does not include any government-funded program such
25 as Medicare or Medicaid, workers' compensation, and accident

1 liability insurers.

2 "Insured patient" means a patient who is insured by a
3 health care plan.

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

6 "Outsource" or "outsourcing" means to contract with a
7 person or entity not employed by the hospital or otherwise not
8 on the hospital staff. "Outsourced" or "outsourcing" is
9 distinct from an in-network or out-of-network contracted
10 relationship with an insurer described in Section 50.

11 "Patient" means the individual receiving services from the
12 hospital and any individual who is the guarantor of the
13 payment for such services.

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

20 "Reasonable payment plan" means a plan to pay a hospital
21 bill that is offered to the patient or the patient's legal
22 representative and takes into account the patient's available
23 income ~~and assets~~, the amount owed, and any prior payments.

24 "Screen" or "screening" means a process whereby a hospital
25 engages with a patient to review and assess the patient's
26 potential eligibility for any financial assistance offered by

1 the hospital, public health insurance program, or other
2 discounted care known to the hospital; informs the patient of
3 the hospital's assessment; documents in the patient's record
4 the circumstances of the screening; and assists with the
5 application for hospital financial assistance.

6 "Uninsured patient" means a patient who is not insured by
7 a health care plan and is not a beneficiary under a
8 government-funded program, workers' compensation, or accident
9 liability insurance.

10 (Source: P.A. 103-323, eff. 1-1-24.)

11 (210 ILCS 88/16)

12 Sec. 16. Screening patients for health insurance and
13 financial assistance.

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

17 (1) public health insurance programs; and

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

19 (b) All screening activities, including initial screenings
20 and all follow-up assistance, must be provided in compliance
21 with the Language Assistance Services Act.

22 (c) If a patient declines or fails to respond to the
23 screening described in subsection (a), the hospital shall
24 document in the patient's record the patient's decision to
25 decline or failure to respond to the screening, confirming the

1 date and method by which the patient declined or failed to
2 respond.

3 (d) If a patient does not decline the screening described
4 in subsection (a), a hospital should screen an uninsured
5 patient during registration unless it would cause a delay of
6 care to the patient, otherwise a hospital must screen an
7 uninsured patient at the earliest reasonable moment.

8 (e) If a patient does not submit screening, financial
9 assistance application, or reasonable payment plan
10 documentation within 30 days after a request as required under
11 Section 45, the hospital shall document the lack of received
12 documentation, confirming the date that the screening took
13 place and that the 30-day timeline for responding to the
14 hospital's request has lapsed, but may be reopened within 90
15 days after the date of discharge, date of service, or
16 completion of the screening.

17 (f) If the screening indicates that the patient may be
18 eligible for a public health insurance program, the hospital
19 shall provide information to the patient about how the patient
20 can apply for the public health insurance program, including,
21 but not limited to, referral to health care navigators who
22 provide free and unbiased eligibility and enrollment
23 assistance, including health care navigators at federally
24 qualified health centers; local, State, or federal government
25 agencies; or any other resources that Illinois recognizes as
26 designed to assist uninsured individuals in obtaining health

1 coverage.

2 (g) If the uninsured patient's application for a public
3 health insurance program is approved, the hospital shall bill
4 the insuring entity and shall not pursue the patient for any
5 aspect of the bill, except for any required copayment,
6 coinsurance, or other similar payment for which the patient is
7 responsible under the insurance. If the uninsured patient's
8 application for public health insurance is denied, the
9 hospital shall again offer to screen the uninsured patient for
10 hospital financial assistance and the timeline for applying
11 for financial assistance under the Hospital Uninsured Patient
12 Discount Act shall begin again.

13 (h) A hospital shall offer to screen an insured patient
14 for hospital financial assistance under this Section if the
15 patient requests financial assistance screening, if the
16 hospital is contacted in response to a bill, if the hospital
17 learns information that suggests an inability to pay, or if
18 the circumstances otherwise suggest the patient's inability to
19 pay.

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

25 (j) A hospital shall not deny any protection or benefit of
26 this Act on the basis of a patient's citizenship or

1 immigration status or assets or prospective assets.

2 (Source: P.A. 103-323, eff. 1-1-24.)

3 (210 ILCS 88/25)

4 Sec. 25. Bill inquiries.

5 (a) A hospital must implement a process for patients to
6 inquire about or dispute a bill. Such process must include a
7 telephone number for billing inquiries and disputes and may
8 include any of the following options:

9 (1) a toll-free telephone number that the patient may
10 call;

11 (2) an address to which he or she may write;

12 (3) a department or identified individual within the
13 hospital he or she may call or write, with appropriate
14 contact information; or

15 (4) a website or e-mail address.

16 (b) All hospital bills and collection notices must provide
17 a telephone number allowing the patient to inquire about or
18 dispute a bill.

19 (c) The hospital must return calls made by patients as
20 promptly as possible, but no later than 2 business days after
21 the call is made. If the hospital's billing inquiry process
22 involves correspondence from the patient, the hospital must
23 respond within 10 business days of receipt of the patient
24 correspondence. For purposes of this Section, "business day"
25 means a day on which the hospital's billing office is open for

1 regular business.

2 (d) A patient who inquires about a denial of financial
3 assistance in whole or in part must be permitted to appeal the
4 decision within at least 90 days from the denial. The hospital
5 must advise the patient about the availability of seeking
6 assistance in resolving the billing dispute or denial of
7 financial assistance from the Health Care Bureau of the Office
8 of the Attorney General and must provide contact information
9 for the Health Care Bureau in the patient's preferred
10 language.

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

12 (210 ILCS 88/27)

13 Sec. 27. Application Procedures for Financial Assistance.

14 (a) Applications. A hospital must use only a uniform
15 financial assistance form developed and provided by the
16 Attorney General no later than December 31, 2026. In
17 developing this form, the Attorney General shall consult with
18 advocates for communities with limited access to affordable
19 health care coverage and other health care consumer advocates,
20 representatives of the hospital industry, and local public
21 health officials. The Attorney General must consult with
22 organizations and consumers by September 1, 2026. A hospital
23 may not request information regarding a patient's assets when
24 a patient applies for financial assistance. Eligibility for
25 financial assistance is determined solely on household income.

1 Approval of eligibility for financial assistance is valid for
2 12 months after the first service date for which the patient
3 submitted a financial assistance application. ~~The Attorney~~
4 ~~General shall, by rule, adopt standard provisions to be~~
5 ~~included in all applications for financial assistance no later~~
6 ~~than June 30, 2013. On or before January 1, 2013, a statewide~~
7 ~~association representing a majority of hospitals may submit to~~
8 ~~the Attorney General recommendations concerning standard~~
9 ~~provisions to be used in an application for financial~~
10 ~~assistance, and the Attorney General shall take those~~
11 ~~recommendations into account when adopting rules under this~~
12 ~~subsection.~~

13 (b) Presumptive Eligibility. The Attorney General shall,
14 by rule, adopt appropriate methodologies for the determination
15 of presumptive eligibility no later than June 30, 2013. On or
16 before January 1, 2013, a statewide association representing a
17 majority of hospitals may submit to the Attorney General
18 recommendations concerning those methodologies, and the
19 Attorney General shall take those recommendations into account
20 when adopting rules under this subsection.

21 (Source: P.A. 97-690, eff. 6-14-12.)

22 (210 ILCS 88/30)

23 Sec. 30. Pursuing collection action.

24 (a) Hospitals and their agents may pursue collection
25 action against an uninsured patient only if the following

1 conditions are met:

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

6 (2) The hospital has given the uninsured patient the
7 opportunity to:

8 (A) assess the accuracy of the bill;

9 (B) apply for financial assistance under the
10 hospital's financial assistance policy; and

11 (C) avail themselves of a reasonable payment plan
12 for which the hospital must collect any amount charged
13 in monthly installments such that a patient is not
14 paying more than 4% of the patient's monthly household
15 income. After a cumulative 36 months of payments, a
16 hospital must consider the patient's bill paid in full
17 and permanently cease any and all collection
18 activities on any balance that remains unpaid. The
19 availability of a capped 4%-of-income reasonable
20 payment plan shall be included in the hospital's
21 financial assistance policy and in information
22 provided to uninsured patients.

23 (3) 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
26 payment plan. The hospital may require the uninsured

1 patient to provide reasonable verification of his or her
2 inability to pay the full amount of the debt in one
3 payment.

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

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

17 (6) If the uninsured patient informs the hospital that
18 he or she has applied for health care coverage under a
19 public health insurance program (and there is a reasonable
20 basis to believe that the patient will qualify for such
21 program) but the patient's application is denied.

22 (a-5) A hospital shall proactively offer information on
23 charity care options available to uninsured patients,
24 regardless of their immigration status or residency. Every
25 hospital bill and every collection notice must notify the
26 patient, in the patient's preferred language, of the

1 availability of hospital financial assistance and charity
2 care.

3 (b) A hospital may not refer a bill, or portion thereof, to
4 a collection agency or attorney for collection action against
5 the insured patient, without first ensuring compliance with
6 Section 16 and offering the patient the opportunity to request
7 a reasonable payment plan for the amount personally owed by
8 the patient. Such an opportunity shall be made available for
9 the 90 days following the date of the initial bill. If the
10 insured patient requests a reasonable payment plan, but fails
11 to agree to a plan within 90 days of the request, the hospital
12 may proceed with collection action against the 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; 103-323, eff. 1-1-24.)

1 (210 ILCS 88/35)

2 Sec. 35. Collection limitations.

3 (a) The hospital shall not pursue legal action for
4 non-payment of a hospital bill against uninsured patients who
5 have clearly demonstrated that they have neither sufficient
6 income ~~nor assets~~ to meet their financial obligations provided
7 the patient has complied with Section 45 of this Act.

8 (b) A hospital may not bill an uninsured patient who
9 requires health care services, as defined in Section 5 of the
10 Hospital Uninsured Patient Discount Act, if it determines,
11 through its financial assistance screening process, that the
12 patient has a household income that qualifies the person for
13 free care under the Hospital Uninsured Patient Discount Act.
14 If the patient is deemed eligible for public health insurance
15 or any other insurance product certified by the Department of
16 Insurance, the hospital shall provide information to the
17 patient about how the patient can apply for the insurance
18 program under subsection (f) of Section 16.

19 (c) Any action on a medical debt by a hospital must be
20 commenced within 3 years after treatment.

21 (Source: P.A. 103-901, eff. 1-1-25; 104-417, eff. 8-15-25.)

22 (210 ILCS 88/40)

23 Sec. 40. Hospital agents; outsourced health care services
24 on-site.

25 (a) The hospital must ensure that any external collection

1 agency, law firm, or individual engaged by the hospital to
2 obtain payment of outstanding bills for hospital services
3 agrees in writing to comply with the collections provisions of
4 this Act.

5 (b) The hospital's obligation to patients under this Act
6 covers all health care services, including, but not limited
7 to, any outsourced health care service provided in a hospital
8 building or facility by a hospital contractor.

9 (c) If the hospital outsources health care services within
10 the hospital facility or on the hospital site, the hospital
11 must ensure that the individual or entity contracted to
12 provide health care services abides by the hospital's
13 financial assistance policy or a substantially similar
14 financial assistance policy, screening obligations,
15 collections provisions, and any other provisions of this Act.

16 (d) The hospital is responsible for ensuring a provider of
17 outsourced health care services complies with this Act.

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

19 (210 ILCS 88/45)

20 Sec. 45. Patient responsibilities.

21 (a) To receive the protection and benefits of this Act, a
22 patient responsible for paying a hospital bill must act
23 reasonably and cooperate in good faith with the hospital in
24 the screening process by providing the hospital with all of
25 the reasonably requested financial and other relevant

1 information and documentation needed to determine the
2 patient's potential eligibility for coverage under a public
3 health insurance program, under the hospital's financial
4 assistance policy, or for a reasonable payment plan within 30
5 days of a request for such information. A hospital must not
6 require a patient to provide any information regarding
7 citizenship, immigration, assets, or prospective assets, even
8 for the purpose of determining eligibility for a public health
9 insurance program.

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

17 (Source: P.A. 103-323, eff. 1-1-24.)

18 (210 ILCS 88/70)

19 Sec. 70. Application.

20 (a) (1) This Act applies to all hospitals licensed under
21 the Hospital Licensing Act or the University of Illinois
22 Hospital Act. This Act does not apply to a hospital that does
23 not charge for its services.

24 (2) This Act applies to all outpatient clinics or
25 facilities affiliated with a hospital or operating under the

1 license of a hospital as described in paragraph (1).

2 (3) This Act applies to any licensed practice that
3 provides outpatient medical, behavioral, optical,
4 radiological, laboratory, dental, or other health care
5 services with revenues of at least \$20,000,000 annually, even
6 if not affiliated with a hospital.

7 (b) The obligations of hospitals under this Act shall take
8 effect for services provided on or after the first day of the
9 month that begins 180 days after the effective date of this
10 Act.

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

16 (Source: P.A. 103-323, eff. 1-1-24.)

17 Section 10. The Hospital Uninsured Patient Discount Act is
18 amended by changing Sections 5, 10, and 15 as follows:

19 (210 ILCS 89/5)

20 Sec. 5. Definitions. As used in this Act:

21 "Community health center" means a federally qualified
22 health center as defined in Section 1905(1)(2)(B) of the
23 federal Social Security Act or a federally qualified health
24 center look-alike.

1 "Cost to charge ratio" means the ratio of a hospital's
2 costs to its charges taken from its most recently filed
3 Medicare cost report (CMS 2552-96 Worksheet C, Part I, PPS
4 Inpatient Ratios).

5 "Critical Access Hospital" means a hospital that is
6 designated as such under the federal Medicare Rural Hospital
7 Flexibility Program.

8 "Family income" means the sum of a family's annual
9 earnings and cash benefits from all sources before taxes, less
10 payments made for child support.

11 "Federal poverty income guidelines" means the poverty
12 guidelines updated periodically in the Federal Register by the
13 United States Department of Health and Human Services under
14 authority of 42 U.S.C. 9902(2).

15 "Financial assistance" means a discount provided to a
16 patient under the terms and conditions a hospital offers to
17 qualified patients or as required by law.

18 "Free and charitable clinic" means a 501(c)(3) tax-exempt
19 health care organization providing health services to
20 low-income uninsured or underinsured individuals that is
21 recognized by either the Illinois Association of Free and
22 Charitable Clinics or the National Association of Free and
23 Charitable Clinics.

24 "Guaranteed income program" means a publicly or privately
25 funded program that provides one-time or recurring
26 unconditional cash transfers or payments, or gifts to

1 individuals or households, for a defined number of months or
2 years for the purposes of reducing poverty, promoting economic
3 mobility, or increasing the financial stability of Illinois
4 residents.

5 "Health care services" means any medically necessary
6 inpatient or outpatient hospital service, including
7 pharmaceuticals or supplies provided by a hospital to a
8 patient.

9 "Hospital" means any facility or institution required to
10 be licensed pursuant to the Hospital Licensing Act or operated
11 under the University of Illinois Hospital Act and includes
12 outpatient clinics or facilities affiliated with a hospital or
13 operating under the license of a hospital.

14 "Illinois resident" means any person who lives in Illinois
15 and who intends to remain living in Illinois indefinitely.
16 Relocation to Illinois for the sole purpose of receiving
17 health care benefits does not satisfy the residency
18 requirement under this Act.

19 "Medically necessary" means any inpatient or outpatient
20 hospital service, including pharmaceuticals or supplies
21 provided by a hospital to a patient, covered under Title XVIII
22 of the federal Social Security Act for beneficiaries with the
23 same clinical presentation as the uninsured patient. A
24 "medically necessary" service does not include any of the
25 following:

26 (1) Non-medical services such as social and vocational

1 services.

2 (2) Elective cosmetic surgery, but not plastic surgery
3 designed to correct disfigurement caused by injury,
4 illness, or congenital defect or deformity.

5 "Outsource" or "outsourcing" means to contract with a
6 person or entity not employed by the hospital, or otherwise
7 not on the hospital staff.

8 "Rural hospital" means a hospital that is located outside
9 a metropolitan statistical area.

10 "Uninsured discount" means a hospital's charges multiplied
11 by the uninsured discount factor.

12 "Uninsured discount factor" means 1.0 less the product of
13 a hospital's cost to charge ratio multiplied by 1.35.

14 "Uninsured patient" means an Illinois resident who is a
15 patient of a hospital and is not covered under a policy of
16 health insurance and is not a beneficiary under a public or
17 private health insurance, health benefit, or other health
18 coverage program, including high deductible health insurance
19 plans, workers' compensation, accident liability insurance, or
20 other third party liability.

21 (Source: P.A. 102-581, eff. 1-1-22; 103-492, eff. 1-1-24.)

22 (210 ILCS 89/10)

23 Sec. 10. Uninsured patient discounts.

24 (a) Eligibility.

25 (1) A hospital, other than a rural hospital or

1 Critical Access Hospital, shall provide a discount from
2 its charges to any uninsured patient who applies for a
3 discount and has family income of not more than 600% of the
4 federal poverty income guidelines for all medically
5 necessary health care services exceeding \$150 in any one
6 inpatient admission or outpatient encounter.

7 (2) A hospital, other than a rural hospital or
8 Critical Access Hospital, shall provide a charitable
9 discount of 100% of its charges for all medically
10 necessary health care services exceeding \$150 in any one
11 inpatient admission or outpatient encounter to any
12 uninsured patient who applies for a discount and has
13 family income of not more than 300% ~~200%~~ of the federal
14 poverty income guidelines.

15 (3) A rural hospital or Critical Access Hospital shall
16 provide a discount from its charges to any uninsured
17 patient who applies for a discount and has annual family
18 income of not more than 300% of the federal poverty income
19 guidelines for all medically necessary health care
20 services exceeding \$300 in any one inpatient admission or
21 outpatient encounter.

22 (4) A rural hospital or Critical Access Hospital shall
23 provide a charitable discount of 100% of its charges for
24 all medically necessary health care services exceeding
25 \$300 in any one inpatient admission or outpatient
26 encounter to any uninsured patient who applies for a

1 discount and has family income of not more than 200% ~~125%~~
2 of the federal poverty income guidelines. A patient or a
3 rural hospital or Critical Access Hospital with household
4 income of 201-400% of the poverty guidelines updated
5 periodically in the Federal Register by the United States
6 Department of Health and Human Services under the
7 authority of 42 U.S.C. 9902(2) shall be charged pursuant
8 to paragraph (6).

9 (5) In determining eligibility under this Act, a
10 hospital subject to this Act shall exclude from
11 consideration any unconditional cash transfers, payments,
12 or gifts received under a guaranteed income program if:

13 (A) such cash transfers, payments, or gifts are
14 excluded from consideration for determining
15 eligibility under public health insurance programs
16 administered by the State in which the State has the
17 authority to waive guaranteed income; and

18 (B) the guaranteed income program is a program for
19 a defined number of months or years designed to reduce
20 poverty, promote social mobility, or increase
21 financial stability for program participants and if
22 there is an explicit plan to collect data.

23 This paragraph is inoperative on and after July 1,
24 2026.

25 (6) Patients with household income of 301-400% of the
26 poverty guidelines updated periodically in the Federal

1 Register by the United States Department of Health and
2 Human Services under the authority of 42 U.S.C. 9902(2)
3 shall be charged no more than the amount calculated in the
4 following manner:

5 (A) recalculate the patient's bill using the
6 Medicare reimbursement rate applicable on the date of
7 service; and

8 (B) the patient shall be charged no more than 25%
9 of this recalculated bill.

10 (7) Patients with household income of 401-600% of the
11 poverty guidelines updated periodically in the Federal
12 Register by the United States Department of Health and
13 Human Services under the authority of 42 U.S.C. 9902(2)
14 shall receive the same discounts as patients with
15 household income of 301-400% of the poverty guidelines if
16 the patient and the patient's household have incurred
17 medical expenses from the hospital's bill and all other
18 medical bills for medically necessary health care services
19 received during the previous 12 months that, in total,
20 exceed 5% of the household's annual income.

21 (8) In addition to other financial assistance provided
22 under this Act, no patient with household income at or
23 below 400% of the poverty guidelines updated periodically
24 in the Federal Register by the United States Department of
25 Health and Human Services under the authority of 42 U.S.C.
26 9902(2) shall be required to pay more than \$2,300 in

1 cumulative medical bills to large health care facilities
2 per year. Upon patient request and documentation, any
3 health care services that have been delivered by one or
4 more hospitals after the \$2,400 limit has been met must be
5 provided as free care.

6 (9) A patient's assets may not be considered when
7 reviewing eligibility under this Act. Eligibility for an
8 uninsured patient discount is determined solely on family
9 income.

10 (10) Hospitals may not make the availability of a
11 discount under this Act contingent upon the uninsured
12 patient first applying for coverage under public health
13 insurance programs.

14 (11) Patients may not be denied a discount under this
15 Act on the basis of citizenship or immigration status or
16 assets or prospective assets.

17 (b) Discount. For all health care services exceeding \$300
18 in any one inpatient admission or outpatient encounter, a
19 hospital shall not collect from an uninsured patient, deemed
20 eligible under subsection (a), more than its charges less the
21 amount of the uninsured discount.

22 (c) Maximum Collectible Amount.

23 (1) The maximum amount that may be collected in a
24 12-month period for health care services provided by the
25 hospital from a patient determined by that hospital to be
26 eligible under subsection (a) is 20% of the patient's

1 family income, and is subject to the patient's continued
2 eligibility under this Act.

3 (2) The 12-month period to which the maximum amount
4 applies shall begin on the first date, after the effective
5 date of this Act, an uninsured patient receives health
6 care services that are determined to be eligible for the
7 uninsured discount at that hospital.

8 (3) To be eligible to have this maximum amount applied
9 to subsequent charges, the uninsured patient shall inform
10 the hospital in subsequent inpatient admissions or
11 outpatient encounters that the patient has previously
12 received health care services from that hospital and was
13 determined to be entitled to the uninsured discount. The
14 availability of the maximum collectible amount shall be
15 included in the hospital's financial assistance
16 information provided to uninsured patients.

17 (4) (Blank). ~~Hospitals may adopt policies to exclude~~
18 ~~an uninsured patient from the application of subdivision~~
19 ~~(c)(1) when the patient owns assets having a value in~~
20 ~~excess of 600% of the federal poverty level for hospitals~~
21 ~~in a metropolitan statistical area or owns assets having a~~
22 ~~value in excess of 300% of the federal poverty level for~~
23 ~~Critical Access Hospitals or hospitals outside a~~
24 ~~metropolitan statistical area, not counting the following~~
25 ~~assets: the uninsured patient's primary residence;~~
26 ~~personal property exempt from judgment under Section~~

1 ~~12-1001 of the Code of Civil Procedure; or any amounts~~
2 ~~held in a pension or retirement plan, provided, however,~~
3 ~~that distributions and payments from pension or retirement~~
4 ~~plans may be included as income for the purposes of this~~
5 ~~Act.~~

6 (d) Each hospital bill, invoice, or other summary of
7 charges to an uninsured patient shall include with it, or on
8 it, a prominent statement that an uninsured patient who meets
9 certain income requirements may qualify for an uninsured
10 discount and information regarding how an uninsured patient
11 may apply for consideration under the hospital's financial
12 assistance policy. The hospital's financial assistance
13 application shall include language that directs the uninsured
14 patient to contact the hospital's financial counseling
15 department with questions or concerns, along with contact
16 information for the financial counseling department, and shall
17 state: "Complaints or concerns with the uninsured patient
18 discount application process or hospital financial assistance
19 process may be reported to the Health Care Bureau of the
20 Illinois Attorney General.". A website, phone number, or both
21 provided by the Attorney General shall be included with this
22 statement.

23 (e) If the hospital outsources health care services within
24 the hospital facility or otherwise on the hospital site, the
25 hospital must ensure that the individual or entity providing
26 the outsourced health services abides by the hospital's

1 uninsured patient discount obligations under this Act or
2 substantially similar financial assistance policies. The
3 hospital shall include charges from any outsourced health
4 service provider within the hospital facility or on the
5 hospital site when calculating the charge, discount, or
6 collectible amount applicable under this Act.

7 (f) The hospital's obligation to patients under this Act
8 covers all health care services, including, but not limited
9 to, outsourced on-site health care services provided by a
10 nonhospital entity.

11 (g) If the hospital outsources health care services within
12 the hospital facility or on the hospital site, the hospital
13 must ensure any provider of outsourced health care services
14 complies with this Act.

15 (Source: P.A. 102-581, eff. 1-1-22; 103-492, eff. 1-1-24.)

16 (210 ILCS 89/15)

17 Sec. 15. Patient responsibility.

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

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

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

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

1 public health insurance program shall be given the opportunity
2 to apply for hospital financial assistance when hospital
3 services are scheduled. An uninsured patient who subsequently
4 becomes eligible for insurance, a public health insurance
5 program, or charity care shall be given the opportunity to
6 apply for hospital financial assistance for any outstanding
7 bill.

8 (1) Income verification. Hospitals may require an
9 uninsured patient who is requesting an uninsured discount
10 to provide documentation of family income. Acceptable
11 family income documentation shall include any one of the
12 following:

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

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

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

17 (D) written income verification from an employer
18 if paid in cash; or

19 (E) one other reasonable form of third-party
20 income verification deemed acceptable to the hospital.

21 (2) ~~(Blank). Asset verification. Hospitals may require~~
22 ~~an uninsured patient who is requesting an uninsured~~
23 ~~discount to certify the existence or absence of assets~~
24 ~~owned by the patient and to provide documentation of the~~
25 ~~value of such assets, except for those assets referenced~~
26 ~~in paragraph (4) of subsection (c) of Section 10.~~

1 ~~Acceptable documentation may include statements from~~
2 ~~financial institutions or some other third party~~
3 ~~verification of an asset's value. If no third party~~
4 ~~verification exists, then the patient shall certify as to~~
5 ~~the estimated value of the asset.~~

6 (3) Illinois resident verification. Hospitals may
7 require an uninsured patient who is requesting an
8 uninsured discount to verify Illinois residency.
9 Acceptable verification of Illinois residency shall
10 include any one of the following:

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

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

13 (C) a recent residential utility bill;

14 (D) a lease agreement;

15 (E) a vehicle registration card;

16 (F) a voter registration card;

17 (G) mail addressed to the uninsured patient at an
18 Illinois address from a government or other credible
19 source;

20 (H) a statement from a family member of the
21 uninsured patient who resides at the same address and
22 presents verification of residency;

23 (I) a letter from a homeless shelter, transitional
24 house or other similar facility verifying that the
25 uninsured patient resides at the facility; or

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

1 (c) Hospital obligations toward an individual uninsured
2 patient under this Act shall cease if that patient
3 unreasonably fails or refuses to provide the hospital with
4 information or documentation requested under subsection (b) ~~or~~
5 ~~to apply for coverage under public programs when requested~~
6 ~~under subsection (a)~~ within 30 days of the hospital's request.

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

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

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

26 (Source: P.A. 102-581, eff. 1-1-22; 103-323, eff. 1-1-24;

1 103-492, eff. 1-1-24; 103-605, eff. 7-1-24.)

2 Section 99. Effective date. This Act takes effect upon
3 becoming law.