HB3232

LRB10215012CPF20367b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB3232

Introduced 2/19/2021, by Rep. Camille Y. Lilly

SYNOPSIS AS INTRODUCED:

See Index

Amends the Community Benefits Act. Provides that the Act applies to all nonprofit and public hospitals licensed under the Hospital Licensing Act or operated under the University of Illinois Hospital Act (rather than not applying to a hospital operated by a unit of government, a hospital located outside of a metropolitan statistical area, or a hospital with 100 or fewer beds). Requires community benefits plans to describe activities the hospital is undertaking to address health equity, reduce health disparities, and improve community health. Provides that, in order to increase transparency and accessibility of charity care and financial assistance data, the Attorney General shall post on the Attorney General's website: all community benefits plans contained in reports submitted by hospitals; and a compiled report that summarizes information from completed community benefits plans. Provides that an electronic version of the compiled report shall be sent to the Governor and each member of the General Assembly. Provides a late filing fee for nonprofit hospitals for community benefits plans of $2,500 per month that the report is late (rather than $100). Makes other changes. Amends the Hospital Uninsured Patient Discount Act. Provides that hospitals, other than a rural hospital or Critical Access Hospitals, shall provide a discount from charges to specified uninsured patients for all medically necessary health care services exceeding $150 (rather than $300) in any one inpatient admission or outpatient encounter. Provides civil monetary penalties of not$1,000 to $5,000 (rather than $500). Requires the Attorney General to publish an annual report that outlines complaints received related to hospital uninsured discount programs and financial assistance applications. Makes other changes. Effective immediately.

LRB102 15012 CPF 20367 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 Community Benefits Act is amended by changing Sections 5, 10, 15, 20, and 25 and by adding Section 22 as follows:

(210 ILCS 76/5)

Sec. 5. Applicability. This Act applies to all nonprofit and public hospitals licensed under the Hospital Licensing Act or operated under the University of Illinois Hospital Act. ~~This Act does not apply to a hospital operated by a unit of government, a hospital located outside of a metropolitan statistical area, or a hospital with 100 or fewer beds.~~ Hospitals that are owned or operated by or affiliated with a health system shall be deemed to be in compliance with this Act if the health system has met the requirements of this Act.

(Source: P.A. 93-480, eff. 8-8-03.)

(210 ILCS 76/10)

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

"Bad debt" means any bill submitted to a patient or guarantor where efforts to collect are exhausted and the bill is not paid in full.

"Charity care" means care provided by a health care provider for which the provider does not expect to receive payment from the patient or a third party payer. "Charity care" includes the actual cost of services provided based upon the total cost to charge ratio derived from the nonprofit hospital's Medicare cost report and not based upon the charges for the services. "Charity care" does not include bad debt.

"Community benefits" means the unreimbursed cost to a hospital or health system of providing charity care, language assistant services, government-sponsored ~~indigent~~ health care, donations, volunteer services, education, government-sponsored program services, research, and subsidized health services and collecting bad debts. "Community benefits" does not include the cost of paying any taxes or other governmental assessments.

"Cost to charge ratio" means the ratio between a hospital's expenses and what the hospital charges, and service costs relative to the charges assigned by the hospital, as provided in the hospital's Medicare Cost Report.

"Financial assistance" means care given at a reduced rate or no cost due to the inability of the patient to pay for such care as a result of being uninsured or underinsured under the terms and conditions the hospital offers to qualified patients and as required by law.

"Government-sponsored~~Government sponsored indigent~~ health care" means the unreimbursed cost to a hospital or health

system of Medicare, providing health care services to recipients of Medicaid, and other federal, State, or local ~~indigent~~ health care programs, eligibility for which is based on financial need.

"Health system" means an entity that owns or operates at least one hospital.

"Net patient revenue" means the amount a hospital or health system expects to be received from a public or private health insurance payer, or paid directly in the form of copayments, coinsurance, or other payment, for health care services provided by the hospital or health system.

"Nonprofit hospital" means a hospital that is organized as a nonprofit corporation, including religious organizations, or a charitable trust under Illinois law or the laws of any other state or country.

"Subsidized health services" means those services provided by a hospital in response to community needs for which the reimbursement is less than the hospital's cost of providing the services that must be subsidized by other hospital or nonprofit supporting entity revenue sources. "Subsidized health services" includes, but is not limited to, emergency and trauma care, neonatal intensive care, community health clinics, and collaborative efforts with local government or private agencies to prevent illness and improve wellness, such as immunization programs.

(Source: P.A. 93-480, eff. 8-8-03.)

(210 ILCS 76/15)

Sec. 15. Organizational mission statement; community benefits plan. A nonprofit hospital shall develop:

(1) an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community; and

(2) a community benefits plan defined as an operational plan for serving the community's health care needs that:

(A) sets out goals and objectives for providing community benefits that include charity care and government-sponsored ~~government sponsored indigent~~ health care; ~~and~~

(B) identifies the populations and communities served by the hospital; and~~.~~

(C) describes activities the hospital is undertaking to address health equity, reduce health disparities, and improve community health. This may include, but is not limited to:

(i) efforts to recruit and promote a racially and culturally diverse and representative workforce;

(ii) efforts to procure goods and services locally and from historically underrepresented communities;

(iii) training that addresses cultural competency and implicit bias; and

(iv) partnerships and investments to address social needs such as food, housing, and community safety.

(Source: P.A. 93-480, eff. 8-8-03.)

(210 ILCS 76/20)

Sec. 20. Annual report for community benefits plan.

(a) Each nonprofit hospital shall prepare an annual report of the community benefits plan. The report must include, in addition to the community benefits plan itself, all of the following background information:

(1) The hospital's mission statement.

(2) A disclosure of the health care needs of the community that were considered in developing the hospital's community benefits plan.

(3) A disclosure of the amount and types of community benefits actually provided, including charity care, and details about financial assistance applications received and processed by hospitals as specified in paragraph (5) of subsection (a) of Section 22. Charity care must be reported separate from other community benefits. In reporting charity care, the hospital must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost

report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), not the charges for the services. For a health system that includes more than one hospital, charity care spending and financial assistance application data must be reported separately for each individual hospital within the health system.

(4) Audited annual financial reports for its most recently completed fiscal year.

(b) Each nonprofit hospital shall annually file a report of the community benefits plan with the Attorney General. The report must be filed not later than the last day of the sixth month after the close of the hospital's fiscal year, beginning with the hospital fiscal year that ends in 2004.

(c) Each nonprofit hospital shall prepare a statement that notifies the public that the annual report of the community benefits plan is:

(1) public information;

(2) filed with the Attorney General; and

(3) available to the public on request from the Attorney General.

This statement shall be made available to the public.

(d) The obligations of a hospital under this Act, except for the filing of its audited financial report, shall take effect beginning with the hospital's fiscal year that begins after the effective date of this Act. Within 60 days of the effective date of this Act, a hospital shall file the audited

annual financial report that has been completed for its most recently completed fiscal year. Thereafter, a hospital shall include its audited annual financial report for its most recently completed fiscal year in its annual report of its community benefits plan.

(Source: P.A. 93-480, eff. 8-8-03.)

(210 ILCS 76/22 new)

Sec. 22. Public reports.

(a) In order to increase transparency and accessibility of charity care and financial assistance data, the Attorney General shall post on the Attorney General's website: all community benefits plans contained in reports submitted by hospitals under Section 20; and a compiled report that summarizes information from completed community benefits plans. Past reports and disclosures shall remain publicly available on the website for at least 15 years. Numerical data shall be published in XML, CSV, and PDF file formats. Hospitals shall also make this information available to the public by publishing this information on the hospital's website in the same location where annual reports are posted. Information made available to the public shall include, but not be limited to, the following:

(1) The reporting period.

(2) Charity care costs consistent with the reporting requirements in paragraph (3) of subsection (a) of Section

20. Charity care costs associated with services provided as part of a hospital's obligation to comply with the federal Emergency Medical Treatment and Labor Act shall be reported as a subset of total charity care costs.

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

(4) Total community benefits spending.

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

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

(B) the number of applications approved, with details as to whether the approval was for full or partial financial assistance, as well as the type of service, including inpatient, outpatient, emergency department, or other, associated with the approved application; and

(C) the number of applications denied, the 5 most frequent reasons for denial, and the type of services associated with the denied application, including inpatient, outpatient, emergency department, or other.

(6) To the extent that race, ethnicity, or preferred language is collected and available for financial assistance applications, the data outlined in paragraph

(5) shall be reported by race, ethnicity, gender, employment status, occupation, housing status, and primary language. If this data is not provided by the patient, the hospital shall indicate this in its reports.

(b) An electronic version of the Attorney General report under subsection (a) shall be sent to the Governor and each member of the General Assembly.

(210 ILCS 76/25)

Sec. 25. Failure to file annual report. The Attorney General may assess a late filing fee against a nonprofit hospital that fails to make a report of the community benefits plan as required under this Act in an amount not to exceed $2,500 per month that the report is late ~~$100~~. The Attorney General may grant extensions for good cause. No penalty may be assessed against a hospital under this Section until 30 business days have elapsed after written notification to the hospital of its failure to file a report.

(Source: P.A. 93-480, eff. 8-8-03.)

Section 10. The Hospital Uninsured Patient Discount Act is amended by changing Sections 5, 10, 15, and 25 as follows:

(210 ILCS 89/5)

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

"Cost to charge ratio" means the ratio of a hospital's

costs to its charges taken from its most recently filed Medicare cost report (CMS 2552-96 Worksheet C, Part I, PPS Inpatient Ratios).

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

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

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

"Financial assistance" means care given at a reduced rate or no cost due to the inability of the patient to pay for such care as a result of being uninsured or underinsured under the terms and conditions the hospital offers to qualified patients and as required by law.

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

"Hospital" means any facility or institution required to be licensed pursuant to the Hospital Licensing Act or operated under the University of Illinois Hospital Act.

"Illinois resident" means any ~~a~~ person who lives in

Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this Act.

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

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

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

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

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

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

"Uninsured patient" means an Illinois resident who ~~is a patient of a hospital and~~ is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health

coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability.

(Source: P.A. 95-965, eff. 12-22-08.)

(210 ILCS 89/10)

Sec. 10. Uninsured patient discounts.

(a) Eligibility.

(1) A hospital, other than a rural hospital or Critical Access Hospital, shall provide a discount from its charges to any uninsured patient who applies for a discount and has family income of not more than 600% of the federal poverty income guidelines for all medically necessary health care services exceeding $150 ~~$300~~ in any one inpatient admission or outpatient encounter.

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

(3) A rural hospital or Critical Access Hospital shall provide a discount from its charges to any uninsured patient who applies for a discount and has annual family

income of not more than 300% of the federal poverty income guidelines for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter.

Hospitals shall notify patients of their ability to include health care received in the last 12 months towards the maximum collectable amount. This information shall be included clearly and in plain language on financial assistance applications, hospital bills, invoices, or summary of charges provided by the hospital.

(4) A rural hospital or Critical Access Hospital shall provide a charitable discount of 100% of its charges for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter to any uninsured patient who applies for a discount and has family income of not more than 125% of the federal poverty income guidelines.

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

(c) Maximum Collectible Amount.

(1) The maximum amount that may be collected in a 12 month period for health care services provided by the hospital from a patient determined by that hospital to be

eligible under subsection (a) is 15% ~~25%~~ of the patient's family income, and is subject to the patient's continued eligibility under this Act.

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

(3) To be eligible to have this maximum amount applied to subsequent charges, the uninsured patient shall inform the hospital in subsequent inpatient admissions or outpatient encounters that the patient has previously received health care services from that hospital and was determined to be entitled to the uninsured discount.

(4) Hospitals may adopt policies to exclude an uninsured patient from the application of subdivision (c)(1) when the patient owns assets having a value in excess of 600% of the federal poverty level for hospitals in a metropolitan statistical area or owns assets having a value in excess of 300% of the federal poverty level for Critical Access Hospitals or hospitals outside a metropolitan statistical area, not counting the following assets: the uninsured patient's primary residence; personal property exempt from judgment under Section 12-1001 of the Code of Civil Procedure; or any amounts held in a pension or retirement plan, provided, however,

that distributions and payments from pension or retirement plans may be included as income for the purposes of this Act.

(d) Each hospital bill, invoice, or other summary of charges to an uninsured patient shall include with it, or on it, a prominent statement that an uninsured patient who meets certain income requirements may qualify for an uninsured discount and information regarding how an uninsured patient may apply for consideration under the hospital's financial assistance policy. Each hospital bill, invoice, or other summary of charges to an uninsured patient shall state: "Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General.". A website, phone number, or both provided by the Attorney General shall be included with this statement.

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

(210 ILCS 89/15)

Sec. 15. Patient responsibility.

(a) Hospitals may make the availability of a discount and the maximum collectible amount under this Act contingent upon the uninsured patient first applying for coverage under public programs, such as Medicare, Medicaid, AllKids, the State Children's Health Insurance Program, or any other program, if there is a reasonable basis to believe that the uninsured

patient may be eligible for such program.

(b) Hospitals shall permit an uninsured patient to initiate an application for financial assistance prior to the receipt of a service ~~apply for a discount~~ within 60 days of the date of discharge or date of service. Hospitals shall permit uninsured patients with an inpatient hospital stay of 20 or more days to initiate an application for financial assistance within 90 days after the date of discharge.

(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

(5) 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; ~~or~~

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

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

(f) Hospitals shall ask for an applicant's race, ethnicity, gender, employment status, occupation, housing status, and preferred language on the financial assistance application. However, the questions shall be clearly marked as optional responses for the patient and shall note that responses or nonresponses by the patient will not have any

impact on the outcome of the application.

(Source: P.A. 95-965, eff. 12-22-08.)

(210 ILCS 89/25)

Sec. 25. Enforcement.

(a) The Attorney General is responsible for administering and ensuring compliance with this Act, including the development of any rules necessary for the implementation and enforcement of this Act.

(b) The Attorney General shall develop and implement a process for receiving and handling complaints from individuals or hospitals regarding possible violations of this Act.

(c) The Attorney General may conduct any investigation deemed necessary regarding possible violations of this Act by any hospital including, without limitation, the issuance of subpoenas to:

(1) require the hospital to file a statement or report or answer interrogatories in writing as to all information relevant to the alleged violations;

(2) examine under oath any person who possesses knowledge or information directly related to the alleged violations; and

(3) examine any record, book, document, account, or paper necessary to investigate the alleged violation.

(d) If the Attorney General determines that there is a reason to believe that any hospital has violated this Act, the

Attorney General may bring an action in the name of the People of the State against the hospital to obtain temporary, preliminary, or permanent injunctive relief for any act, policy, or practice by the hospital that violates this Act. Before bringing such an action, the Attorney General may permit the hospital to submit a Correction Plan for the Attorney General's approval.

(e) This Section applies if:

(1) A court orders a party to make payments to the Attorney General and the payments are to be used for the operations of the Office of the Attorney General; or

(2) A party agrees in a Correction Plan under this Act to make payments to the Attorney General for the operations of the Office of the Attorney General.

(f) Moneys paid under any of the conditions described in subsection (e) shall be deposited into the Attorney General Court Ordered and Voluntary Compliance Payment Projects Fund. Moneys in the Fund shall be used, subject to appropriation, for the performance of any function, pertaining to the exercise of the duties, to the Attorney General including, but not limited to, enforcement of any law of this State and conducting public education programs; however, any moneys in the Fund that are required by the court to be used for a particular purpose shall be used for that purpose.

(g) The Attorney General may seek the assessment of a civil monetary penalty <u>of not less than $1,000 but</u> not to

exceed $5,000 for a ~~$500 per~~ violation in any action filed under this Act where a hospital, by pattern or practice, knowingly violates Section 10 of this Act.

(h) In the event a court grants a final order of relief against any hospital for a violation of this Act, the Attorney General may, after all appeal rights have been exhausted, refer the hospital to the Illinois Department of Public Health for possible adverse licensure action under the Hospital Licensing Act.

(i) Each hospital shall file Worksheet C Part I from its most recently filed Medicare Cost Report with the Attorney General within 60 days after the effective date of this Act and thereafter shall file each subsequent Worksheet C Part I with the Attorney General within 30 days of filing its Medicare Cost Report with the hospital's fiscal intermediary.

(j) On and after January 1, 2022, the Attorney General shall publish an annual report that outlines complaints received related to hospital uninsured discount programs and financial assistance applications. The initial report shall include the following:

(1) The number of complaints received, listed by hospital.

(2) The status of each of the complaints.

(3) The number of violations found by the Attorney General, and any actions, including monetary penalties issued by the Attorney General, since January 1, 2012.

Numerical data shall be published in XML, CSV, and PDF file formats. Subsequent annual reports may be limited to only reflect the most recent completed calendar year.

(Source: P.A. 95-965, eff. 12-22-08.)

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

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