

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 Community Benefits Act is amended by  
5 changing Sections 10, 15, and 20 and by adding Section 22 as  
6 follows:

7 (210 ILCS 76/10)

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

9 "Bad debt" means the current period charge for actual or  
10 expected doubtful accounting resulting from the extension of  
11 credit.

12 "Charity care" means care provided by a health care  
13 provider for which the provider does not expect to receive  
14 payment from the patient or a third party payer. "Charity  
15 care" includes the actual cost of services provided based upon  
16 the total cost to charge ratio derived from a nonprofit  
17 hospital's most recently filed Medicare cost report Worksheet  
18 C and not based upon the charges for the services. "Charity  
19 care" does not include bad debt.

20 "Community benefits" means the unreimbursed cost to a  
21 hospital or health system of providing charity care, language  
22 assistant services, government-sponsored ~~indigent~~ health care,  
23 donations, volunteer services, education,

1 government-sponsored program services, research, and  
2 subsidized health services and collecting bad debts.  
3 "Community benefits" does not include the cost of paying any  
4 taxes or other governmental assessments.

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

8 "Government-sponsored ~~Government-sponsored indigent~~  
9 health care" means the unreimbursed cost to a hospital or  
10 health system of Medicare, providing health care services to  
11 recipients of Medicaid, and other federal, State, or local  
12 ~~indigent~~ health care programs, eligibility for which is based  
13 on financial need.

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

16 "Net patient revenue" means gross service revenue less  
17 provisions for contractual adjustments with third-party  
18 payors, courtesy and policy discounts, or other adjustments  
19 and deductions, excluding charity care.

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

24 "Subsidized health services" means those services provided  
25 by a hospital in response to community needs for which the  
26 reimbursement is less than the hospital's cost of providing

1 the services that must be subsidized by other hospital or  
2 nonprofit supporting entity revenue sources. "Subsidized  
3 health services" includes, but is not limited to, emergency  
4 and trauma care, neonatal intensive care, community health  
5 clinics, and collaborative efforts with local government or  
6 private agencies to prevent illness and improve wellness, such  
7 as immunization programs.

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

9 (210 ILCS 76/15)

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

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

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

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

22 (B) identifies the populations and communities  
23 served by the hospital; and-

24 (C) describes activities the hospital is  
25 undertaking to address health equity, reduce health

1 disparities, and improve community health. This may  
2 include, but is not limited to:

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

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

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

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

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

15 (210 ILCS 76/20)

16 Sec. 20. Annual report for community benefits plan.

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

21 (1) The hospital's mission statement.

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

25 (3) A disclosure of the amount and types of community

1 benefits actually provided, including charity care, and  
2 details about financial assistance applications received  
3 and processed by the hospital as specified in paragraph  
4 (5) of subsection (a) of Section 22. Charity care must be  
5 reported separate from other community benefits. In  
6 reporting charity care, the hospital must report the  
7 actual cost of services provided, based on the total cost  
8 to charge ratio derived from the hospital's Medicare cost  
9 report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient  
10 Ratios), not the charges for the services. For a health  
11 system that includes more than one hospital, charity care  
12 spending and financial assistance application data must be  
13 reported separately for each individual hospital within  
14 the health system.

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

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

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

25 (1) public information;

26 (2) filed with the Attorney General; and

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

3           This statement shall be made available to the public.

4           (d) The obligations of a hospital under this Act, except  
5           for the filing of its audited financial report, shall take  
6           effect beginning with the hospital's fiscal year that begins  
7           after the effective date of this Act. Within 60 days of the  
8           effective date of this Act, a hospital shall file the audited  
9           annual financial report that has been completed for its most  
10          recently completed fiscal year. Thereafter, a hospital shall  
11          include its audited annual financial report for its most  
12          recently completed fiscal year in its annual report of its  
13          community benefits plan.

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

15           (210 ILCS 76/22 new)

16           Sec. 22. Public reports.

17           (a) In order to increase transparency and accessibility of  
18           charity care and financial assistance data, a hospital shall  
19           make the annual hospital community benefits plan report  
20           submitted to the Attorney General under Section 20 available  
21           to the public by publishing the information on the hospital's  
22           website in the same location where annual reports are posted  
23           or on a prominent location on the homepage of the hospital's  
24           website. A hospital is not required to post its audited  
25           financial statements. Information made available to the public

1 shall include, but shall not be limited to, the following:

2 (1) The reporting period.

3 (2) Charity care costs consistent with the reporting  
4 requirements in paragraph (3) of subsection (a) of Section  
5 20. Charity care costs associated with services provided  
6 in a hospital's emergency department shall be reported as  
7 a subset of total charity care costs.

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

11 (4) Total community benefits spending. If a hospital  
12 is owned or operated by a health system, total community  
13 benefits spending may be reported as a health system.

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

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

19 (B) the number of applications approved; and

20 (C) the number of applications denied and the 5  
21 most frequent reasons for denial.

22 (6) To the extent that race, ethnicity, sex, or  
23 preferred language is collected and available for  
24 financial assistance applications, the data outlined in  
25 paragraph (5) shall be reported by race, ethnicity, sex,  
26 and preferred language. If this data is not provided by

1 the patient, the hospital shall indicate this in its  
2 reports. Public reporting of this information shall begin  
3 with the community benefit report filed on or after July  
4 1, 2022. A hospital that files a report without having a  
5 full year of demographic data as required by this Act may  
6 indicate this in its report.

7 (b) The Attorney General shall provide notice on the  
8 Attorney General's website informing the public that, upon  
9 request, the Attorney General will provide the annual reports  
10 filed with the Attorney General under Section 20. The notice  
11 shall include the contact information to submit a request.

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

14 (210 ILCS 89/5)

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

16 "Community health center" means a federally qualified  
17 health center as defined in Section 1905(1)(2)(B) of the  
18 federal Social Security Act or a federally qualified health  
19 center look-alike.

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

24 "Critical Access Hospital" means a hospital that is



1 designated as such under the federal Medicare Rural Hospital  
2 Flexibility Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (210 ILCS 89/10)

6 Sec. 10. Uninsured patient discounts.

7 (a) Eligibility.

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

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

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

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

5 (4) A rural hospital or Critical Access Hospital shall  
6 provide a charitable discount of 100% of its charges for  
7 all medically necessary health care services exceeding  
8 \$300 in any one inpatient admission or outpatient  
9 encounter to any uninsured patient who applies for a  
10 discount and has family income of not more than 125% of the  
11 federal poverty income guidelines.

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

17 (c) Maximum Collectible Amount.

18 (1) The maximum amount that may be collected in a  
19 12-month ~~12-month~~ period for health care services provided  
20 by the hospital from a patient determined by that hospital  
21 to be eligible under subsection (a) is 20% ~~25%~~ of the  
22 patient's family income, and is subject to the patient's  
23 continued eligibility under this Act.

24 (2) The 12-month ~~12-month~~ period to which the maximum  
25 amount applies shall begin on the first date, after the  
26 effective date of this Act, an uninsured patient receives

1 health care services that are determined to be eligible  
2 for the uninsured discount at that hospital.

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

12 (4) Hospitals may adopt policies to exclude an  
13 uninsured patient from the application of subdivision  
14 (c)(1) when the patient owns assets having a value in  
15 excess of 600% of the federal poverty level for hospitals  
16 in a metropolitan statistical area or owns assets having a  
17 value in excess of 300% of the federal poverty level for  
18 Critical Access Hospitals or hospitals outside a  
19 metropolitan statistical area, not counting the following  
20 assets: the uninsured patient's primary residence;  
21 personal property exempt from judgment under Section  
22 12-1001 of the Code of Civil Procedure; or any amounts  
23 held in a pension or retirement plan, provided, however,  
24 that distributions and payments from pension or retirement  
25 plans may be included as income for the purposes of this  
26 Act.

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

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

19 (210 ILCS 89/15)

20 Sec. 15. Patient responsibility.

21 (a) Hospitals may make the availability of a discount and  
22 the maximum collectible amount under this Act contingent upon  
23 the uninsured patient first applying for coverage under public  
24 health insurance programs, such as Medicare, Medicaid,  
25 AllKids, the State Children's Health Insurance Program, or any

1 other program, if there is a reasonable basis to believe that  
2 the uninsured patient may be eligible for such program.

3 (b) Hospitals shall permit an uninsured patient to apply  
4 for a discount within 90 ~~60~~ days of the date of discharge or  
5 date of service.

6 Hospitals shall offer uninsured patients who receive  
7 community-based primary care provided by a community health  
8 center or a free and charitable clinic, are referred by such an  
9 entity to the hospital, and seek access to nonemergency  
10 hospital-based health care services with an opportunity to be  
11 screened for and assistance with applying for public health  
12 insurance programs if there is a reasonable basis to believe  
13 that the uninsured patient may be eligible for a public health  
14 insurance program. An uninsured patient who receives  
15 community-based primary care provided by a community health  
16 center or free and charitable clinic and is referred by such an  
17 entity to the hospital for whom there is not a reasonable basis  
18 to believe that the uninsured patient may be eligible for a  
19 public health insurance program shall be given the opportunity  
20 to apply for hospital financial assistance when hospital  
21 services are scheduled.

22 (1) Income verification. Hospitals may require an  
23 uninsured patient who is requesting an uninsured discount  
24 to provide documentation of family income. Acceptable  
25 family income documentation shall include any one of the  
26 following:

- 1 (A) a copy of the most recent tax return;
- 2 (B) a copy of the most recent W-2 form and 1099  
3 forms;
- 4 (C) copies of the 2 most recent pay stubs;
- 5 (D) written income verification from an employer  
6 if paid in cash; or
- 7 (E) one other reasonable form of third party  
8 income verification deemed acceptable to the hospital.
- 9 (2) Asset verification. Hospitals may require an  
10 uninsured patient who is requesting an uninsured discount  
11 to certify the existence or absence of assets owned by the  
12 patient and to provide documentation of the value of such  
13 assets, except for those assets referenced in paragraph  
14 (4) of subsection (c) of Section 10. Acceptable  
15 documentation may include statements from financial  
16 institutions or some other third party verification of an  
17 asset's value. If no third party verification exists, then  
18 the patient shall certify as to the estimated value of the  
19 asset.
- 20 (3) Illinois resident verification. Hospitals may  
21 require an uninsured patient who is requesting an  
22 uninsured discount to verify Illinois residency.  
23 Acceptable verification of Illinois residency shall  
24 include any one of the following:
- 25 (A) any of the documents listed in paragraph (1);
- 26 (B) a valid state-issued identification card;



- 1 (C) a recent residential utility bill;
- 2 (D) a lease agreement;
- 3 (E) a vehicle registration card;
- 4 (F) a voter registration card;
- 5 (G) mail addressed to the uninsured patient at an  
6 Illinois address from a government or other credible  
7 source;
- 8 (H) a statement from a family member of the  
9 uninsured patient who resides at the same address and  
10 presents verification of residency; ~~or~~
- 11 (I) a letter from a homeless shelter, transitional  
12 house or other similar facility verifying that the  
13 uninsured patient resides at the facility; or.
- 14 (J) a temporary visitor's drivers license.

15 (c) Hospital obligations toward an individual uninsured  
16 patient under this Act shall cease if that patient  
17 unreasonably fails or refuses to provide the hospital with  
18 information or documentation requested under subsection (b) or  
19 to apply for coverage under public programs when requested  
20 under subsection (a) within 30 days of the hospital's request.

21 (d) In order for a hospital to determine the 12 month  
22 maximum amount that can be collected from a patient deemed  
23 eligible under Section 10, an uninsured patient shall inform  
24 the hospital in subsequent inpatient admissions or outpatient  
25 encounters that the patient has previously received health  
26 care services from that hospital and was determined to be

1 entitled to the uninsured discount.

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

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

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

15 (210 ILCS 89/25)

16 Sec. 25. Enforcement.

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

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

24 (c) The Attorney General may conduct any investigation  
25 deemed necessary regarding possible violations of this Act by

1 any hospital including, without limitation, the issuance of  
2 subpoenas to:

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

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

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

11 (d) If the Attorney General determines that there is a  
12 reason to believe that any hospital has violated this Act, the  
13 Attorney General may bring an action in the name of the People  
14 of the State against the hospital to obtain temporary,  
15 preliminary, or permanent injunctive relief for any act,  
16 policy, or practice by the hospital that violates this Act.  
17 Before bringing such an action, the Attorney General may  
18 permit the hospital to submit a Correction Plan for the  
19 Attorney General's approval.

20 (e) This Section applies if:

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

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

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

11           (g) The Attorney General may seek the assessment of a  
12 civil monetary penalty not to exceed \$500 per violation in any  
13 action filed under this Act where a hospital, by pattern or  
14 practice, knowingly violates Section 10 of this Act.

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

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

1       (j) No later than September 1, 2022, the Attorney General  
2       shall provide data on the Attorney General's website regarding  
3       enforcement efforts performed under this Act from July 1, 2021  
4       through June 30, 2022. Thereafter, no later than September 1  
5       of each year through September 1, 2027, the Attorney General  
6       shall annually provide data on the Attorney General's website  
7       regarding enforcement efforts performed under this Act from  
8       July 1 through June 30 of each year. The data shall include the  
9       following:

10           (1) The total number of complaints received.

11           (2) The total number of open investigations.

12           (3) The number of complaints for which assistance in  
13       resolving complaints was provided to constituents  
14       throughout the State by the Attorney General without  
15       resorting to investigations or actions filed.

16           (4) The total number of resolved complaints.

17           (5) The total number of actions filed.

18           (6) A list of the names of facilities found by a  
19       pattern or practice to knowingly violate Section 10, along  
20       with any civil penalties assessed against a listed  
21       facility.

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

23       Section 99. Effective date. This Act takes effect January  
24       1, 2022.