

**[210 Ill. Comp. Stat. §§ 89/1 through 89/25.]**

§§ 89/1 through 89/25: Hospital Uninsured Patient Discount Act

**§ 1. Short title.**

This Act may be cited as the Hospital Uninsured Patient Discount Act.

**§ 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).

"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 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.

#### **§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 \$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 \$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.

(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 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.

#### **§ 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 apply for a discount within 60 days of the date of discharge or date of service.

(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 of assets owned by the patient and to provide documentation of the value of such assets. 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.

(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.

## **§ 20. Exemptions and limitations.**

(a) Hospitals that do not charge for their services are exempt from the provisions of this Act.

(b) Nothing in this Act shall be used by any private or public health care insurer or plan as a basis for reducing its payment or reimbursement rates or policies with any hospital. Notwithstanding any other provisions of law, discounts authorized under this Act shall not be used by any private or public health care insurer or plan, regulatory agency, arbitrator, court, or other third party to determine a hospital's usual and customary charges for any health care service.

(c) Nothing in this Act shall be construed to require a hospital to provide an uninsured patient with a particular type of health care service or other service.

(d) Nothing in this Act shall be deemed to reduce or infringe upon the rights and obligations of hospitals and patients under the Fair Patient Billing Act.

(e) The obligations of hospitals under this Act shall take effect for health care services provided on or after the first day of the month that begins 90 days after the effective date of this Act or 90 days after the initial adoption of rules authorized under subsection (a) of Section 25, whichever occurs later.

**§ 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 not to exceed \$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.