AN ACT concerning public aid.

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

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

(210 ILCS 89/5)

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

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

"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 a discount provided to a patient under the terms and conditions a hospital offers to qualified patients or as required by law.

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

"Guaranteed income program" means a publicly or privately funded program that provides one-time or recurring unconditional cash transfers or payments, or gifts to individuals or households, for a defined number of months or years for the purposes of reducing poverty, promoting economic mobility, or increasing the financial stability of Illinois residents.

"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 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. 102-581, eff. 1-1-22.)

(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 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 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.

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

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

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

This paragraph is inoperative on and after July 1,

2026.

(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 20% 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. The availability of the maximum collectible amount shall be included in the hospital's financial assistance

information provided to uninsured patients.

(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. The hospital's financial assistance application shall include language that directs the uninsured patient to contact the hospital's financial counseling department with questions or concerns, along with contact

information for the financial counseling department, and 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. 102-581, eff. 1-1-22.)

(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 health insurance programs, such as Medicare, Medicaid, AllKids, the State Children's Health Insurance Program, the Health Benefits for Immigrants 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 90 days of the date of discharge or date of service.

Hospitals shall offer uninsured patients who receive community-based primary care provided by a community health center or a free and charitable clinic, are referred by such an entity to the hospital, and seek access to nonemergency

hospital-based health care services with an opportunity to be screened for and assistance with applying for public health insurance programs if there is a reasonable basis to believe that the uninsured patient may be eligible for a public health insurance program. An uninsured patient who receives community-based primary care provided by a community health center or free and charitable clinic and is referred by such an entity to the hospital for whom there is not a reasonable basis to believe that the uninsured patient may be eligible for a public health insurance program shall be given the opportunity to apply for hospital financial assistance when hospital services are scheduled.

(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 (4) 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;

(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, sex, 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. 102-581, eff. 1-1-22.)

Section 10. The Illinois Public Aid Code is amended by changing Section 1-7 as follows:

(305 ILCS 5/1-7) (from Ch. 23, par. 1-7)

Sec. 1-7. (a) For purposes of determining eligibility for assistance under this Code, the Illinois Department, County Departments, and local governmental units shall exclude from consideration restitution payments, including all income and resources derived therefrom, made to persons of Japanese or Aleutian ancestry pursuant to the federal Civil Liberties Act of 1988 and the Aleutian and Pribilof Island Restitution Act, P.L. 100-383.

(b) For purposes of any program or form of assistance where a person's income or assets are considered in determining eligibility or level of assistance, whether under this Code or another authority, neither the State of Illinois nor any entity or person administering a program wholly or partially financed by the State of Illinois or any of its political subdivisions shall include restitution payments, including all income and resources derived therefrom, made

pursuant to the federal Civil Liberties Act of 1988 and the Aleutian and Pribilof Island Restitution Act, P.L. 100-383, in the calculation of income or assets for determining eligibility or level of assistance.

(c) For purposes of determining eligibility for or the amount of assistance under this Code, except for the determination of eligibility for payments or programs under the TANF employment, education, and training programs and the Food Stamp Employment and Training Program, the Illinois Department, County Departments, and local governmental units shall exclude from consideration any financial assistance received under any student aid program administered by an agency of this State or the federal government, by a person who is enrolled as a full-time or part-time student of any public or private university, college, or community college in this State.

(d) For purposes of determining eligibility for or the amount of assistance under this Code, except for the determination of eligibility for payments or programs under the TANF employment, education, and training programs and the SNAP Employment and Training Program, the Illinois Department, County Departments, and local governmental units shall exclude from consideration, for a period of 36 months, any financial assistance, including wages, that is provided to a person who is enrolled in a demonstration project that is not funded with general revenue funds and that is intended as a bridge to

self-sufficiency by offering (i) intensive workforce support and training and (ii) support services for new and expectant parents that are intended to foster multi-generational healthy families as described in Section 12-4.51.

(e)(1) Notwithstanding any other provision of this Code, and to the maximum extent permitted by federal law, for purposes of determining eligibility and the amount of assistance under this Code, the Illinois Department and local governmental units shall exclude from consideration~~, for a period of no more than 60 months,~~ any financial assistance, including ~~wages,~~ cash transfers~~,~~ or gifts, that is provided to a person through a guaranteed income program. As used in this subsection, "guaranteed income program" means a publicly or privately funded program that provides one-time or recurring unconditional cash transfers or payments, or gifts to individuals or households, for a defined number of months or years for the purposes of reducing poverty, promoting economic mobility, or increasing the financial stability of Illinois residents. ~~who is enrolled in a program or research project that is not funded with general revenue funds and that is intended to investigate the impacts of policies or programs designed to reduce poverty, promote social mobility, or increase financial stability for Illinois residents if there is an explicit plan to collect data and evaluate the program or initiative that is developed prior to participants in the study being enrolled in the program and if a research team has~~

~~been identified to oversee the evaluation.~~

(2) The Department shall choose State options and seek all necessary federal approvals or waivers to implement this subsection.

(Source: P.A. 100-806, eff. 1-1-19; 101-415, eff. 8-16-19.)

Section 99. Effective date. This Act takes effect January 1, 2024.