AN ACT concerning regulation.

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

Section 1. Short title. This Act may be cited as the Hospital Uninsured Patient Discount Act.

Section 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.

Section 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 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.

(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.

Section 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.

Section 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.

Section 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.

Section 30. Home rule. A home rule unit may not regulate hospitals in a manner inconsistent with the provisions of this

Act. This Section is a limitation under subsection (i) of Section 6 of Article VII of the Illinois Constitution on the concurrent exercise by home rule units of powers and functions exercised by the State.

Section 90. The Comprehensive Health Insurance Plan Act is amended by changing Section 2 as follows:

(215 ILCS 105/2) (from Ch. 73, par. 1302)

Sec. 2. Definitions. As used in this Act, unless the context otherwise requires:

"Plan administrator" means the insurer or third party administrator designated under Section 5 of this Act.

"Benefits plan" means the coverage to be offered by the Plan to eligible persons and federally eligible individuals pursuant to this Act.

"Board" means the Illinois Comprehensive Health Insurance Board.

"Church plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Continuation coverage" means continuation of coverage under a group health plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal

or State law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Sections 367.2, 367e, and 367e.1 of the Illinois Insurance Code, or any other similar requirement in another State.

"Covered person" means a person who is and continues to remain eligible for Plan coverage and is covered under one of the benefit plans offered by the Plan.

"Creditable coverage" means, with respect to a federally eligible individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage (including group health insurance coverage).

(C) Medicare.

(D) Medical assistance.

(E) Chapter 55 of title 10, United States Code.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A state health benefits risk pool.

(H) A health plan offered under Chapter 89 of title 5, United States Code.

(I) A public health plan (as defined in regulations consistent with Section 104 of the Health Care Portability and Accountability Act of 1996 that may be promulgated by the Secretary of the U.S. Department of Health and Human Services).

(J) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(K) Any other qualifying coverage required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or regulations under that Act.

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in Section 2791(c) of title XXVII of the Public Health Service Act (42 U.S.C. 300 gg-91), nor does it include any period of coverage under any of items (A) through (K) that occurred before a break of more than 90 days or, if the individual has been certified as eligible pursuant to the federal Trade Act of 2002, a break of more than 63 days during all of which the individual was not covered under any of items (A) through (K) above.

Any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in determining if there has been a break of more than 90 days in any creditable coverage.

"Department" means the Illinois Department of Insurance.

"Dependent" means an Illinois resident: who is a spouse; or who is claimed as a dependent by the principal insured for purposes of filing a federal income tax return and resides in

the principal insured's household, and is a resident unmarried child under the age of 19 years; or who is an unmarried child who also is a full-time student under the age of 23 years and who is financially dependent upon the principal insured; or who is a child of any age and who is disabled and financially dependent upon the principal insured.

"Direct Illinois premiums" means, for Illinois business, an insurer's direct premium income for the kinds of business described in clause (b) of Class 1 or clause (a) of Class 2 of Section 4 of the Illinois Insurance Code, and direct premium income of a health maintenance organization or a voluntary health services plan, except it shall not include credit health insurance as defined in Article IX 1/2 of the Illinois Insurance Code.

"Director" means the Director of the Illinois Department of Insurance.

"Effective date of medical assistance" means the date that eligibility for medical assistance for a person is approved by the Department of Human Services or the Department of Healthcare and Family Services, except when the Department of Human Services or the Department of Healthcare and Family Services determines eligibility retroactively. In such circumstances, the effective date of the medical assistance is the date the Department of Human Services or the Department of Healthcare and Family Services determines the person to be eligible for medical assistance.

"Eligible person" means a resident of this State who qualifies for Plan coverage under Section 7 of this Act.

"Employee" means a resident of this State who is employed by an employer or has entered into the employment of or works under contract or service of an employer including the officers, managers and employees of subsidiary or affiliated corporations and the individual proprietors, partners and employees of affiliated individuals and firms when the business of the subsidiary or affiliated corporations, firms or individuals is controlled by a common employer through stock ownership, contract, or otherwise.

"Employer" means any individual, partnership, association, corporation, business trust, or any person or group of persons acting directly or indirectly in the interest of an employer in relation to an employee, for which one or more persons is gainfully employed.

"Family" coverage means the coverage provided by the Plan for the covered person and his or her eligible dependents who also are covered persons.

"Federally eligible individual" means an individual resident of this State:

(1)(A) for whom, as of the date on which the individual seeks Plan coverage under Section 15 of this Act, the aggregate of the periods of creditable coverage is 18 or more months or, if the individual has been certified as eligible pursuant to the federal Trade Act of 2002, 3 or

more months, and (B) whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

(2) who is not eligible for coverage under (A) a group health plan (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), (B) part A or part B of Medicare due to age (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), or (C) medical assistance, and does not have other health insurance coverage (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002);

(3) with respect to whom (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002) the most recent coverage within the coverage period described in paragraph (1)(A) of this definition was not terminated based upon a factor relating to nonpayment of premiums or fraud;

(4) if the individual (other than an individual who has been certified as eligible pursuant to the federal Trade

Act of 2002) had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

However, an individual who has been certified as eligible pursuant to the federal Trade Act of 2002 shall not be required to elect continuation coverage under a COBRA continuation provision or under a similar state program.

"Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with that plan.

"Group health plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Governmental plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, non-profit health care service plan contract, health maintenance organization or other subscriber contract,

or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. Health insurance coverage shall not include short term, accident only, disability income, hospital confinement or fixed indemnity, dental only, vision only, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization and a voluntary health services plan) that is authorized to transact health insurance business in this State. Such term does not include a group health plan.

"Health Maintenance Organization" means an organization as defined in the Health Maintenance Organization Act.

"Hospice" means a program as defined in and licensed under the Hospice Program Licensing Act.

"Hospital" means a duly licensed institution as defined in the Hospital Licensing Act, an institution that meets all comparable conditions and requirements in effect in the state in which it is located, or the University of Illinois Hospital

as defined in the University of Illinois Hospital Act.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance.

"Insured" means any individual resident of this State who is eligible to receive benefits from any insurer (including health insurance coverage offered in connection with a group health plan) or health insurance issuer as defined in this Section.

"Insurer" means any insurance company authorized to transact health insurance business in this State and any corporation that provides medical services and is organized under the Voluntary Health Services Plans Act or the Health Maintenance Organization Act.

"Medical assistance" means the State medical assistance or medical assistance no grant (MANG) programs provided under Title XIX of the Social Security Act and Articles V (Medical Assistance) and VI (General Assistance) of the Illinois Public Aid Code (or any successor program) or under any similar program of health care benefits in a state other than Illinois.

"Medically necessary" means that a service, drug, or supply is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided. When specifically applied to a confinement

it further means that the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient. A service, drug, or supply shall not be medically necessary if it: (i) is investigational, experimental, or for research purposes; or (ii) is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider; or (iii) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or (iv) could have been omitted without adversely affecting the covered person's condition or the quality of medical care; or (v) involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration.

"Medical care" means the ordinary and usual professional services rendered by a physician or other specified provider during a professional visit for treatment of an illness or injury.

"Medicare" means coverage under both Part A and Part B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395, et seq.

"Minimum premium plan" means an arrangement whereby a specified amount of health care claims is self-funded, but the insurance company assumes the risk that claims will exceed that amount.

"Participating transplant center" means a hospital

designated by the Board as a preferred or exclusive provider of services for one or more specified human organ or tissue transplants for which the hospital has signed an agreement with the Board to accept a transplant payment allowance for all expenses related to the transplant during a transplant benefit period.

"Physician" means a person licensed to practice medicine pursuant to the Medical Practice Act of 1987.

"Plan" means the Comprehensive Health Insurance Plan established by this Act.

"Plan of operation" means the plan of operation of the Plan, including articles, bylaws and operating rules, adopted by the board pursuant to this Act.

"Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, registered pharmacist acting within the scope of that registration, or any other person or entity licensed in Illinois to furnish medical care.

"Qualified high risk pool" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Resident" means a person who is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in this State that remains that person's principal residence and from which that person is absent only for temporary or transitory purpose.

"Skilled nursing facility" means a facility or that portion of a facility that is licensed by the Illinois Department of Public Health under the Nursing Home Care Act or a comparable licensing authority in another state to provide skilled nursing care.

"Stop-loss coverage" means an arrangement whereby an insurer insures against the risk that any one claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount.

"Third party administrator" means an administrator as defined in Section 511.101 of the Illinois Insurance Code who is licensed under Article XXXI 1/4 of that Code.

(Source: P.A. 92-153, eff. 7-25-01; 93-33, eff. 6-23-03; 93-34, eff. 6-23-03; 93-477, eff. 8-8-03; 93-622, eff. 12-18-03.)

Section 99. Effective date. This Act takes effect upon becoming law, except that Sections 1 through 30 take effect 90 days after becoming law.