

September 6, 2023

**ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M**

SUBJECT: PA 103-0323: Fair Patient Billing – Screening

Summary

On July 28, 2023, Gov. JB Pritzker signed [PA 103-0323](#) codifying current hospital practices that provide patients with timely and meaningful access to any financial assistance available through the hospital and any public health insurance programs for which patients may be eligible.

Effective for services provided on or after July 1, 2024, PA 103-0323 requires hospitals to screen patients for financial assistance or public health insurance program eligibility at the earliest reasonable moment. Hospitals must also ensure that patients deemed eligible for hospital financial assistance or public health insurance programs are not improperly billed, steered into payment plans, or sent to collections. The Act specifically states that hospitals must screen uninsured patients, and insured patients upon the patient's request, and assist the patient in obtaining hospital financial assistance for which they are eligible, before pursuing collection action.

PA 103-0323 amends three Illinois Acts impacting hospitals including the Fair Patient Billing Act, the Hospital Uninsured Patient Discount Act (HUPDA), and the Community Benefits Act. A summary of these amendments, by Act, are below.

Changes to the Fair Patient Billing Act

Amendments to the Fair Patient Billing Act strengthen current financial assistance screening processes to better facilitate the provision of financial assistance or public health insurance program application for eligible patients.

Screening is defined as a process whereby a hospital engages with a patient to review and assess the patient's potential eligibility for any financial assistance offered by the hospital, public health insurance program, or other discounted care known to the hospital; informs the patient of the hospital's assessment; documents in the patient's record the circumstances of the screening; and assists the patient with applying for hospital financial assistance as appropriate.

A public health insurance program is defined as Medicare, Medicaid, medical assistance under the Non-Citizen Victims of Trafficking, Torture and Other Serious Crimes Program, Health Benefit for Immigrant Adults, Health Benefit for Immigrant Seniors, All Kids, or other medical

assistance programs offered by the Illinois Dept. of Healthcare and Family Services. Hospitals are encouraged to review current processes used to ascertain potential eligibility for public insurance, ensuring it adequately accounts for patient characteristics like household income when determining potential eligibility.

Illinois hospitals are already required to have a hospital financial assistance process and application in place and available on their public website. Criteria for hospital financial assistance eligibility are outlined in HUPDA as follows:

- Free care (100% discount) for uninsured Illinois residents with family incomes up to 200% of the federal poverty level (FPL) in urban areas, and 125% FPL in rural areas or at Critical Access Hospitals.
- Care discounted to 135% of hospital cost for uninsured Illinois residents with family incomes up to 600% FPL in urban areas, and 300% FPL in rural areas or at Critical Access Hospitals.
- For families that do not have excessive assets and meet the household income criteria above, the hospital cannot collect more than 20% of the family's annual gross income. Patients may certify to the absence of assets.
- This applies to medically necessary hospital services greater than \$150 in urban areas, and greater than \$300 in rural areas in any one inpatient admission or outpatient encounter.

PA 103-0323 does not change the substance or criteria for financial assistance applications or eligibility. Rather, it strengthens these provisions by requiring hospitals to conduct this screening, upon the uninsured patient's agreement, at the earliest reasonable moment. Under the Act, the hospital should screen uninsured patients during registration unless it would cause a delay in patient care. Hospitals should develop an internal policy for how to ensure financial assistance screening is offered to uninsured patients, particularly when the screening cannot occur at registration.

IHA encourages hospitals to make every attempt to offer the screening prior to patient discharge, and have a documented process for instances when the screening must be offered after discharge. This policy may include ensuring the hospital has the appropriate contact information for the patient prior to discharge, and document attempts to follow-up with the patient and offer financial screening. It may also involve informing the patient that a hospital representative will be calling them at a specific date and time, and explaining what to expect during that phone call. We encourage hospitals to document in the patient record any interaction with the patient regarding financial assistance.

If a patient declines or fails to respond to the screening, the hospital must document in the patient's record the patient's decision to decline or failure to respond to the screening, confirming the date and method by which the patient declined or failed to respond.

Timelines and Patient Responsibility

When a patient does submit to screening for financial assistance, the hospital may still require follow-up information. Specifically, patients must cooperate in good faith with the hospital in the screening process by providing the hospital with all reasonably requested financial and other relevant information and documentation needed to determine the patient's potential eligibility for coverage under a public health insurance program, the hospital's financial assistance policy, or for a reasonable payment plan. This information must be provided within 30 days of request for such information. If the patient fails to submit requested documentation within 30 days, the hospital should document the lack of received documentation, confirm the date that the screening took place, and confirm that the 30 day timeline for responding to document requests has lapsed. However, in alignment with hospital financial assistance protections under HUPDA, the financial assistance process may be reopened within 90 days after the date of discharge, date of service, or completion of screening. Collection actions should not be taken until the 90 day timeline expires.

Potential Public Health Insurance Eligibility

If the screening indicates that the patient may be eligible for public health insurance, the hospital is responsible for providing information to the patient on how they can apply for such insurance. Such information includes, but is not limited to, referring the patient to a healthcare navigator that can provide free and unbiased eligibility and enrollment assistance. Such navigators may be available at federally qualified health centers (FQHCs); local, state and federal government agencies; or at other organizations in your community. IHA encourages hospitals to compile a list of resources to refer patients to when they are deemed potentially eligible for public health insurance. Hospitals are not responsible for assisting patients with the actual public health insurance application; rather, hospitals are required to connect patients with resources or organizations that can assist with the application.

If the uninsured patient's application for a public health insurance program is approved, the hospital must bill the insuring entity and cannot pursue the patient for any aspect of the bill, except for any required copayment, coinsurance, or other similar payment for which the patient is responsible under the insurance. If the uninsured patient's application for public health insurance is denied, the hospital must again offer to screen the uninsured patient for hospital financial assistance and the 90 day timeline for applying for financial assistance under HUPDA must start again.

Insured Patients

A hospital must offer to screen an insured patient for hospital financial assistance if the patient requests financial assistance screening, if the hospital is contacted in response to a bill, if the hospital learns information that suggests an inability to pay, or if the circumstances otherwise suggest the patient's inability to pay.

Collections

Hospitals may not pursue collection action against an uninsured patient until they have complied with all screening requirements and exhausted any available discount under HUPDA. The hospital must also first give the uninsured patient the opportunity to assess the accuracy of the bill, apply for hospital financial assistance, and avail themselves of a reasonable payment plan.

As is current practice, hospitals are still required to provide written approval from an authorized employee that can reasonably conclude that conditions for pursuing collection under the Fair Patient Billing Act have been met before a collection agency, law firm, or individual may initiate legal action for nonpayment of a hospital bill against a patient.

IHA encourages hospitals to review their collection action policies to ensure compliance with the Fair Patient Billing Act and HUPDA timelines and requirements.

Language Services

All screening activities, including the initial screening and all follow-up assistance, must be provided in compliance with the [Language Assistance Services Act](#). The Language Assistance Services Act requires health facilities, including hospitals, to adopt and review annually a policy for providing language assistance services to patients with language or communication barriers. This should include, to the extent possible, the use of an interpreter whenever a language or communication barrier exists unless the patient chooses to use a family member or friend who volunteers to interpret. There are several other requirements under the Language Assistance Services Act, and hospitals should review the Act to ensure they are in compliance.

Changes to HUPDA

After receiving feedback from stakeholders that some uninsured patients may decline applying for public health insurance program due to immigration-related concerns, the Hospital Uninsured Patient Discount Act (HUPDA) was amended to provide hospitals direction in assisting such patients. Specifically, if a hospital has reason to believe a patient is eligible for public health insurance, but the patient declines applying due to immigration-related concerns, the hospital may refer the patient to a free, unbiased resource such as an Immigrant Family Resource Program to address the patient's concerns and assist them in applying for public health insurance.

The hospital may still screen the patient for eligibility under its financial assistance policy. And hospitals must allow uninsured patients to apply for a discount within 90 days of the date of discharge, date of service, completion of the screening under the Fair Patient Billing Act, or denial of an application for a public health insurance program.

To comply with this amendment to HUPDA, we encourage hospitals to coordinate with local health clinics, including FQHCs, and determine whether there are individuals and resources

available to assist applicable patients with immigration-related concerns. If no such resource exists in your community, there may be an opportunity to partner with immigration organizations in other areas of the state via telehealth. IHA encourages hospitals to secure such contacts and partnership prior to the effective date of this amendment.

Changes to the Community Benefits Act

Certain nonprofit hospitals in Illinois are required to submit annual community benefit reports to the Office of the Attorney General. These reports must contain certain information on hospital spending, financial assistance, and patient demographics. PA 103-0323 added a new reporting requirement related to financial assistance applications. Specifically, community benefit reports must now include information on the number of uninsured patients who have declined or failed to respond to screening for financial assistance or public health insurance program eligibility, as described in the Fair Patient Billing Act. The report must also include the five most frequent reasons uninsured patients provide for declining the screening.

The Community Benefits Act does not apply to hospitals operated by the government, hospitals located outside of a metropolitan statistical area, or hospitals with 100 or fewer beds.

Please send questions or comments [here](#).