



Illinois Hospital Association

June 10, 2008

MEMORANDUM

TO: Chief Executive Officers, Member Hospitals and Health Systems
Chief Financial Officers
Government Relations
Patient Financial Services

FROM: Sandy Kraiss, Senior Director, Finance
Kathleen Pankau, Staff Counsel

SUBJECT: SB 2380 - “Hospital Uninsured Patient Discount Act”

BACKGROUND

SB 2380 passed out of the Illinois legislature on May 30, 2008 and is on its way to the Governor for signature. Sections 1 through 30 reflect the agreement between the IHA and the Illinois Attorney General on pricing for uninsured hospital patients. It requires hospitals to provide a discount from charges to uninsured Illinois residents with incomes at or below 600% of the federal poverty level (“FPL”) (300% FPL at critical access hospitals (CAH) and hospitals located in rural areas).¹ Charges are to be discounted to 135% of cost. In addition, a hospital will not be able to collect more than 25% of an uninsured patient’s family’s gross income (“the cap”) in any one year period. A summary of the legislation and text of the bill can be found on the IHA website ([click here](#)).

Below are frequently asked questions about this legislation that should be considered when preparing for implementation of these new requirements.

FREQUENTLY ASKED QUESTIONS

1. The Discount and the Cap

How is the discount calculated?

For charges in excess of \$300, the discount is calculated as the difference between the charges for the uninsured patient and 135% of cost, using a total (line 103) cost-to-charge ratio from the hospital’s most recently filed Medicare cost report, Worksheet C Part I.

¹ For a family of four, 600% FPL is \$127,200; 300% FPL is \$63,600.

Why does this bill derive the cost to charge ratio from the Medicare cost report?

The cost-to-charge ratio in this bill is calculated in the same manner as the cost-to-charge ratio under the Illinois Community Benefits Act to reduce charity charges to charity cost. While the Medicare cost report does not capture the entirety of a hospital's costs and charges, it provides a public, administratively simple, and easily verifiable calculation of a cost-to-charge ratio. Hospitals will need to annually file a copy of Worksheet C with the Attorney General's office.

How are assets considered when applying the 25% cap?

A patient who is determined to be eligible for the discount may also be eligible for the 25% cap if they do not have assets exceeding a value of 600% of the FPL (300% of the FPL at CAHs and rural hospitals). Certain assets are exempt from consideration: the family's primary residence, amounts held in pension or retirement plans and certain personal property listed in Section 12-1001 of the Code of Civil Procedure ([see attached](#)).

For the purposes of the 25% cap, when does the twelve month period begin?

Hospitals cannot collect more than 25% of an uninsured patient's family gross income in any twelve month period. The twelve month period begins on the date of service for which the hospital first determines the patient is eligible for the discount. Thereafter, for any subsequent hospital services, the patient must inform the hospital that he or she received a discount and continues to be eligible for the discount.

Does the hospital need to coordinate with other providers for purposes of the cap?

No. The cap is applicable to the services provided at an individual hospital. The hospital does not need to include services provided at other facilities.

Can the discount be treated as charity care? This bill does not change how charity care is determined and accounted for. A patient eligible for the discount may also be eligible under the hospital's charity policy and therefore any charges foregone may be considered charity charges. A hospital should examine its charity policy within this context, to determine if the discounts and caps required under this Act should be incorporated into the hospital's charity policy.

Can a hospital provide the discount without verifying the patient's eligibility?

Yes. A hospital may always be more generous in the provision of financial assistance, if it chooses. This Act is a minimum requirement. However, discounts that are not based on a patient's ability to pay (e.g. Income) cannot be considered charity for accounting purposes.

Can other payers use the discount in this bill to argue it is a hospital's "usual and customary" rate?

No, there is specific language in the bill prohibiting such claims. Section 20 states:

"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."

2. Health Care Services

Does this bill require hospitals to provide non-emergency or elective services to patients?

No. While a hospital's obligation to treat emergency medical conditions under EMTALA is unaffected, this bill does not expand in any way a hospital's responsibility to treat a particular patient or a particular condition. Section 20 states:

"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."

Does the discount apply to cosmetic surgeries or social and vocational services?

No. The discount only applies to medically necessary service that would be covered by Medicare for a patient with the same clinical presentation.

Does the discount apply to outpatient procedures?

Yes, but the discount is applied only for charges over and above \$300 in any one encounter.

Does the discount apply to hospital-based physician charges?

No. The Act applies only to hospital services.

3. Patient Eligibility

Who is an "uninsured" patient?

An uninsured patient is an Illinois resident who is not covered under any third party coverage of any kind, including high deductible plans, workers' compensation, accident liability insurance, or other third party liability.

If a patient has insurance, but the service he or she received is not covered, does the discount still apply?

No. The discount only applies to an uninsured patient, one who is not a beneficiary under any type of plan. Patients that are insured, but not covered for a particular service, are still defined as being insured.

What type of documentation is needed to determine income eligibility?

Hospitals may require documentation of family income from an uninsured patient requesting a discount. Acceptable documentation includes 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.

How does a hospital determine if a patient is an Illinois resident?

A hospital may ask for one of the following: A) any document listed above for determination of income; B) a valid state-issued ID; 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.

What information is needed to verify assets for purposes of eligibility for the 25% cap?

Hospitals may require an uninsured patient to certify to the existence of assets owned and 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.

What impact would this legislation have on the immigrant population?

This bill does not change the immigrant population's current ability to access care. As long as they can verify Illinois residency and meet the income and medical necessity criteria, they are eligible for the discount. Hospitals are free to provide this discount to anyone, but are only required to provide it to uninsured Illinois residents with incomes at or below 600% FPL/300% FPL.

4. Patient Responsibilities

Does a patient have to apply for the discount or should it be given automatically?

Nothing in the bill prohibits a hospital from providing the specified discount to any uninsured patient. However, under the bill, a hospital may require a patient to apply to the hospital for the discount within 60 days of the date of discharge or date of service. Patients who may be eligible for coverage under public programs may be required to first apply to those programs.

What type of documentation must an uninsured patient supply?

Hospitals may require documentation of family income, Illinois residency and existence and value of assets owned by the patient as outlined in the Patient Eligibility section above. Hospitals may always be more generous in the provision of financial assistance and may choose to forgo documentation verification.

What are the hospital's obligations if the patient fails to provide documentation or apply for public programs?

The hospital obligations toward an uninsured patient shall cease if the patient fails to provide the documentation requested or apply for coverage under public programs within 30 days of the hospital's request.

What happens if a patient has not been fully truthful on the application?

The patient forfeits the discount and may be responsible for payment of the hospital's full charges.

5. Hospital Notice Provisions

What notice provisions are included in this bill?

The bill requires:

“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”.

This is very similar to the notice requirement already in place under the Fair Patient Billing Act and hospitals should verify that their current statement would cover the notice requirement under this Act or modify such statement.

6. Effective Date and Enforcement

How long will hospitals have to implement the discount?

Once the Governor signs the bill, hospitals will have 180 days to prepare for implementation to accommodate the provisions in this bill. The legislation becomes effective 90 days after the bill becomes law (e.g., when the Governor signs it) and hospital obligations begin 90 days after that effective date.

How will this bill be enforced?

The Attorney Generals’ Office will enforce the provisions in this bill. The process will be complaint driven and the Attorney General will investigate allegations of violations. If there is reason to believe that there has been a violation, the Attorney General will allow a hospital to submit a correction plan before bringing a civil action against the hospital to obtain injunctive relief. The Attorney General may fine hospitals if there has been a pattern or practice of not applying the proper discount and cap to the accounts of eligible uninsured patients.

Should you have questions, please contact Sandy Kraiss at 630-276-5522 or skraiss@ihastaff.org or Kathleen Pankau at 630-276-5598 or kpankau@ihastaff.org.