



Access to Health Care/Covering the Uninsured

More than 14% of the state's population lacks health insurance, and many residents have experienced periods of time when health benefits were not affordable, available or adequate to cover all their health care needs. By providing access to health care to the growing number of uninsured, hospitals benefit their communities in a multitude of ways:

- Illinois hospitals provided \$1.4 billion in uncompensated care in 2006. Nearly 1.8 million Illinoisans lack health insurance and thousands more are underinsured. A new report from Families USA estimates that 3.6 million Illinoisans, or 32.4% of the population, were uninsured for all or part of 2006-2007, and that 2.2 million Illinoisans were uninsured for six months or more during that time period.
- Illinois hospitals adopted voluntary guidelines on charity care and collection practices for the uninsured that provide free care to patients whose income is at or below the poverty level and discounts to those up to two times the poverty level. Many hospitals have been able to institute substantially more generous policies than these.

As hospitals and emergency rooms fill the health care void by serving as the first and last resort for vulnerable populations, there is a growing need to address the increasing overload on the current health care delivery system. To this end, hospitals need support from their government partners. Medicare and Medicaid patients account for over half of the average hospital's revenue. Each of these programs pay, on average, less than the cost of providing that care. Medicare covers about 90% of the cost, and Medicaid covers only 62%.

As a result, 55% of Illinois hospitals have a negative patient margin. At the same time hospitals are treating rising numbers of under and uninsured patients, hospitals also are struggling to obtain new life-saving technology, make improvements to facilities, and provide an attractive work environment to recruit and retain quality health care professionals.

In 2006, IHA supported the efforts of the Adequate Health Care Task Force to develop a plan to solve the problem of the uninsured/underinsured in Illinois. The IHA Board formally supported the final report, which was submitted to the Illinois General Assembly in early 2007. The proposal addressed various coverage issues for both the under- and uninsured including the public insurance for those in greatest need, availability of subsidies, and other health care system improvements.

As new health care reform proposals are introduced by the Governor and in the Illinois General Assembly, each proposal is evaluated by IHA on its own merits and whether it follows our adopted policy/principles on universal and continuous access to health insurance coverage that incorporates the strengths of a pluralistic private and public system without eroding coverage for those currently insured.

IHA believes that we can no longer sit by as the crisis of the uninsured grows. We hope you agree that access to health care remains a top priority of the Illinois General Assembly. At the same time, the State must fully fund health care programs without increasing the Medicaid payment cycle, reducing payment rates or decreasing access to those eligible for health programs.

Proposals on Mandatory Hospital Discounts to the Uninsured

Last year, a proposal (HB684) was introduced (but did not advance) in the General Assembly to require hospitals to provide automatic discounts to ALL uninsured patients, **regardless of their income and assets, where they live and if the care was medically necessary.** However, the state has income and asset tests as well as residency requirements and medical necessity requirements in order for people to qualify for Medicaid coverage. It would be inconsistent and unreasonable to force hospitals to have no such requirements in order for uninsured patients to qualify for discounts.

Some of the uninsured are poor, but some of the uninsured choose not to obtain coverage even though they can afford it. Proposals that would mandate discounts without means testing makes no distinction between those who have adequate income and go without health care coverage, and those who are low-income and cannot afford health insurance. Such proposals would prohibit hospitals from collecting more than 110% of the Medicare rate from the wealthy uninsured – even if they want to pay more. In fact, there are more than 250,000 uninsured Illinoisans with incomes above 400 percent of the federal poverty level (which is \$82,600 for a family of four). And Illinois hospitals, on average, only receive 90% of cost from Medicare with many receiving less than 90%.

Imposing unreasonable and administratively burdensome mandates will harm hospitals financially and possibly lead to a reduction in services, new technology or improvements. More than half of hospitals in Illinois already lose money on patient care, and nearly one out of every three hospitals lose money on their operations. Hospitals need revenue in order to maintain and improve the quality of care.

Hospitals already provide free care and discounts – up to 100 % of charges – to low-income uninsured patients, based on financial need, without legislative mandates. Statewide, hospitals provide more than \$1.2 billion in uncompensated care each year. Moreover, according to the annual community benefit reports that about half the hospitals are required to file with the Attorney General's office, they provide more than \$4.2 billion in total community benefits a year.

The Illinois Hospital Association last year offered reasonable changes to **HB684** that would include appropriate income thresholds (up to 400 percent of the Federal Poverty Level) residency requirements and medical necessity in order to qualify for discounted care. These changes were rejected, but the hospital community remains committed to working with the General Assembly and others to find meaningful and workable solutions to meeting the health care needs of the uninsured.

Solving the problem of the uninsured should not come at the expense of local community hospitals, which, unlike any other health care provider, meet community needs 24 hours a day, seven days a week, every day of the year.

Reform and Extend the Sunset on Certificate of Need

Illinois' Certificate of Need (CON) process was established in 1974 when the Illinois Health Facilities Planning Act (IHFPA) was signed into law. Its purpose was to promote access to quality health care by preventing unnecessary duplication of health care facilities and services.

Twenty-six years later, in June 2000, the General Assembly enacted significant CON reforms. Some reforms focused the program on major clinical capital expenditures, leaving other expenditures to market pressures. Other reforms sought to enhance CON's predictability and accountability. For example, the legislation added a sunset provision intended to facilitate regular review by the General Assembly.

Legislative action to extend the sunset of the Act was taken twice in spring 2007. After an interim two-month extension under PA 95-0001, PA 95-0005 extended the sunset until August 31, 2008. The legislation also established a 19-member task force to make recommendations regarding reform of the Act. A report will be issued to the Governor and to the General Assembly, including any necessary implementing legislation and recommendations for changes to policies, rules or procedures that are not included in the legislation.

Illinois hospitals advocate an extension of the IHFPA in the spring 2008 legislative session. Illinois hospitals also support significant reforms to a program that is not working well. The pool of projects that are subject to review should be narrowed. The work of the Planning Board then needs to be focused so that those projects that are most important, such as construction of new health facilities and significant increases in beds, get the most scrutiny. The application and administrative processes, the review criteria themselves, and post permit requirements should be streamlined. The program needs to become more predictable and accountable to regulated entities and the public. Finally, the Board needs to be larger and to include more experts in hospital management who have recent experience.

Illinois needs an effective health facilities planning process to promote access to health care for all Illinoisans. The CON process allows hospitals across the state to continue to provide essential, but money-losing, safety net services to their communities, including 24/7 emergency services, perinatal services, behavioral health services, community education services, and others. Many services would simply be unavailable if limited service providers who care for the best insured and least complex patients were allowed to proliferate, leaving hospitals with the sickest and poorest patients.

Concerns about limited service providers have increased since the federal suspension on Medicare certification of physician-owned limited service hospitals has been lifted. In Illinois, harmful legislation has been considered that would have authorized ambulatory surgical treatment centers to become specialty surgical hospitals and nursing homes to become long-term acute care hospitals without having to meet all of the standards that hospitals must meet and without having to first obtain a CON permit.

The state's Task Force on Health Planning Reform will have an important role in determining the scope of the CON program, the appropriate size, composition and role of the Planning Board, and many specific issues that are set forth in PA 95-0005. Despite the complexity of the issues and multiple interests that will be represented by stakeholders on the Task Force, it will be critical to craft a consensus report to the Governor and General Assembly that supports an extension of the Act and includes reforms to improve the regulatory program for hospitals.

Medical Liability Reform: Protecting Access to Health Care

In 2005, the General Assembly and the Governor took the critical and necessary step of enacting a law (SB475/PA94-677) to implement comprehensive and meaningful medical liability reforms to address the state's medical liability crisis that has been endangering patient access to needed health care. Under the new law, non-economic damage awards cannot exceed \$500,000 against doctors and \$1 million against hospitals. The reform law also gives state insurance regulators more power to review and lower rates that they deem too high and strengthens state oversight of physicians.

Since the law took effect in August 2005, there have been some promising signs that the medical liability environment is becoming more stable – with a decrease in the number of filings of medical malpractice cases, a decrease in physicians' malpractice premiums, fewer doctors leaving the state, and some hospitals reporting that they are having fewer difficulties in recruiting physicians.

But caution must be used in looking at numbers because there is no direct hard evidence yet of the impact of the new law and because it's likely that many plaintiff lawyers are awaiting the outcome of a legal challenge to the law and have not been filing malpractice suits as a result. Because of the uncertainty about whether the law will be upheld as constitutional, we have not seen the full benefit and impact of the law. An appeal of a Cook County circuit court judge's ruling striking down the law (*LeBron v. Gottlieb*) is going directly to the Illinois Supreme Court, with arguments to be made in the case as soon as May 2008. The circuit court ruling has physicians and hospitals very concerned that insurance rates could skyrocket again.

The medical liability crisis in Illinois is far from over:

- Illinois is still one of 17 states identified by the American Medical Association as being in a medical liability crisis because of unaffordable insurance premiums deterring physicians from practicing in the state.
- Illinois is among the TOP FOUR states with the highest medical liability insurance premiums for obstetrics/gynecology. Because of the medical liability crisis in Illinois, many women with high-risk pregnancies are struggling to find obstetricians.
- According to the *Cook County Jury Verdict Reporter*, the ratio of non-economic damages to real economic damages in medical liability cases in the county remained highly skewed at 6 to 1 in 2006.
- Cook County remains on the American Tort Reform Association's 2007 annual list of top ten "judicial hellholes" or high-litigation jurisdictions (ranked third in the country), and Madison and St. Clair counties remain on the group's "watch list."
- Nationally, medical malpractice tort costs continued to increase in 2006, to a total of \$30.3 billion, according to Tillinghast insurance consulting practice, Towers Perrin.



Illinois Hospital Association

Illinois Hospitals Committed to Nurses and Patients

The hospitals of Illinois are engaged in many efforts to provide an excellent workplace environment and provide rewarding career opportunities for nurses. As part of that commitment to nurses, over the past five years, IHA and the hospital community have worked with the General Assembly to support the enactment of a series of landmark legislation to enhance nurses' work environment, increase the nurse supply, and promote patient safety.

Illinois is unique as the only state that has passed such comprehensive and extensive nursing legislation. Each one of Illinois' new laws, including this year's groundbreaking Patient Acuity Nurse Staffing bill, reflect the concerns of both staff nurses and hospitals in order to best serve and deliver quality, patient care.

Below is a summary of each of these landmark laws:

The first law of its kind in the country, the **Hospital Report Card Act (HRCA)** (PA93-0563 in 2003) is intended to provide Illinois consumers a picture of each hospital's staffing process and effectiveness as it relates to a critical public interest – patient outcomes. The HRCA provides consumers access to useful information about nursing coverage and patient outcomes. The HRCA requires Illinois hospitals to share their current unit schedules, nurse-patient assignment rosters, and the methodologies to determine and adjust staffing levels with the public upon request. And, following the state's official rulemaking process, hospitals will be required to report extensive nurse staffing information and infection measures to the Illinois Department of Public Health (IDPH) for public disclosure.

Illinois became the 11th state to **prohibit the use of mandated overtime** in hospitals when the Prohibition of Mandated Overtime (PA94-349) became law in 2005. Only in the event of an unforeseen emergent circumstance may nurses be required to work overtime and then only for four hours beyond a nurse's predetermined, agreed-to work shift. Should they choose to do so, nurses are able to voluntarily assume extra hours beyond their regularly assigned work schedules.

Illinois became only the third state in the nation to enact **Adverse Health Care Event Reporting Law** as embodied in PA94-242 in 2005. This legislation requires hospitals and Ambulatory Surgery Treatment Centers to report any adverse health care event to IDPH along with a root cause analysis and implement a corrective action plan.

Housed within the Illinois Department of Financial and Professional Regulation, the **Illinois Center for Nursing (ICN)** was created in 2006 under PA94-1020. The ICN will work with industry professionals and educational institutions to ensure that Illinois has the nursing workforce necessary to meet the demands of a growing and aging population. The ICN is examining the current demand for nurses, the number of nurses our educational system is producing, the rate of nurses retiring, and the needs of the overall nursing workforce to better understand the state of the nursing shortage in Illinois. The ICN will also develop strategic initiatives to recruit new nurses, offer ongoing training to practicing nurses to ensure constant skill development, retain nursing professionals currently practicing, and promote excellence in nursing education.

Nurse Staffing by Patient Acuity: PA95-0401 (2007) addresses staff planning using a hospital's acuity model, based on recommendations from a nursing care committee comprised of 50% direct care nurses. This new law assures direct care staff a significant voice in the nurse staffing process; aligns staffing considerations based on patient needs and nursing resources; reinforces an evidence-based approach to nurse staffing; and recognizes the diverse staffing needs from patients needing care at large academic medical centers to smaller, critical access hospitals and all points in between.

Illinois has not maintained the status quo, but instead taken the lead in enacting legislation to both address the quality of health care and the working environment for nurses.

At the same time, the hospital community and many nurses across the state have evaluated mandated nurse-patient ratio proposals and considered California's negative experience – unhappy caregivers, dissatisfied patients and reduced access to care.

Health care professionals also have serious concerns about the negative impact not only to their professional autonomy and their ability to deliver quality care to their patients, but also the ways in which mandatory ratios are likely to reduce access to patient services, creating unintended consequences and/or causing harm to the communities where the nurses work.

Additional Material:

- [IHA's Advocacy Campaign on Nurse Staffing Laws](#)
- [Governor Signs Nurse Staffing by Patient Acuity into Law](#)