



Sen. Ann Gillespie

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LRB101 04243 RAB 58305 a

1 AMENDMENT TO SENATE BILL 650

2 AMENDMENT NO. _____. Amend Senate Bill 650 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. Short title. This Act may be cited as the
5 Outpatient Dialysis Payer Transparency Act.

6 Section 5. Definitions. As used in this Act, unless the
7 context requires otherwise:

8 "Financially interested" means any entity or outpatient
9 dialysis provider described by either of the following
10 criteria:

11 (A) An outpatient dialysis provider that receives a
12 direct or indirect financial benefit from a third-party
13 premium payment.

14 (B) An entity that receives the majority of its funding
15 from one or more financially interested outpatient
16 dialysis providers, parent companies of outpatient

1 dialysis providers, subsidiaries of outpatient dialysis
2 providers, or related entities.

3 "Outpatient dialysis provider" means any professional
4 person, organization, health facility, or other person or
5 institution certified by the Centers for Medicare and Medicaid
6 Services as an independent dialysis facility as described in
7 Part 494 of Title 42 of the Code of Federal Regulations.

8 "Third-party premium payment" means any premium payment
9 for a health care plan or accident and health insurance plan
10 made directly by an outpatient dialysis provider or other third
11 party, made indirectly through payments to the individual for
12 the purpose of making health care plan premium payments or
13 accident and health insurance premium payments, or provided to
14 one or more intermediaries with the intention that the funds be
15 used to make health care plan premium payments or accident and
16 health insurance premium payments for the individuals.

17 Section 10. Third-party premium payments.

18 (a) A financially interested entity making third-party
19 premium payments shall comply with all of the following
20 requirements:

21 (1) It shall provide assistance for the full plan year
22 and notify the enrollee prior to any open enrollment
23 periods, if applicable, if financial assistance will be
24 discontinued. Assistance may be discontinued at the
25 request of an enrollee who obtains other health coverage,

1 or if the enrollee dies during the plan year.

2 (2) If the entity provides coverage for an enrollee
3 with end stage renal disease, the entity shall agree not to
4 condition financial assistance on eligibility for, or
5 receipt of, any surgery, transplant, procedure, drug, or
6 device.

7 (3) It shall inform an applicant of financial
8 assistance, and shall inform a recipient annually, of all
9 available health coverage options, including, but not
10 limited to, Medicare, Medicaid, individual market plans,
11 and employer plans, if applicable.

12 (4) It shall agree not to steer, direct, or advise the
13 patient into or away from a specific coverage program
14 option, health care plan contract, or accident and health
15 insurance plan contract.

16 (5) It shall agree that financial assistance shall not
17 be conditioned on the use of a specific outpatient dialysis
18 facility or other health care provider.

19 (b) A financially interested entity shall not make a
20 third-party premium payment unless the entity:

21 (1) annually provides a statement to the health care
22 plan or accident and health insurance plan that it meets
23 the requirements set forth in subsection (a), as
24 applicable; and

25 (2) discloses to the health care plan or accident and
26 health insurance plan, before making the initial payment,

1 the name of the enrollee for each health care plan contract
2 or accident and health insurance plan contract on whose
3 behalf a third-party premium payment described in this
4 Section will be made.

5 Section 90. The Illinois Insurance Code is amended by
6 adding Section 356z.33 as follows:

7 (215 ILCS 5/356z.33 new)

8 Sec. 356z.33. Third-party premium payments; determination
9 of reimbursement.

10 (a) As used in this Section, unless the context requires
11 otherwise:

12 "Financially interested" means any entity or outpatient
13 dialysis provider described by either of the following
14 criteria:

15 (A) An outpatient dialysis provider that receives a
16 direct or indirect financial benefit from a third-party
17 premium payment.

18 (B) An entity that receives the majority of its funding
19 from one or more financially interested outpatient
20 dialysis providers, parent companies of outpatient
21 dialysis providers, subsidiaries of outpatient dialysis
22 providers, or related entities.

23 "Outpatient dialysis provider" means any professional
24 person, organization, health facility, or other person or

1 institution certified by the Centers for Medicare and Medicaid
2 Services as an independent dialysis facility as described in
3 Part 494 of Title 42 of the Code of Federal Regulations.

4 "Third-party premium payment" means any accident and
5 health plan premium payment made directly by an outpatient
6 dialysis provider or other third party, made indirectly through
7 payments to the individual for the purpose of making health
8 care plan premium payments, or provided to one or more
9 intermediaries with the intention that the funds be used to
10 make health care plan premium payments for the individuals.

11 (b) If a financially interested entity makes a third-party
12 premium payment to an accident and health insurer on behalf of
13 an enrollee, reimbursement to a financially interested
14 outpatient dialysis provider for covered services provided
15 shall be determined by the following:

16 (1) For a contracted financially interested outpatient
17 dialysis provider that makes a third-party premium payment
18 or has a financial relationship with the entity making the
19 third-party premium payment, the amount of reimbursement
20 for covered services that shall be paid to the financially
21 interested outpatient dialysis provider on behalf of the
22 enrollee shall be governed by the terms and conditions of
23 the enrollee's accident and health insurance plan contract
24 or the Medicare reimbursement rate, whichever is lower.
25 Financially interested outpatient dialysis providers shall
26 not bill the enrollee or seek reimbursement from the

1 enrollee for any services provided, except for cost sharing
2 pursuant to the terms and conditions of the enrollee's
3 accident and health insurance plan contract. If an
4 enrollee's contract imposes a coinsurance payment for a
5 claim that is subject to this paragraph, the coinsurance
6 payment shall be based on the amount paid by the accident
7 and health insurance plan pursuant to this paragraph.

8 (2) For a noncontracting financially interested
9 outpatient dialysis provider that makes a third-party
10 premium payment or has a financial relationship with the
11 entity making the third-party premium payment, the amount
12 of reimbursement for covered services that shall be paid to
13 the financially interested outpatient dialysis provider on
14 behalf of the enrollee shall be governed by the terms and
15 conditions of the enrollee's accident and health insurance
16 plan contract or the Medicare reimbursement rate,
17 whichever is lower. Financially interested outpatient
18 dialysis providers shall not bill the enrollee or seek
19 reimbursement from the enrollee for any services provided,
20 except for cost sharing pursuant to the terms and
21 conditions of the enrollee's accident and health insurance
22 plan contract. If an enrollee's contract imposes a
23 coinsurance payment for a claim that is subject to this
24 paragraph, the coinsurance payment shall be based on the
25 amount paid by the accident and health insurance plan
26 pursuant to this paragraph. A claim submitted to an

1 accident and health insurance plan by a noncontracting
2 financially interested outpatient dialysis provider may be
3 considered an incomplete claim and contested by the
4 accident and health insurance plan if the financially
5 interested outpatient dialysis provider has not provided
6 the information as required in subsection (b) of Section 10
7 of the Outpatient Dialysis Payer Transparency Act.

8 (c) The following shall occur if an accident and health
9 insurer subsequently discovers that a financially interested
10 entity fails to provide disclosure pursuant to subsection (b)
11 of Section 10 of the Outpatient Dialysis Payer Transparency
12 Act:

13 (1) The accident and health insurer shall be entitled
14 to recover 120% of the difference between any payment made
15 to an outpatient dialysis provider and the payment to which
16 the outpatient dialysis provider would have been entitled
17 pursuant to subsection (b), including interest on that
18 difference.

19 (2) The accident and health insurer shall notify the
20 Department of Insurance of the amount by which the
21 outpatient dialysis provider was overpaid and shall remit
22 to the Department of Insurance any amount exceeding the
23 difference between the payment made to the outpatient
24 dialysis provider and the payment to which the outpatient
25 dialysis provider would have been entitled pursuant to
26 subsection (b), including interest on that difference that

1 was recovered pursuant to paragraph (1).

2 (c) Each accident and health insurer authorized to transact
3 business in this State that is subject to this Section shall
4 provide to the Department of Insurance information regarding
5 premium payments by financially interested entities and
6 reimbursement for services to outpatient dialysis providers
7 under subsection (b). The information shall be provided at
8 least annually at the discretion of the Department of Insurance
9 and shall include, to the best of the accident and health
10 insurer's knowledge, the number of enrollees whose premiums
11 were paid by financially interested entities, disclosures
12 provided to the insurer pursuant to subsection (b) of Section
13 10 of the Outpatient Dialysis Payer Transparency Act, the
14 identities of any outpatient dialysis providers whose
15 reimbursement rate was governed by subsection (b), the
16 identities of any outpatient dialysis providers who failed to
17 provide disclosure as described in subsection (b) of Section 10
18 of the Outpatient Dialysis Payer Transparency Act, and, at the
19 discretion of the Department of Insurance, additional
20 information necessary for the implementation of this Section.

21 (d) This Section does not affect a contracted payment rate
22 for an outpatient dialysis provider who is not financially
23 interested.

24 (e) This Section does not give an insurer any additional
25 ability to refuse to accept premium payments or to cancel or
26 refuse to renew an existing enrollment or subscription,

1 regardless of the source of payment.

2 (f) An accident and health insurer shall accept premium
3 payments from the following third-party entities without the
4 entities needing to comply with reporting requirements:

5 (1) Any member of the individual's family, defined for
6 purposes of this Section to include the individual's
7 spouse, domestic partner, child, parent, grandparent, and
8 siblings, unless the true source of funds used to make the
9 premium payment originates with a financially interested
10 entity.

11 (2) An entity making the premium payments for coverage
12 of Medicare services pursuant to contracts with the United
13 States government, Medicare supplement coverage, long-term
14 care insurance, coverage issued as a supplement to
15 liability insurance, insurance arising out of workers'
16 compensation law or similar law, automobile medical
17 payment insurance, or insurance under which benefits are
18 payable with or without regard to fault and that is
19 statutorily required to be contained in any liability
20 insurance policy or equivalent self-insurance.

21 Section 95. The Health Maintenance Organization Act is
22 amended by changing Section 1-2 and by adding Sections 4-5.1 as
23 follows:

24 (215 ILCS 125/1-2) (from Ch. 111 1/2, par. 1402)

1 Sec. 1-2. Definitions. As used in this Act, unless the
2 context otherwise requires, the following terms shall have the
3 meanings ascribed to them:

4 (1) "Advertisement" means any printed or published
5 material, audiovisual material and descriptive literature of
6 the health care plan used in direct mail, newspapers,
7 magazines, radio scripts, television scripts, billboards and
8 similar displays; and any descriptive literature or sales aids
9 of all kinds disseminated by a representative of the health
10 care plan for presentation to the public including, but not
11 limited to, circulars, leaflets, booklets, depictions,
12 illustrations, form letters and prepared sales presentations.

13 (2) "Director" means the Director of Insurance.

14 (3) "Basic health care services" means emergency care, and
15 inpatient hospital and physician care, outpatient medical
16 services, mental health services and care for alcohol and drug
17 abuse, including any reasonable deductibles and co-payments,
18 all of which are subject to the limitations described in
19 Section 4-20 of this Act and as determined by the Director
20 pursuant to rule.

21 (4) "Enrollee" means an individual who has been enrolled in
22 a health care plan.

23 (5) "Evidence of coverage" means any certificate,
24 agreement, or contract issued to an enrollee setting out the
25 coverage to which he is entitled in exchange for a per capita
26 prepaid sum.

1 (5.5) "Financially interested" means any entity or
2 outpatient dialysis provider described by either of the
3 following criteria:

4 (A) An outpatient dialysis provider that receives a
5 direct or indirect financial benefit from a third-party
6 premium payment.

7 (B) An entity that receives the majority of its funding
8 from one or more financially interested outpatient
9 dialysis providers, parent companies of outpatient
10 dialysis providers, subsidiaries of outpatient dialysis
11 providers, or related entities.

12 (6) "Group contract" means a contract for health care
13 services which by its terms limits eligibility to members of a
14 specified group.

15 (7) "Health care plan" means any arrangement whereby any
16 organization undertakes to provide or arrange for and pay for
17 or reimburse the cost of basic health care services, excluding
18 any reasonable deductibles and copayments, from providers
19 selected by the Health Maintenance Organization and such
20 arrangement consists of arranging for or the provision of such
21 health care services, as distinguished from mere
22 indemnification against the cost of such services, except as
23 otherwise authorized by Section 2-3 of this Act, on a per
24 capita prepaid basis, through insurance or otherwise. A "health
25 care plan" also includes any arrangement whereby an
26 organization undertakes to provide or arrange for or pay for or

1 reimburse the cost of any health care service for persons who
2 are enrolled under Article V of the Illinois Public Aid Code or
3 under the Children's Health Insurance Program Act through
4 providers selected by the organization and the arrangement
5 consists of making provision for the delivery of health care
6 services, as distinguished from mere indemnification. A
7 "health care plan" also includes any arrangement pursuant to
8 Section 4-17. Nothing in this definition, however, affects the
9 total medical services available to persons eligible for
10 medical assistance under the Illinois Public Aid Code.

11 (8) "Health care services" means any services included in
12 the furnishing to any individual of medical or dental care, or
13 the hospitalization or incident to the furnishing of such care
14 or hospitalization as well as the furnishing to any person of
15 any and all other services for the purpose of preventing,
16 alleviating, curing or healing human illness or injury.

17 (9) "Health Maintenance Organization" means any
18 organization formed under the laws of this or another state to
19 provide or arrange for one or more health care plans under a
20 system which causes any part of the risk of health care
21 delivery to be borne by the organization or its providers.

22 (10) "Net worth" means admitted assets, as defined in
23 Section 1-3 of this Act, minus liabilities.

24 (11) "Organization" means any insurance company, a
25 nonprofit corporation authorized under the Dental Service Plan
26 Act or the Voluntary Health Services Plans Act, or a

1 corporation organized under the laws of this or another state
2 for the purpose of operating one or more health care plans and
3 doing no business other than that of a Health Maintenance
4 Organization or an insurance company. "Organization" shall
5 also mean the University of Illinois Hospital as defined in the
6 University of Illinois Hospital Act or a unit of local
7 government health system operating within a county with a
8 population of 3,000,000 or more.

9 (11.5) "Outpatient dialysis provider" means any
10 professional person, organization, health facility, or other
11 person or institution certified by the Centers for Medicare and
12 Medicaid Services as an independent dialysis facility as
13 described in Part 494 of Title 42 of the Code of Federal
14 Regulations.

15 (12) "Provider" means any physician, hospital facility,
16 facility licensed under the Nursing Home Care Act, or facility
17 or long-term care facility as those terms are defined in the
18 Nursing Home Care Act or other person which is licensed or
19 otherwise authorized to furnish health care services and also
20 includes any other entity that arranges for the delivery or
21 furnishing of health care service.

22 (13) "Producer" means a person directly or indirectly
23 associated with a health care plan who engages in solicitation
24 or enrollment.

25 (14) "Per capita prepaid" means a basis of prepayment by
26 which a fixed amount of money is prepaid per individual or any

1 other enrollment unit to the Health Maintenance Organization or
2 for health care services which are provided during a definite
3 time period regardless of the frequency or extent of the
4 services rendered by the Health Maintenance Organization,
5 except for copayments and deductibles and except as provided in
6 subsection (f) of Section 5-3 of this Act.

7 (15) "Subscriber" means a person who has entered into a
8 contractual relationship with the Health Maintenance
9 Organization for the provision of or arrangement of at least
10 basic health care services to the beneficiaries of such
11 contract.

12 (16) "Third-party premium payment" means any health care
13 plan premium payment made directly by an outpatient dialysis
14 provider or other third party, made indirectly through payments
15 to the individual for the purpose of making health care plan
16 premium payments, or provided to one or more intermediaries
17 with the intention that the funds be used to make health care
18 plan premium payments for the individuals.

19 (Source: P.A. 98-651, eff. 6-16-14; 98-841, eff. 8-1-14; 99-78,
20 eff. 7-20-15.)

21 (215 ILCS 125/4-5.1 new)

22 Sec. 4-5.1. Third-party premium payments; determination of
23 reimbursement.

24 (a) If a financially interested entity makes a third-party
25 premium payment to a Health Maintenance Organization on behalf

1 of an enrollee, reimbursement to a financially interested
2 outpatient dialysis provider for covered services provided
3 shall be determined by the following:

4 (1) For a contracted financially interested outpatient
5 dialysis provider that makes a third-party premium payment
6 or has a financial relationship with the entity making the
7 third-party premium payment, the amount of reimbursement
8 for covered services that shall be paid to the financially
9 interested outpatient dialysis provider on behalf of the
10 enrollee shall be governed by the terms and conditions of
11 the enrollee's health care plan contract or the Medicare
12 reimbursement rate, whichever is lower. Financially
13 interested outpatient dialysis providers shall not bill
14 the enrollee or seek reimbursement from the enrollee for
15 any services provided, except for cost sharing pursuant to
16 the terms and conditions of the enrollee's health care plan
17 contract. If an enrollee's contract imposes a coinsurance
18 payment for a claim that is subject to this paragraph, the
19 coinsurance payment shall be based on the amount paid by
20 the Health Maintenance Organization pursuant to this
21 paragraph.

22 (2) For a noncontracting financially interested
23 outpatient dialysis provider that makes a third-party
24 premium payment or has a financial relationship with the
25 entity making the third-party premium payment, the amount
26 of reimbursement for covered services that shall be paid to

1 the financially interested outpatient dialysis provider on
2 behalf of the enrollee shall be governed by the terms and
3 conditions of the enrollee's health care plan contract or
4 the Medicare reimbursement rate, whichever is lower.
5 Financially interested outpatient dialysis providers shall
6 not bill the enrollee or seek reimbursement from the
7 enrollee for any services provided, except for cost sharing
8 pursuant to the terms and conditions of the enrollee's
9 health care plan contract. If an enrollee's contract
10 imposes a coinsurance payment for a claim that is subject
11 to this paragraph, the coinsurance payment shall be based
12 on the amount paid by the Health Maintenance Organization
13 pursuant to this paragraph. A claim submitted to a Health
14 Maintenance Organization by a noncontracting financially
15 interested outpatient dialysis provider may be considered
16 an incomplete claim and contested by the Health Maintenance
17 Organization if the financially interested outpatient
18 dialysis provider has not provided the information as
19 required in subsection (b) of Section 10 of the Outpatient
20 Dialysis Payer Transparency Act.

21 (b) The following shall occur if a Health Maintenance
22 Organization subsequently discovers that a financially
23 interested entity fails to provide disclosure pursuant to
24 subsection (b) of Section 10 of the Outpatient Dialysis Payer
25 Transparency Act:

26 (1) The Health Maintenance Organization shall be

1 entitled to recover 120% of the difference between any
2 payment made to an outpatient dialysis provider and the
3 payment to which the outpatient dialysis provider would
4 have been entitled pursuant to subsection (a), including
5 interest on that difference.

6 (2) The Health Maintenance Organization shall notify
7 the Department of Insurance of the amount by which the
8 outpatient dialysis provider was overpaid and shall remit
9 to the Department of Insurance any amount exceeding the
10 difference between the payment made to the outpatient
11 dialysis provider and the payment to which the outpatient
12 dialysis provider would have been entitled pursuant to
13 subsection (a), including interest on that difference that
14 was recovered pursuant to paragraph (1).

15 (c) Each Health Maintenance Organization subject to this
16 Section shall provide to the Department of Insurance
17 information regarding premium payments by financially
18 interested entities and reimbursement for services to
19 outpatient dialysis providers under subsection (a). The
20 information shall be provided at least annually at the
21 discretion of the Department of Insurance and shall include, to
22 the best of the Health Maintenance Organization's knowledge,
23 the number of enrollees whose premiums were paid by financially
24 interested entities, disclosures provided to the Health
25 Maintenance Organization pursuant to subsection (b) of Section
26 10 of the Outpatient Dialysis Payer Transparency Act the

1 identities of any outpatient dialysis providers whose
2 reimbursement rate was governed by subsection (a), the
3 identities of any outpatient dialysis providers who failed to
4 provide disclosure as described in subsection (b) of Section 10
5 of the Outpatient Dialysis Payer Transparency Act, and, at the
6 discretion of the Department of Insurance, additional
7 information necessary for the implementation of this Section.

8 (d) This Section does not affect a contracted payment rate
9 for an outpatient dialysis provider who is not financially
10 interested.

11 (e) This Section does not give an insurer any additional
12 ability to refuse to accept premium payments or to cancel or
13 refuse to renew an existing enrollment or subscription,
14 regardless of the source of payment.

15 (f) A Health Maintenance Organization shall accept premium
16 payments from the following third-party entities without the
17 entities needing to comply with reporting requirements:

18 (1) Any member of the individual's family, defined for
19 purposes of this Section to include the individual's
20 spouse, domestic partner, child, parent, grandparent, and
21 siblings, unless the true source of funds used to make the
22 premium payment originates with a financially interested
23 entity.

24 (2) An entity making the premium payments for coverage
25 of Medicare services pursuant to contracts with the United
26 States government, Medicare supplement coverage, long-term

1 care insurance, coverage issued as a supplement to
2 liability insurance, insurance arising out of workers'
3 compensation law or similar law, automobile medical
4 payment insurance, or insurance under which benefits are
5 payable with or without regard to fault and that is
6 statutorily required to be contained in any liability
7 insurance policy or equivalent self-insurance."