Sen. Ann Gillespie

Filed: 3/21/2019

AMENDMENT TO SENATE BILL 650

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

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

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

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

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

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

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

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

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

Section 10. Third-party premium payments.

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

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

or if the enrollee dies during the plan year.

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

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

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

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

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

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

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

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

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

(215 ILCS 5/356z.33 new)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

was recovered pursuant to paragraph (1).

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

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

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

regardless of the source of payment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(215 ILCS 125/4-5.1 new)

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

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

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

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

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

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

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

(1) The Health Maintenance Organization shall be

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

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

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

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

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

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

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

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

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

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