



Sen. Ann Gillespie

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LRB101 04243 AMC 59407 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       (d) 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, the identities of  
12 any outpatient dialysis providers whose reimbursement rate was  
13 governed by subsection (b), the identities of any outpatient  
14 dialysis providers who failed to provide disclosure as  
15 described in subsection (b) of Section 10 of the Outpatient  
16 Dialysis Payer Transparency Act, and, at the discretion of the  
17 Department of Insurance, additional information necessary for  
18 the implementation of this Section. Information provided to the  
19 Department pursuant to this subsection shall be exempt from  
20 public disclosure unless first aggregated or masked in such a  
21 way as to not disclose the identity of any outpatient dialysis  
22 facilities.

23       (e) Information obtained by an insurer pursuant to  
24 subsection (b) of Section 10 of the Outpatient Dialysis Payer  
25 Transparency Act shall be used only for the proper execution of  
26 this Section and shall not be disclosed other than as necessary



1 to comply with this Section.

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

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

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

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

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

1           insurance policy or equivalent self-insurance.

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

5           (215 ILCS 125/1-2) (from Ch. 111 1/2, par. 1402)

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

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

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

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

1 pursuant to rule.

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

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

8 (5.5) "Financially interested" means any entity or  
9 outpatient dialysis provider described by either of the  
10 following 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  
17 dialysis providers, subsidiaries of outpatient dialysis  
18 providers, or related entities.

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

22 (7) "Health care plan" means any arrangement whereby any  
23 organization undertakes to provide or arrange for and pay for  
24 or reimburse the cost of basic health care services, excluding  
25 any reasonable deductibles and copayments, from providers  
26 selected by the Health Maintenance Organization and such

1 arrangement consists of arranging for or the provision of such  
2 health care services, as distinguished from mere  
3 indemnification against the cost of such services, except as  
4 otherwise authorized by Section 2-3 of this Act, on a per  
5 capita prepaid basis, through insurance or otherwise. A "health  
6 care plan" also includes any arrangement whereby an  
7 organization undertakes to provide or arrange for or pay for or  
8 reimburse the cost of any health care service for persons who  
9 are enrolled under Article V of the Illinois Public Aid Code or  
10 under the Children's Health Insurance Program Act through  
11 providers selected by the organization and the arrangement  
12 consists of making provision for the delivery of health care  
13 services, as distinguished from mere indemnification. A  
14 "health care plan" also includes any arrangement pursuant to  
15 Section 4-17. Nothing in this definition, however, affects the  
16 total medical services available to persons eligible for  
17 medical assistance under the Illinois Public Aid Code.

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

24 (9) "Health Maintenance Organization" means any  
25 organization formed under the laws of this or another state to  
26 provide or arrange for one or more health care plans under a

1 system which causes any part of the risk of health care  
2 delivery to be borne by the organization or its providers.

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

5 (11) "Organization" means any insurance company, a  
6 nonprofit corporation authorized under the Dental Service Plan  
7 Act or the Voluntary Health Services Plans Act, or a  
8 corporation organized under the laws of this or another state  
9 for the purpose of operating one or more health care plans and  
10 doing no business other than that of a Health Maintenance  
11 Organization or an insurance company. "Organization" shall  
12 also mean the University of Illinois Hospital as defined in the  
13 University of Illinois Hospital Act or a unit of local  
14 government health system operating within a county with a  
15 population of 3,000,000 or more.

16 (11.5) "Outpatient dialysis provider" means any  
17 professional person, organization, health facility, or other  
18 person or institution certified by the Centers for Medicare and  
19 Medicaid Services as an independent dialysis facility as  
20 described in Part 494 of Title 42 of the Code of Federal  
21 Regulations.

22 (12) "Provider" means any physician, hospital facility,  
23 facility licensed under the Nursing Home Care Act, or facility  
24 or long-term care facility as those terms are defined in the  
25 Nursing Home Care Act or other person which is licensed or  
26 otherwise authorized to furnish health care services and also

1 includes any other entity that arranges for the delivery or  
2 furnishing of health care service.

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

6 (14) "Per capita prepaid" means a basis of prepayment by  
7 which a fixed amount of money is prepaid per individual or any  
8 other enrollment unit to the Health Maintenance Organization or  
9 for health care services which are provided during a definite  
10 time period regardless of the frequency or extent of the  
11 services rendered by the Health Maintenance Organization,  
12 except for copayments and deductibles and except as provided in  
13 subsection (f) of Section 5-3 of this Act.

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

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

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

1 eff. 7-20-15.)

2 (215 ILCS 125/4-5.1 new)

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

5 (a) If a financially interested entity makes a third-party  
6 premium payment to a Health Maintenance Organization on behalf  
7 of an enrollee, reimbursement to a financially interested  
8 outpatient dialysis provider for covered services provided  
9 shall be determined by the following:

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

1       the Health Maintenance Organization pursuant to this  
2       paragraph.

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



1 Dialysis Payer Transparency Act.

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

7 (1) The Health Maintenance Organization shall be  
8 entitled to recover 120% of the difference between any  
9 payment made to an outpatient dialysis provider and the  
10 payment to which the outpatient dialysis provider would  
11 have been entitled pursuant to subsection (a), including  
12 interest on that difference.

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

22 (c) Each Health Maintenance Organization subject to this  
23 Section shall provide to the Department of Insurance  
24 information regarding premium payments by financially  
25 interested entities and reimbursement for services to  
26 outpatient dialysis providers under subsection (a). The

1 information shall be provided at least annually at the  
2 discretion of the Department of Insurance and shall include, to  
3 the best of the Health Maintenance Organization's knowledge,  
4 the number of enrollees whose premiums were paid by financially  
5 interested entities, the identities of any outpatient dialysis  
6 providers whose reimbursement rate was governed by subsection  
7 (a), the identities of any outpatient dialysis providers who  
8 failed to provide disclosure as described in subsection (b) of  
9 Section 10 of the Outpatient Dialysis Payer Transparency Act,  
10 and, at the discretion of the Department of Insurance,  
11 additional information necessary for the implementation of  
12 this Section. Information provided to the Department pursuant  
13 to this subsection shall be exempt from public disclosure  
14 unless first aggregated or masked in such a way as to not  
15 disclose the identity of any outpatient dialysis facilities.

16 (d) Information obtained by an insurer pursuant to  
17 subsection (b) of Section 10 of the Outpatient Dialysis Payer  
18 Transparency Act shall be used only for the proper execution of  
19 this Section and shall not be disclosed other than as necessary  
20 to comply with this Section.

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

24 (f) 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 (g) A Health Maintenance Organization 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 99. Effective date. This Act takes effect upon  
22 becoming law."