Sen. Ann Gillespie

Filed: 4/29/2019

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 Dialysis Patient Protection Act.

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

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, and any amendments thereto or regulations or guidance issued under those Acts.

"Health insurance marketplace" means the health insurance marketplace established for Illinois under the Affordable Care Act.

"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.

"Qualified health plan" means a plan of health insurance that is certified by the health insurance marketplace and meets the requirements of the Affordable Care Act, including coverage of essential health benefits.

"Qualified individual" means an individual who has been determined to be eligible to enroll through the health insurance marketplace in a qualified health plan in the individual market.

"Third-party premium payment" means any premium payment for a health care plan or accident and health insurance plan made directly or indirectly 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 individual.

Section 10. Third-party premium payments.

(a) A qualified individual enrolled in a qualified health plan on the health insurance marketplace may allow a third-party premium payment to be made on his or her behalf to

pay any applicable premium or cost-sharing owed by the qualified individual to the health insurance issuer issuing the qualified health plan, and the health insurance issuer issuing the qualified health plan shall accept a third-party premium payment made on behalf of the qualified individual that complies with the requirements of this Act.

(b) An outpatient dialysis provider shall notify the health care plan or accident and health insurance plan the first time in a calendar year that the outpatient dialysis provider bills a health care service plan for reimbursement resulting from services provided to an enrollee who meets any of the following descriptions:

(1) During the calendar year, premiums for the enrollee's health care plan or accident and health insurance plan have been paid, directly or indirectly, by the outpatient dialysis provider, parent company of the outpatient dialysis provider, a subsidiary of the outpatient dialysis provider, or a related entity.

(2) During the calendar year, premiums for the enrollee's health care plan or accident and health insurance plan have been paid directly or indirectly by a third party.

(c) An outpatient dialysis provider shall make a good faith effort to identify all patients to which it provides health care services whose premiums have been paid under an arrangement described in subsection (b). That good faith effort

includes, but is not limited to, the following:

(1) The outpatient dialysis provider receives notification from a patient or from the entity making the premium payments that the patient's premiums were paid under an arrangement described in paragraph (1) or (2) of subsection (b).

(2) The parent company of the outpatient dialysis provider, a subsidiary of the outpatient dialysis provider, or a related entity becomes aware that a patient's premiums were paid under an arrangement described in paragraph (1) or (2) of subsection (b).

(3) The outpatient dialysis provider receives notification as required by federal Health and Human Services Office of Inspector General Advisory Opinion 97-1, or a related successor advisory opinion, that a patient's premiums were paid under an arrangement authorized by that advisory opinion.

Section 15. Patient rights. An outpatient dialysis provider shall always keep the best interests of patients in mind when providing patients with information about a third-party health insurance premium program's eligibility, benefits, conditions, and related information, and when assisting patients in applying for the health insurance premium program or other assistance from a third party. The outpatient dialysis provider shall remind patients that the patients are

the persons who should make any decisions concerning their health insurance premium program assistance, including, but not limited to, applying for, changing, stopping, or re-enrolling in health insurance coverage. The outpatient dialysis provider shall take reasonable steps to overcome educational, linguistic, and cultural barriers in informing patients about their health insurance options. The outpatient dialysis provider shall provide accurate and impartial information designed to enable patients to make informed decisions about their health insurance coverage choice. Where applicable, such information shall include financial implications associated with the choice of a particular coverage option to the extent such information is available. Information provided may include, but is not limited to:

(1) out-of-pocket expenses, including, but not limited to, co-pays, deductibles, and other uncovered costs;

(2) reenrollment requirements;

(3) potential Medicare late enrollment penalties, if any; and

(4) a recommendation that the patient review with his or her transplant center the impact, if any, of his or her health care coverage choice on transplant status.

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:

"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 or indirectly 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 an accident and health insurer receives notification under Section 10 of the Dialysis Patient Protection Act on behalf of an enrollee, reimbursement to the outpatient dialysis provider for covered services provided on behalf of the enrollee shall be determined by the following:

(1) For a contracted outpatient dialysis provider, the amount of reimbursement for covered services 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. 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 outpatient dialysis provider, the amount of reimbursement for covered services 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. 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

outpatient dialysis provider may be considered an incomplete claim and contested by the accident and health insurance plan if the outpatient dialysis provider has not provided the information as required in subsection (b) of Section 10 of the Dialysis Patient Protection Act.

(c) The following shall occur if an accident and health insurer subsequently discovers that an outpatient dialysis provider fails to provide disclosure pursuant to subsection (b) of Section 10 of the Dialysis Patient Protection 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).

(d) 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.

Section 95. The Health Maintenance Organization Act is amended by changing Section 1-2 and by adding Section 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.

(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 or indirectly 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 Health Maintenance Organization receives notification under Section 10 of the Dialysis Patient Protection Act on behalf of an enrollee, reimbursement to the outpatient dialysis provider for covered services provided on

behalf of the enrollee shall be determined by the following:

(1) For a contracted outpatient dialysis provider, the amount of reimbursement for covered services shall be governed by the terms and conditions of the enrollee's health care plan contract or the Medicare reimbursement rate, whichever is lower. 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 outpatient dialysis provider, the amount of reimbursement for covered shall be governed by the terms and conditions of the enrollee's health care plan contract or the Medicare reimbursement rate, whichever is lower. 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 outpatient dialysis provider may be considered an incomplete claim and contested by the Health Maintenance Organization if the outpatient dialysis provider has not provided the information as required in subsection (b) of Section 10 of the Dialysis Patient Protection Act.

(b) The following shall occur if a Health Maintenance Organization subsequently discovers that an outpatient dialysis provider fails to provide disclosure pursuant to subsection (b) of Section 10 of the Dialysis Patient Protection 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) 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.

Section 99. Effective date. This Act takes effect upon becoming law.".