



Sen. Ann Gillespie

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LRB101 04243 CPF 60005 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 Dialysis Patient Protection Act.

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

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

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

15 "Outpatient dialysis provider" means any professional
16 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 "Qualified health plan" means a plan of health insurance
5 that is certified by the health insurance marketplace and meets
6 the requirements of the Affordable Care Act, including coverage
7 of essential health benefits.

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

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

22 Section 10. Third-party premium payments.

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

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

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

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

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

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

1 includes, but is not limited to, the following:

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

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

12 (3) The outpatient dialysis provider receives
13 notification as required by federal Health and Human
14 Services Office of Inspector General Advisory Opinion
15 97-1, or a related successor advisory opinion, that a
16 patient's premiums were paid under an arrangement
17 authorized by that advisory opinion.

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

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

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

17 (2) reenrollment requirements;

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

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

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

1 (215 ILCS 5/356z.33 new)

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

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

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

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

19 (b) If an accident and health insurer receives notification
20 under Section 10 of the Dialysis Patient Protection Act on
21 behalf of an enrollee, reimbursement to the outpatient dialysis
22 provider for covered services provided on behalf of the
23 enrollee shall be determined by the following:

24 (1) For a contracted outpatient dialysis provider, the
25 amount of reimbursement for covered services shall be
26 governed by the terms and conditions of the enrollee's

1 accident and health insurance plan contract or the Medicare
2 reimbursement rate, whichever is lower. Outpatient
3 dialysis providers shall not bill the enrollee or seek
4 reimbursement from the enrollee for any services provided,
5 except for cost sharing pursuant to the terms and
6 conditions of the enrollee's accident and health insurance
7 plan contract. If an enrollee's contract imposes a
8 coinsurance payment for a claim that is subject to this
9 paragraph, the coinsurance payment shall be based on the
10 amount paid by the accident and health insurance plan
11 pursuant to this paragraph.

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

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

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

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

16 (2) The accident and health insurer shall notify the
17 Department of Insurance of the amount by which the
18 outpatient dialysis provider was overpaid and shall remit
19 to the Department of Insurance any amount exceeding the
20 difference between the payment made to the outpatient
21 dialysis provider and the payment to which the outpatient
22 dialysis provider would have been entitled pursuant to
23 subsection (b), including interest on that difference that
24 was recovered pursuant to paragraph (1).

25 (d) This Section does not give an insurer any additional
26 ability to refuse to accept premium payments or to cancel or

1 refuse to renew an existing enrollment or subscription,
2 regardless of the source of payment.

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

6 (215 ILCS 125/1-2) (from Ch. 111 1/2, par. 1402)

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

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

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

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

1 Section 4-20 of this Act and as determined by the Director
2 pursuant to rule.

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

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

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

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

1 providers selected by the organization and the arrangement
2 consists of making provision for the delivery of health care
3 services, as distinguished from mere indemnification. A
4 "health care plan" also includes any arrangement pursuant to
5 Section 4-17. Nothing in this definition, however, affects the
6 total medical services available to persons eligible for
7 medical assistance under the Illinois Public Aid Code.

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

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

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

21 (11) "Organization" means any insurance company, a
22 nonprofit corporation authorized under the Dental Service Plan
23 Act or the Voluntary Health Services Plans Act, or a
24 corporation organized under the laws of this or another state
25 for the purpose of operating one or more health care plans and
26 doing no business other than that of a Health Maintenance

1 Organization or an insurance company. "Organization" shall
2 also mean the University of Illinois Hospital as defined in the
3 University of Illinois Hospital Act or a unit of local
4 government health system operating within a county with a
5 population of 3,000,000 or more.

6 (11.5) "Outpatient dialysis provider" means any
7 professional person, organization, health facility, or other
8 person or institution certified by the Centers for Medicare and
9 Medicaid Services as an independent dialysis facility as
10 described in Part 494 of Title 42 of the Code of Federal
11 Regulations.

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

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

22 (14) "Per capita prepaid" means a basis of prepayment by
23 which a fixed amount of money is prepaid per individual or any
24 other enrollment unit to the Health Maintenance Organization or
25 for health care services which are provided during a definite
26 time period regardless of the frequency or extent of the

1 services rendered by the Health Maintenance Organization,
2 except for copayments and deductibles and except as provided in
3 subsection (f) of Section 5-3 of this Act.

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

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

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

19 (215 ILCS 125/4-5.1 new)

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

22 (a) If a Health Maintenance Organization receives
23 notification under Section 10 of the Dialysis Patient
24 Protection Act on behalf of an enrollee, reimbursement to the
25 outpatient dialysis provider for covered services provided on

1 behalf of the enrollee shall be determined by the following:

2 (1) For a contracted outpatient dialysis provider, the
3 amount of reimbursement for covered services shall be
4 governed by the terms and conditions of the enrollee's
5 health care plan contract or the Medicare reimbursement
6 rate, whichever is lower. Outpatient dialysis providers
7 shall not bill the enrollee or seek reimbursement from the
8 enrollee for any services provided, except for cost sharing
9 pursuant to the terms and conditions of the enrollee's
10 health care plan contract. If an enrollee's contract
11 imposes a coinsurance payment for a claim that is subject
12 to this paragraph, the coinsurance payment shall be based
13 on the amount paid by the Health Maintenance Organization
14 pursuant to this paragraph.

15 (2) For a noncontracting outpatient dialysis provider,
16 the amount of reimbursement for covered shall be governed
17 by the terms and conditions of the enrollee's health care
18 plan contract or the Medicare reimbursement rate,
19 whichever is lower. Outpatient dialysis providers shall
20 not bill the enrollee or seek reimbursement from the
21 enrollee for any services provided, except for cost sharing
22 pursuant to the terms and conditions of the enrollee's
23 health care plan contract. If an enrollee's contract
24 imposes a coinsurance payment for a claim that is subject
25 to this paragraph, the coinsurance payment shall be based
26 on the amount paid by the Health Maintenance Organization

1 pursuant to this paragraph. A claim submitted to a Health
2 Maintenance Organization by a noncontracting outpatient
3 dialysis provider may be considered an incomplete claim and
4 contested by the Health Maintenance Organization if the
5 outpatient dialysis provider has not provided the
6 information as required in subsection (b) of Section 10 of
7 the Dialysis Patient Protection Act.

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

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

19 (2) The Health Maintenance Organization shall notify
20 the 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 (a), including interest on that difference that

1 was recovered pursuant to paragraph (1).

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

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