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Amendment No. _____

Signature of Sponsor

AMEND Senate Bill No. 1444

House Bill No. 720*

by deleting all language after the enacting clause and substituting the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 1, Part 1, is amended by adding the following new section:

Notwithstanding any other law to the contrary:

(1) For purposes of this section:

(A) "Payer" includes any managed care organization that has entered into an agreement with this state to administer and provide reimbursement to providers pursuant to the TennCare II medicaid demonstration waiver, or any successor waiver or any other medical assistance program administered by this state; and

(B) "Plan of care" means an individualized education plan (IEP), Section 504 plan, or other eligibility program, and accompanying supporting documentation from the licensed healthcare provider who provides services within the scope of the provider's license, registration, or certification.

(2)

(A) A local education agency (LEA) is entitled to bill for medically necessary services, including, but not limited to, the services described in § 71-5-107, that are provided by the LEA to eligible students pursuant to the student's plan of care.



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(B) Notwithstanding any other law, a plan of care establishes medical necessity and qualifies for prior authorization for all covered services described in the plan of care.

(3) If a covered service is provided by an employee of an LEA or by a third party pursuant to an agreement with an LEA, then the LEA is entitled to the prevailing federal financial participation (FFP) rate multiplied by the in-network fee schedule published by the payer. The payer shall provide the fee schedule to the LEA upon request.

(4) The LEA must execute a provider agreement with the payer to be eligible for payment pursuant to subdivision (3). The payer shall not deny an LEA request to become a registered provider and to be included in the payer network unless the LEA fails to satisfy reasonable credentialing requirements. A payer shall not use calculations that determine the adequacy of payer networks or network sufficiency to prohibit or effectively prohibit the enrollment of an LEA as a provider.

SECTION 2. This act shall take effect July 1, 2019, the public welfare requiring it.

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Amendment No. _____

Signature of Sponsor

AMEND Senate Bill No. 612*

House Bill No. 709

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 1, is amended by adding the following new section:

(a) As used in this section:

(1) "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:

- (A) Placing the person's health in serious jeopardy;
- (B) Serious impairment to bodily functions; or
- (C) Serious dysfunction of any bodily organ or part;

(2) "Emergency services":

(A) Means healthcare items and services furnished in a hospital that are required to determine, evaluate, or treat:

- (i) An emergency medical condition; or
- (ii) Active labor; and

(B) Includes healthcare items and services related to inpatient admissions through an emergency department;

(3) "Fair health value" means the eightieth (80th) percentile of all submitted billed charges for the particular healthcare service performed by a provider in the same or similar specialty that are provided in the same



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geographical area as reported in a benchmarking database maintained by a nonprofit organization that is specified by the commissioner and not affiliated with, or has ownership interest by, an insurance carrier or healthcare provider;

(4) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer, other plans administered by the state government, or any certificate issued under the policies, contracts, or plans. "Health benefit plan" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement as defined in § 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1)), specified disease, vision care, other limited benefit health insurance, coverage issued as a supplement to liability insurance, workers' compensation insurance, 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; and

(5) "Health insurer" means any entity offering a health benefit plan.

(b) Notwithstanding any other law to the contrary, if a person covered by a health benefit plan receives out-of-network emergency services, then the person's health insurer shall reimburse the healthcare provider or facility that provided the emergency services at a rate that is no less than fair health value.

SECTION 2. This act shall take effect July 1, 2019, the public welfare requiring it, and applies to reimbursements for emergency services rendered on or after that date.

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Amendment No. _____

Signature of Sponsor

AMEND Senate Bill No. 322

House Bill No. 278*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-2-125, is amended by deleting the section.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 2, is amended by adding the following new part:

56-2-1001.

The general assembly finds that healthcare consumers are forced to make choices within the healthcare marketplace based upon insufficient information about the costs for services and the quality of providers. Increasing transparency within the healthcare marketplace by providing consumers with accurate healthcare cost and quality data will enable healthcare consumers to increase the value they receive for their healthcare purchases by limiting out-of-pocket costs and choosing higher-quality providers. A more transparent healthcare marketplace is also more likely to experience increased quality and price competition among providers, result in less spending for unnecessary healthcare services, and encourage price competition among insurers, leading to less consumer spending on premiums and deductibles. It is the intent of the general assembly to increase transparency in the healthcare marketplace through the establishment of an all payer claims database that includes a public information portal to provide healthcare consumers in this state access to accurate healthcare service cost and provider quality information.

56-2-1002.

As used in this part:



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(1) "Agency" means the health services development agency created by § 68-11-1604;

(2) "All payer claims database" or "database" means a database composed of health insurance issuer and group health plan claims information that excludes the data elements in 45 CFR 164.514(e)(2);

(3) "Director" means the director of the agency;

(4) "Group health plan":

(A) Means an employee welfare benefit plan, as defined in § 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1002(1)), to the extent that the plan provides medical care to employees or their dependents, as defined under the terms of the plan, or an administrator of the plan; and

(B) Does not include:

(i) A plan that is offered through a health insurance issuer;

or

(ii) A self-funded or self-insured plan that uses a health insurance issuer to administer plan benefits;

(5) "Health insurance coverage" means health insurance coverage as defined in § 56-7-2902, as well as medicare supplemental health insurance;

(6) "Health insurance issuer" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization, and a nonprofit hospital and medical service corporation. "Health insurance issuer" also means a pharmacy benefits manager, a third-party administrator, the state medicaid program, any managed care organization contracted with the state medicaid program to administer enrollee benefits, and an entity described in § 56-2-121; and

(7) "Lead entity" means the organization selected by the agency through the competitive bidding process and authorized by the agency to manage the operations of the all payer claims database.

56-2-1003.

(a) The director shall, no later than January 1, 2020, establish an all payer claims database to support transparent public reporting of healthcare information.

(b) The database must be designed to improve transparency by:

(1) Assisting healthcare consumers, providers, and facilities to make informed choices about health care;

(2) Enabling healthcare providers and facilities to improve performance and value in the delivery of health care to consumers by benchmarking their performance against that of others;

(3) Enabling healthcare consumers to identify value, build accurate expectations into their purchasing strategy, and reward improvement over time; and

(4) Promoting competition based on healthcare quality and cost.

(c) The database must enable the commissioner of finance and administration, the director of TennCare, the commissioner of mental health and substance abuse services, the commissioner of intellectual and developmental disabilities, the commissioner of health, and the commissioner of labor and workforce development to carry out the following duties:

(1) Improve the accessibility, adequacy, and affordability of patient health care and healthcare coverage;

(2) Identify health and healthcare needs and inform health and healthcare policy;

(3) Determine the capacity and distribution of existing healthcare resources;

(4) Evaluate the effectiveness of intervention programs on improving patient outcomes;

(5) Review costs among various treatment settings, providers, and approaches; and

(6) Provide publicly available information on healthcare providers' quality of care and cost of services.

(d) This section does not prevent a health insurance issuer from providing information on healthcare providers' quality of care in accordance with § 56-32-130(e).

(e)

(1) As required by HIPAA, the director or the lead entity shall not publicly disclose from the all payer claims database individually identifiable health information as defined in 45 CFR 160.103. Use of the all payer claims database is subject to restrictions required by HIPAA and other applicable privacy laws and policies. The director shall restrict access to the all payer claims database to agency staff or a lead entity contracted and authorized to perform the analyses contemplated by this part. The director shall develop procedures and safeguards to protect the security and confidentiality of data contained in the all payer claims database.

(2)

(A)

(i) The all payer claims database; summaries, source, or draft information used to construct or populate the all payer claims database; patient level claims data; reports derived from the all payer claims database; and other information submitted under this part, whether in electronic or paper form, are not a public record and are not open for inspection by members of the public under § 10-7-503. The information contained in the all payer claims database is confidential and not subject to subpoena.

(ii) The director may promulgate rules to authorize the public release of reports derived from the information. The director shall ensure that any release of reports does not result in the information losing its confidentiality or cause it to be admissible in a legal proceeding, except in administrative proceedings authorized under the rules adopted by the director.

(B) The director shall, through memoranda of understanding, allow the use of the all payer claims database by the department of finance and administration, the department of health, the department of mental health and substance abuse services, the department of intellectual and developmental disabilities, the bureau of TennCare, the department of labor and workforce development, and other departments of state government for the purposes listed in subsections (b) and (c).

(C) Except for officials of this state or those officials' designees as permitted by subdivision (e)(1), this part does not permit access to or discovery of the source or draft information used to construct or populate the all payer claims database.

(f) The all payer claims database must contain unique healthcare provider identifiers for use in public reports. However, any information that could reveal the identity of a patient from the all payer claims database must not be made available to the public. To ensure that individual patients are not identified, a group health plan or health insurance issuer shall not include the following data in any transmission to the agency or lead entity for the all payer claims database or in any source or draft information used to construct or populate the all payer claims database:

- (1) Patient names;
- (2) Patient street addresses;
- (3) All elements of patient birth dates, except year of birth;
- (4) Patient telephone numbers;

- (5) Patient facsimile numbers;
- (6) Patient electronic mail addresses;
- (7) Patient social security numbers;
- (8) Medical record numbers;
- (9) Health plan beneficiary numbers;
- (10) Patient account numbers;
- (11) Patient certificate or license numbers;
- (12) Vehicle identifiers and serial numbers, including license plate numbers;
- (13) Device identifiers and serial numbers;
- (14) Web universal resource locators (URLs);
- (15) Internet protocol (IP) address numbers;
- (16) Biometric identifiers including fingerprints, voiceprints, and genetic code;
- (17) Full-face photographic images and any comparable images; or
- (18) Any other unique patient identifying number, characteristic, or code, except encrypted index numbers assigned prior to the transmission by group health plans or health insurance issuers to the state or lead entity for the purpose of linking procedures by patient; provided, that a patient's identity cannot be determined from the encrypted index number.

56-2-1004.

(a) The agency shall, no later than October 1, 2019, use a competitive solicitation procurement process, in accordance with title 12, chapter 3, to select a lead entity from among the best potential bidders to coordinate and manage the database.

(b) Due to the complexities of the all payer claims database and the unique privacy, quality, and financial objectives, the agency must award extra points in the scoring evaluation for the following elements:

(1) The bidder's degree of experience in healthcare data collection, analysis, analytics, and security, and in the development of a transparent data delivery tool;

(2) Whether the bidder has a long-term self-sustainable financial model;

(3) The bidder's experience in convening and effectively engaging stakeholders to develop reports;

(4) The bidder's experience in meeting budget requirements and timelines for report generations; and

(5) The bidder's ability to combine cost and quality data.

(c) The lead entity may enter into a contract with a data vendor to perform data collection, processing, aggregation, extracts, and analytics. The lead entity or any contracted data vendor must:

(1) Establish a web portal that, no later than September 1, 2020, is accessible by the general public and that contains searchable information on the costs of common medical procedures and healthcare services, a system of quality ratings for healthcare providers and facilities, and a tool or interface for cost and quality comparisons among providers and facilities;

(2) Consistent with the requirements of this part, make information from the database available as a resource for public and private entities, including carriers, employers, providers, hospitals, and consumers of health care;

(3) Establish a secure data submission process with data submitters;

(4) Design data collection mechanisms with consideration for the time and cost incurred by data suppliers and others in submission and collection, and the benefits that measurement would achieve, ensuring the data submitted meet quality standards and are reviewed for quality assurance;

(5) Review submitted data files according to standards established by the agency;

- (6) Assess each record for compliance with established format, frequency, and consistency criteria;
 - (7) Maintain responsibility for quality assurance, including, but not limited to:
 - (A) The accuracy and validity of data suppliers' data;
 - (B) The accuracy of dates of service spans;
 - (C) Maintaining consistency of record layout and counts; and
 - (D) Identifying duplicate records;
 - (8) Assign unique identifiers to individuals represented in the database;
 - (9) Ensure that direct patient identifiers, indirect patient identifiers, and proprietary financial information are released only in compliance with this part;
 - (10) Demonstrate internal controls and affiliations with separate organizations as appropriate to ensure safe data collection, security of the data with state-of-the-art encryption methods, actuarial support, and data review for accuracy and quality assurance;
 - (11) Develop protocols and policies, including prerelease peer review by data suppliers, to ensure the quality of data releases and reports;
 - (12) Store data on secure servers that are compliant with HIPAA and federal regulations, with access to the data strictly controlled and limited to staff with appropriate training, clearance, and background checks; and
 - (13) Maintain state-of-the-art security standards for transferring data to approved data requestors.
- (d) The lead entity and any contracted data vendor shall submit detailed descriptions to the chief information officer of the agency to ensure robust security methods are in use. The director shall report the chief information officer's findings to the governor, the commerce and labor committee of the senate, and the insurance committee of the house of representatives.

(e) The lead entity is responsible for internal governance, management, and operation of the database.

56-2-1005.

(a)

(1)

(A) No later than January 1, 2020, and every month thereafter, all group health plans and health insurance issuers shall provide electronic health insurance claims data for state residents to the agency or lead entity, in accordance with standards and procedures adopted by the director by rule.

(B) All group health plans and health insurance issuers shall provide additional information as the director subsequently establishes by rule for the purpose of creating and maintaining the all payer claims database.

(C) The director shall strive for standards and procedures that are the least burdensome for data submitters.

(2) The collection, storage, and release of health and healthcare data and statistical information that are subject to the federal requirements of HIPAA are governed by the rules adopted in 45 CFR parts 160 and 164.

(3) All group health plans and health insurance issuers that collect the health employer data and information set (HEDIS) shall annually submit the HEDIS information to the agency in a form and in a manner prescribed by the National Committee for Quality Assurance (NCQA).

(4) If any group health plan or health insurance issuer fails to submit required data to the agency on a timely basis, the director may impose a civil penalty of up to two hundred fifty dollars (\$250) for each day of delay.

(b) The director, in the director's discretion, may allow some group health plans and health insurance issuers to submit data on a quarterly basis. The director may also

establish by rule exceptions to the reporting requirements of this part for entities based upon an entity's size, an entity's amount of claims, or other relevant factors deemed appropriate.

56-2-1006.

Beginning January 1, 2021, and no later than January 1 each year thereafter, the director shall report to the commerce and labor committee of the senate and the insurance committee of the house of representatives on the status of the all payer claims database, including statistics on usage of the database by consumers, observed trends in healthcare costs and quality, and any recommendations for improvements to the database.

56-2-1007.

The director may, subject to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, promulgate rules for purposes of implementing this part. The director is authorized to promulgate the initial rules as emergency rules pursuant to the Uniform Administrative Procedures Act prior to July 1, 2019, for the purpose of creating the all payer claims database.

56-2-1008.

If any provision of this part or its application to any person or circumstance is held invalid, then the invalidity does not affect other provisions or applications of this part that can be given effect without the invalid provision or application, and to that end the provisions of this part are severable.

SECTION 3. For purposes of promulgating rules and initiating the procurement process, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect July 1, 2019, the public welfare requiring it.

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Amendment No. _____

Signature of Sponsor

AMEND Senate Bill No. 348*

House Bill No. 610

by deleting all language after the enacting clause and substituting the following:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Eligible individual" means any individual eligible for either individual or group health insurance coverage in this state; and

(2) "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. The term does not include accident-only insurance, credit insurance, dental-only insurance, vision-only insurance, Medicare supplement insurance, disability income insurance, coverage for on-site medical clinics, benefits for long-term care, home health care, community-based care or any combination thereof, specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates, or other limited benefit or supplemental health insurance excluded from the definition of health insurance in § 56-1-105.

(b) Notwithstanding this title to the contrary, a health carrier offering a health benefit plan providing individual or group health insurance coverage shall issue the health benefit plan coverage to any eligible individual or employer in this state that applies for the health benefit plan coverage.



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(c)

(1) Notwithstanding this title to the contrary, a health carrier offering a health benefit plan providing individual or small group health insurance coverage shall develop its premium rates based on the following:

(A) Whether the health benefit plan covers an individual or family;

(B) Rating areas, as may be established by the commissioner;

(C) Age, as long as the rate does not vary by a factor of more than five (5) to one (1) for adults; and

(D) Tobacco use, as long as the rate does not vary by a factor of more than one and one-half (1.5) to one (1).

(2) A premium rate must not vary with respect to any particular health benefit plan by any other factor not described in subdivision (c)(1).

(d) A health carrier providing individual or group health insurance coverage shall not limit or exclude coverage for an individual by imposing a preexisting condition exclusion on that individual.

SECTION 2. Tennessee Code Annotated, Section 56-7-1503(b), is amended by deleting the following language:

more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

and substituting the following language:

because it involved a preexisting condition.

SECTION 3. Tennessee Code Annotated, Section 56-7-2207(a), is amended by deleting subdivisions (1), (2), and (4), and substituting the following as new subdivision (1):

(1) A health benefit plan shall not impose a preexisting condition exclusion to limit or deny coverage;

SECTION 4. Tennessee Code Annotated, Section 56-7-2207(i), is amended by deleting the subsection.

SECTION 5. Tennessee Code Annotated, Section 56-7-2208(a)(5), is amended by deleting the language "except as provided in § 56-7-2207(a)(4)".

SECTION 6. Tennessee Code Annotated, Section 56-7-2302(e), is amended by deleting the language "if the adoption or placement for adoption occurs while the parent is eligible for coverage".

SECTION 7. Tennessee Code Annotated, Section 56-7-2317, is amended by deleting the language "not excluded by the group policy".

SECTION 8. Tennessee Code Annotated, Section 56-7-2351, is amended by deleting the second sentence of the section and substituting the following:

Pregnancy and maternity benefits shall not be excluded from coverage, limited, or denied as a preexisting condition.

SECTION 9. Tennessee Code Annotated, Section 56-7-2803, is amended by deleting subsection (a) and substituting the following:

(a) A group health plan and a health insurance issuer offering group health insurance coverage shall not, with respect to a participant or beneficiary, impose a preexisting condition exclusion.

SECTION 10. Tennessee Code Annotated, Section 56-7-2803, is amended by deleting subsection (f).

SECTION 11. Tennessee Code Annotated, Section 56-7-2803(i)(1), is amended by deleting the language "and that does not impose any preexisting condition exclusion allowed under subsection (a) with respect to any particular coverage option".

SECTION 12. Tennessee Code Annotated, Section 56-7-2805, is amended by deleting subdivision (g)(1)(C).

SECTION 13. Tennessee Code Annotated, Section 56-7-2809, is amended by deleting the word "eligible" from subsection (a) and deleting subsection (b).

SECTION 14. Tennessee Code Annotated, Section 56-7-2910, is amended by deleting subsection (e).

SECTION 15. Tennessee Code Annotated, Section 56-42-105(a), is amended by deleting the language "preexisting conditions,".

SECTION 16. Tennessee Code Annotated, Section 56-42-105, is amended by deleting subsection (c).

SECTION 17. This act shall take effect July 1, 2019, the public welfare requiring it, and shall apply to policies and contracts that are entered into, renewed, amended, or delivered on or after that date.

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Signature of Sponsor

AMEND Senate Bill No. 1215

House Bill No. 1010*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following new section:

(a) Notwithstanding any other law to the contrary, reimbursement for a drug pursuant to a health insurance policy or prescription drug benefit must not be denied on the basis that the drug is not indicated for use with the covered patient's medical condition or disease if the drug is prescribed to the patient to treat or manage the symptoms of a rare disease or condition by a licensed physician acting in the physician's good faith medical judgment.

(b) For purposes of this section, "rare disease or condition" means any disease or condition that:

(1) Affects less than two hundred thousand (200,000) people in the United States; or

(2) Affects more than two hundred thousand (200,000) people in the United States and for which there is no reasonable expectation that the cost of developing and making available in the United States a drug for the disease or condition will be recovered from sales of the drug in the United States.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

