House Life & Health Insurance Subcommittee Am. # 1

Amendment No._____

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Signature of Sponsor

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AMEND Senate Bill No. 1892 **House Bill No. 1699***

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

SECTION 1. Tennessee Code Annotated, Section 56-7-1002, is amended by adding the following as a new subsection (h) and redesignating the existing subsection (h) accordingly:

(h) Telehealth is subject to utilization review under the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title.

SECTION 2. Tennessee Code Annotated, Section 56-7-1002(a), is amended by adding the following as a new subdivision:

( ) "Originating site" means the location where a patient is located pursuant to subdivision (a)(6)(A) and that originates a telehealth service to another qualified site;

SECTION 3. Tennessee Code Annotated, Section 56-7-1002(e), is amended by deleting the language "A health insurance entity shall provide coverage for healthcare services" and substituting instead the language "A health insurance entity shall provide coverage and reimbursement for healthcare services".

SECTION 4. Tennessee Code Annotated, Section 56-7-1002(f), is amended by deleting the subsection and substituting the following:

(f) Except as provided in SECTION 6, this section does not require a health insurance entity to pay total reimbursement for a telehealth encounter, including the use of telehealth equipment, in an amount that exceeds the amount that would be paid for the same service provided by a healthcare services provider in an in-person encounter.

SECTION 5. Tennessee Code Annotated, Section 56-7-1002(h), is amended by deleting the subsection and substituting the following:

(h)

(1) This section does not apply to accident-only, specified disease, hospital indemnity, plans described in § 1251 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended and § 2301 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, as amended (both in 42 U.S.C. § 18011), plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.), medicare supplement, disability income, long-term care, or other limited benefit hospital insurance policies.

(2) This section does apply to the basic health plans authorized under title 8, chapter 27, parts 1, 2, 3, and 7.

SECTION 6. Tennessee Code Annotated, Section 56-7-1002, is amended by adding the following as a new subsection:

A health insurance entity shall reimburse an originating site hosting a patient as part of a telehealth encounter an originating site fee in accordance with Centers for Medicare and Medicaid services telehealth services rule 42 C.F.R. § 410.78 and the amount established for the medicare telehealth originating facility fee for calendar year 2020 as of November 15, 2019, published in the Federal Register at 84 F.R. 62568.

SECTION 7. Tennessee Code Annotated, Section 56-7-1003, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Health insurance entity" has the same meaning as defined in § 56-7-109 and includes managed care organizations participating in the medical assistance program under title 71, chapter 5;

(2) "Healthcare services" has the same meaning as defined in § 56-61-102;

(3) "Healthcare services provider" means an individual acting within the scope of a valid license issued pursuant to title 63 or any state-contracted crisis service provider employed by a facility licensed under title 33;

(4) "Healthcare system" means two (2) or more healthcare organizations as defined in § 63-1-150, that are affiliated through shared ownership or pursuant to a contractual relationship that controls payment terms and service delivery;

(5) "Practice group" means two (2) or more healthcare services providers that share a common employer for the purposes of the healthcare services providers' clinical practice;

(6) "Provider-based telemedicine":

(A) Means the use of Health Insurance Portability and Accessibility Act (HIPAA) (42 U.S.C. § 1320d et seq.) compliant real-time, interactive audio, video telecommunication, or electronic technology, or store-and-forward telemedicine services, used over the course of an interactive visit by a healthcare services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when:

(i) The healthcare services provider is at a qualified site other than the site where the patient is located and has access to the relevant medical record for that patient;

(ii) The patient is located at a location the patient deems appropriate to receive the healthcare service that is equipped to engage in the telecommunication described in this section; and

(iii) The healthcare services provider makes use of HIPAA compliant real-time, interactive audio, video telecommunication or electronic technology, or store-and-forward telemedicine services to deliver healthcare services to a patient within the scope of

practice of the healthcare services provider as long as the healthcare services provider, the healthcare services provider's practice group, or the healthcare system has established a provider-patient relationship by submitting to a health insurance entity evidence of an in-person encounter between the healthcare service provider, the healthcare services provider's practice group, or the healthcare system and the patient within eighteen (18) months prior to the interactive visit; and

(B) Does not include:

(i) An audio-only conversation;

(ii) An electronic mail message or phone text message;

(iii) A facsimile transmission;

(iv) Remote patient monitoring; or

(v) Healthcare services provided pursuant to a contractual relationship between a health insurance entity and an entity that facilitates the delivery of provider-based telemedicine as the substantial portion of the entity's business;

(7) "Qualified site" means the primary or satellite office of a healthcare services provider, a hospital licensed under title 68, a facility recognized as a rural health clinic under federal medicare regulations, a federally qualified health center, a facility licensed under title 33, or any other location deemed acceptable by the health insurance entity; and

(8) "Store and forward telemedicine services":

(A) Means the use of asynchronous computer-based communications between a patient and healthcare services provider at a distant site for the purpose of diagnostic and therapeutic assistance in the care of patients; and

(B) Includes the transferring of medical data from one (1) site to another through the use of a camera or similar device that records or stores an image that is sent or forwarded via telecommunication to another site for consultation.

(b) Healthcare services provided through a provider-based telemedicine encounter must comply with state licensure requirements promulgated by the appropriate licensure boards. Provider-based telemedicine providers are held to the same standard of care as healthcare services providers providing the same healthcare service through in-person encounters.

(c) A provider-based telemedicine provider who seeks to contract with or who has contracted with a health insurance entity to participate in the health insurance entity's network is subject to the same requirements and contractual terms as any other healthcare services provider in the health insurance entity's network.

(d) A health insurance entity:

(1) Shall provide coverage under a health insurance policy or contract for covered healthcare services delivered through provider-based telemedicine;

(2) Shall reimburse a healthcare services provider for a healthcare service covered under an insured patient's health insurance policy or contract that is provided through provider-based telemedicine without any distinction or consideration of the geographic location or any federal, state, or local designation, or classification of the geographic area where the patient is located;

(3) Shall not exclude from coverage a healthcare service solely because it is provided through provider-based telemedicine and is not provided through an in-person encounter between a healthcare services provider and a patient; and

(4) Shall reimburse healthcare services providers who are out-of-network for provider-based telemedicine care services under the same reimbursement policies applicable to other out-of-network healthcare services providers.

(e) A health insurance entity shall provide coverage and reimbursement for healthcare services provided during a provider-based telemedicine encounter in a manner that is consistent with what the health insurance policy or contract provides for in-person encounters for the same service, and shall reimburse for healthcare services provided during a provider-based telemedicine encounter without distinction or consideration of the geographic location, or any federal, state, or local designation or classification of the geographic area where the patient is located.

(f) This section does not require a healthcare services provider to submit a claim for reimbursement to a health insurance entity for provider-based telemedicine services performed under subsection (e).

(g) This section does not require a health insurance entity to pay total reimbursement for a provider-based telemedicine encounter in an amount that exceeds the amount that would be paid for the same service provided by a healthcare services provider for an in-person encounter.

(h) Any provisions not required by this section are governed by the terms and conditions of the health insurance policy or contract.

(i) Provider-based telemedicine is subject to utilization review under the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title.

(j)

(1) This section does not apply to accident-only, specified disease, hospital indemnity, plans described in § 1251 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended and § 2301 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, as amended (both in 42 U.S.C. § 18011), plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.), medicare supplement, disability income, long-term care, or other limited benefit hospital insurance policies.

(2) This section does apply to the basic health plans authorized under title 8, chapter 27, parts 1, 2, 3, and 7.

SECTION 8. 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, "remote patient monitoring services" means using digital technologies to collect medical and other forms of health data from a patient and then electronically transmitting that information securely to healthcare providers in a different location for interpretation and recommendation.

(b) A health insurance entity shall consider any remote patient monitoring service a covered medical service if the same service is covered by medicare. The appropriate parties shall negotiate the rate for these services in the manner in which is deemed appropriate by the parties.

(c) Remote patient monitoring services are subject to utilization review under the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title.

(d) This section does not apply to a health incentive program operated by a health insurance entity that utilizes an electronic device for physiological monitoring.

SECTION 9. Tennessee Code Annotated, Section 63-1-155(a), is amended by deleting subdivision (2) and substituting instead the following:

(2) "Telehealth", "telemedicine", and "provider-based telemedicine" mean, notwithstanding any restriction imposed by § 56-7-1002 or § 56-7-1003:

(A) The use of real-time audio, video, or other electronic media and telecommunication technology that enables interaction between a healthcare provider and a patient; or

(B) Store-and-forward telemedicine services, as defined in § 56-7-1002, for the purpose of diagnosis, consultation, or treatment of a patient in another location where there may be no in-person exchange.

SECTION 10. This act shall take effect July 1, 2021, the public welfare requiring it, and shall apply to insurance policies or contracts issued, entered into, renewed, or amended on or after that date.

House Life & Health Insurance Subcommittee Am. # 1

Amendment No._____

Signature of Sponsor

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AMEND Senate Bill No. 2132 **House Bill No. 2162***

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

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 25, is amended by adding the following as a new section:

56-7-2509.

(a) As used in this section:

(1) "Advanced metastatic cancer" means cancer that spreads from the primary or original site to the nearby tissues, lymph nodes, or other parts of the body;

(2) "Associated conditions" means the symptoms or side effects associated with advanced metastatic cancer, or its treatment, that in the judgment of a healthcare practitioner, further jeopardize the health of a patient if left untreated;

(3) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services; and

(4) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit

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hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or healthcare services.

(b) If a health benefit plan provides coverage for advanced metastatic cancer and associated conditions, then the health benefit plan shall not require, before providing coverage of a prescription drug approved by the United States food and drug administration, that an enrollee:

(1) Fails to successfully respond to a different drug; or

(2) Proves a history of failure of a different drug.

(c) This section applies only to the use of a drug that is:

(1) Consistent with best practices for the treatment of advanced metastatic cancer or an associated condition;

(2) Supported by peer-reviewed, evidence-based literature; and

(3) Approved by the United States food and drug administration.

(d) This section applies to any health benefit plan offered by any state or local insurance program under title 8, chapter 27.

(e) Notwithstanding § 56-7-1005, this section does not apply to:

(1) The TennCare program under title 71, chapter 5, part 1, or any successor medicaid program under title 71, chapter 5; or

(2) The CoverKids Act of 2006, compiled in title 71, chapter 3, part 11, or any successor program.

SECTION 2. This act shall take effect July 1, 2020, the public welfare requiring it, and applies to all health benefit plans entered into, renewed, amended, or delivered on or after that date.