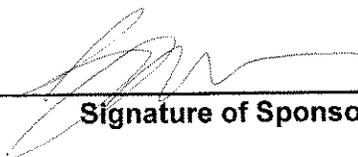


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Amendment No. _____



 Signature of Sponsor

AMEND Senate Bill No. 2085*

House Bill No. 2499

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

SECTION 1. Tennessee Code Annotated, Section 56-7-2360(e), is amended by deleting the language "Not later than January 31, 2020, the department shall issue a report" and substituting instead the language "Not later than January 31, 2020, and not later than January 31 of each year thereafter, the department shall issue a report".

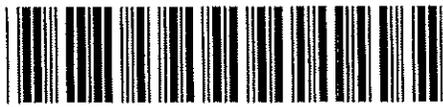
SECTION 2. Tennessee Code Annotated, Section 56-7-2360(e), is amended by deleting subdivision (3) and substituting the following:

(3) Identify market conduct examinations conducted or completed during the preceding twelve-month period regarding compliance with parity in mental health or alcoholism or drug dependency benefits under state and federal laws and summarize the results of the market conduct examinations. Individually identifiable information must be excluded from the reports consistent with federal privacy protections, including, but not limited to, 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67. This discussion must include:

(A) The total number of health insurance carriers currently regulated by the department;

(B) The total number of health insurance carriers domiciled in this state that are subject to the department's regular market conduct examinations;

(C) The total number of health insurance carriers currently regulated by the department that have certification or accreditation for network adequacy or parity compliance;



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- (D) The current schedule of regular market conduct examinations;
- (E) Any letters of approval from the commissioner in response to an exemption request made pursuant to subsection (c);
- (F) The number of regular market conduct examinations initiated and completed;
- (G) The benefit classifications examined by each market conduct examination;
- (H) The subject matter of each market conduct examination, including methodologies and analyses used by the department to evaluate quantitative and non-quantitative treatment limitations; and
- (I) A summary of the basis for the final decision rendered in each market conduct examination;

SECTION 3. Tennessee Code Annotated, Section 56-7-2360(e)(5), is amended by deleting the subdivision and substituting the following:

- (5) Detail the department's educational approach to mental health parity for the public, including consumer feedback from each training, the number of trainings conducted, the number of attendees, and the marketing plan for the events; and

SECTION 4. Tennessee Code Annotated, Section 56-7-2360, is amended by adding the following as a new subsection:

The department shall make available to the public on its publicly accessible website a log of mental health parity complaints along with an explanation of mental health parity and how the public can file a complaint with the department. The log must include any mental health parity complaints that were outside of the department's jurisdiction and the ultimate disposition of the complaints, either by the United States department of labor or the regulatory agency responsible for oversight of the health insurance carrier that is the subject of each complaint that is domiciled in another state.

SECTION 5. This act shall take effect July 1, 2020, the public welfare requiring it.

Amendment No. _____



Signature of Sponsor

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AMEND Senate Bill No. 2847

House Bill No. 2178*

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

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

(a) As used in this section:

(1) "Covered entity" has the same meaning as defined in § 56-7-3102;

(2) "Group medical benefit contract" means an agreement between an entity licensed under the insurance laws of this state and an insured for the provision of medical services;

(3) "Hospital outpatient infusion center" means a healthcare facility where a patient receives infusion therapy on an outpatient basis;

(4) "Insured" means the party named on a policy or certificate of insurance with a legal right to the benefits provided by the policy;

(5) "Pharmacy benefit contract" means an agreement between an entity licensed under the insurance laws of this state and an insured for the coverage of prescription drugs;

(6) "Pharmacy benefits manager" has the same meaning as defined in § 56-7-3102;

(7) "Prescription drug" has the same meaning as defined in § 63-10-204;

(8) "Specialty drug" means a prescription drug that is:

(A) Prescribed to a person with a chronic, complex, rare, or life-threatening medical condition;



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(B) Injected or infused into a patient; and

(C) Not usually self-administered by a patient.

(b) A covered entity or a pharmacy benefits manager shall:

(1) Permit a person covered under a group medical benefit contract that provides coverage for prescription drugs to obtain a specialty drug from a physician's office, or hospital outpatient infusion center, that provides and administers the specialty drug;

(2) Permit a person covered under a pharmacy benefit contract that provides coverage for prescription drugs to obtain a specialty drug from a physician's office or hospital outpatient infusion center that provides and administers the specialty drug;

(3) Not limit coverage or benefits of a person covered under a group medical benefit contract or a pharmacy benefit contract;

(4) Not require a person covered under a group medical benefit contract that provides coverage for specialty drugs to pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other penalty if the person obtains a specialty drug from a physician's office, or a hospital outpatient infusion center, that provides and administers the specialty drug; and

(5) Not require a person covered under a pharmacy benefit contract that provides coverage for specialty drugs to pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other penalty if the person obtains a specialty drug from a physician's office, or a hospital outpatient infusion center, that provides and administers the specialty drug.

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

Amendment No. _____

Signature of Sponsor

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AMEND Senate Bill No. 1935

House Bill No. 1866*

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

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

56-7-3501. Legislative findings.

The general assembly finds and declares the following:

(1) Health insurance plans are increasingly making use of step therapy protocols under which patients are required to try one (1) or more prescription drugs before coverage is provided for a drug selected by the patient's healthcare provider;

(2) Step therapy protocols, where the protocols are based on well-developed, scientific standards and administered in a flexible manner that takes into account the individual needs of patients, can play an important role in controlling healthcare costs;

(3) However, in some cases, requiring a patient to follow a step therapy protocol may have adverse and even dangerous consequences for the patient who may either not realize a benefit from taking a prescription drug or may suffer harm from taking an inappropriate drug;

(4) Without uniform policies in this state for step therapy protocols, all patients may not receive the equivalent or most appropriate treatment;

(5) It is imperative that step therapy protocols in this state preserve the healthcare provider's right to make treatment decisions in the best interest of the patient; and



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(6) It is a matter of public interest that the general assembly require health insurers to base step therapy protocols on appropriate clinical practice guidelines or published peer reviewed data developed by independent experts with knowledge of the condition or conditions under consideration; that patients be exempt from step therapy protocols when those protocols are inappropriate or otherwise not in the best interest of the patients; and that patients have access to a fair, transparent, and independent process for requesting an exception to a step therapy protocol when the patient's physician deems appropriate.

56-7-3502. Part definitions.

As used in this part:

(1) "Clinical practice guidelines" means a systematically developed statement to assist decision making by healthcare providers and patient decisions about appropriate health care for specific clinical circumstances and conditions;

(2) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by an insurer, health plan, or utilization review organization to determine the medical necessity and appropriateness of healthcare services;

(3) "Emergency medical condition" has the same meaning as defined in § 56-7-2355;

(4) "Health plan" means a health benefit plan, as defined in § 56-61-102;

(5) "Insurer" means a health carrier, as defined in § 56-61-102;

(6) "Medically necessary" means healthcare services and supplies that, under the applicable standard of care, are appropriate:

(A) To improve or preserve health, life, or bodily function;

(B) To slow the deterioration of health, life, or bodily function; or

(C) For the early screening, prevention, evaluation, diagnosis, or treatment of a disease, condition, illness, or injury;

(7) "Step therapy exception" means that a step therapy protocol is overridden in favor of immediate coverage of the healthcare provider's selected prescription drug;

(8) "Step therapy protocol" means a protocol, policy, or program that establishes a specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are covered by an insurer or health plan; and

(9) "Utilization review organization" means an entity that conducts utilization review, other than an insurer or health plan performing utilization review for its own health plans.

56-7-3503. Clinical review criteria.

(a) Clinical review criteria used to establish a step therapy protocol must be based on clinical practice guidelines that:

(1) Recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol;

(2) Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

(A) Requiring members to disclose any potential conflict of interest with an entity, including an insurer, a health plan, and a pharmaceutical manufacturer, and recuse themselves from voting if the member has a conflict of interest;

(B) Using a methodologist to work with writing and review groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(C) Offering opportunities for public review and comment;

(3) Are based on high quality studies, research, and medical practice;

(4) Are created by an explicit and transparent process that:

- (A) Minimizes biases and conflicts of interest;
 - (B) Explains the relationship between treatment options and outcomes;
 - (C) Rates the quality of the evidence supporting recommendations; and
 - (D) Considers relevant patient subgroups and preferences; and
- (5) Are continually updated through a review of new evidence, research, and newly developed treatments.

(b) In the absence of clinical practice guidelines that meet the requirements of subsection (a), peer reviewed publications may be substituted.

(c) When establishing a step therapy protocol, a utilization review agent shall also take into account the needs of atypical patient populations and diagnoses when establishing clinical review criteria.

(d) This section does not require an insurer, a health plan, or this state to establish a new entity to develop clinical review criteria used for step therapy protocols.

56-7-3504. Exception process.

(a) If coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan, or utilization review organization through the use of a step therapy protocol, then the patient and prescribing practitioner must have access to a clear, readily accessible, and convenient process to request a step therapy exception. The process must be easily accessible on the website of the insurer, health plan, or utilization review organization. An insurer, health plan, or utilization review organization may use its existing medical exceptions process to satisfy the requirements of this subsection (a).

(b) An insurer, health plan, or utilization review organization shall grant a step therapy exception if:

- (1) The required prescription drug is contraindicated or will likely cause an adverse reaction by, or physical or mental harm to, the patient;

(2) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(3) The patient, while under the current or a previous health insurance or health plan, has previously tried:

(A) The required prescription drug; or

(B) Another prescription drug in the same pharmacologic class or with the same mechanism of action as the required prescription drug, and the other prescription drug was discontinued due to a lack of efficacy or effectiveness, a diminished effect, or an adverse event;

(4) The required prescription drug is not in the best interest of the patient, based on medical necessity; or

(5) The patient is stable on a prescription drug selected by the patient's healthcare provider for the medical condition under consideration while on a current or previous health insurance or health plan.

(c) Upon granting a step therapy exception, the insurer, health plan, or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient's treating healthcare provider.

(d) The insurer, health plan, or utilization review organization shall grant or deny a step therapy exception request or an appeal within seventy-two (72) hours of receipt. However, if an emergency medical condition exists, then an insurer, health plan, or utilization review organization shall respond within twenty-four (24) hours of receipt. If a response by an insurer, health plan, or utilization review organization is not received within the time period required by this subsection (d), then the exception is granted.

(e) A step therapy exception is eligible for appeal by an insured.

(f) This section does not prevent:

(1) An insurer, health plan, or utilization review organization from requiring a patient to try an AB-rated generic equivalent or interchangeable

biological product prior to providing coverage for the equivalent branded prescription drug;

(2) An insurer, health plan, or utilization review organization from requiring a pharmacist to substitute a prescription drug consistent with the laws of this state; or

(3) A healthcare provider from prescribing a prescription drug that is determined to be medically appropriate.

56-7-3505. Rulemaking.

The commissioner of commerce and insurance shall promulgate rules to effectuate this act. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

56-7-3506. Applicability.

This part applies to any group health plan or health insurance coverage offered in connection with a group health plan that provides coverage for a prescription drug pursuant to a policy that meets the definition of a medication step therapy protocol as defined in § 56-7-3502, regardless of whether the policy is described as a step therapy protocol, and includes any state or local insurance program, under title 8, chapter 27, and any managed care organization contracting with the state to provide insurance through the TennCare program.

SECTION 2. The headings to sections in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 3. For the purpose of promulgating rules, this act shall take effect upon becoming law, the public welfare requiring it. For all other purposes, this act shall take effect January 1, 2021, the public welfare requiring it, and applies to agreements for health insurance or health plans entered into, amended, or renewed on or after that date.

Amendment No. _____



Signature of Sponsor

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Clerk _____
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AMEND Senate Bill No. 2684

House Bill No. 2680*

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

SECTION 1. Tennessee Code Annotated, Title 56, is amended by adding the following language as a new chapter:

56-33-101. Purpose.

The purpose of this chapter is to alleviate the effects of a "balance bill" received by a patient for healthcare services performed by out-of-network providers. To hold the patient harmless from incurring an unanticipated balance bill, this chapter establishes an independent dispute resolution process that ensures a fair reimbursement for out-of-network services; implements a balance bill prohibition for emergency services in an out-of-network facility and for facility-based non-emergency services; and creates opportunities for transparency and notice to a patient of unexpected medical bills that arise from receiving care from out-of-network providers.

56-33-102. Chapter definitions.

As used in this chapter:

(1) "Balance bill" means a bill for healthcare services, other than emergency services, received by:

(A) An enrollee for services rendered by an out-of-network facility-based physician at a participating hospital or ambulatory surgical treatment center, where a participating physician is unavailable or an out-of-network facility-based physician renders services without the enrollee's knowledge, or unforeseen medical services arise at the time the



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healthcare services are rendered. However, a "balance bill" does not mean a bill received for healthcare services when a participating physician is available and the enrollee has elected to obtain services from an out-of-network facility-based physician;

(B) An enrollee for services rendered by an out-of-network facility-based physician, where the services were referred by a participating physician to an out-of-network facility-based physician without explicit written consent of the enrollee acknowledging that the participating physician is referring the enrollee to an out-of-network facility-based physician and that the referral may result in costs not covered by the health benefit plan; or

(C) A patient who is not insured for services rendered by a physician at a hospital or ambulatory surgical treatment center;

(2) "Carrier" or "health carrier" means a health insurance entity as defined in § 56-7-109;

(3) "Commissioner" means the commissioner of commerce and insurance;

(4) "Emergency medical condition" has the same meaning as defined in § 56-7-2355;

(5) "Emergency services" has the same meaning as defined in § 56-7-2355;

(6) "Enrollee" means an individual who is eligible to receive medical care through a health benefit plan;

(7) "Health benefit plan" means health insurance coverage as defined in § 56-7-109;

(8) "Healthcare facility" or "facility" means an institution licensed under title 33 or 68;

(9) "Network" means the providers and healthcare facilities that have contracted to provide healthcare services to the enrollees of a health benefit plan, including a network operated by a carrier or a network with which a carrier has contracted;

(10) "Out-of-network facility-based physician" means a physician:

(A) To whom a participating healthcare facility has granted clinical privileges;

(B) Who provides services to patients of the participating healthcare facility pursuant to those clinical privileges;

(C) Who does not have a current contract or provider agreement with the enrollee's health carrier; and

(D) Who is licensed under title 63, chapter 6 or 9; and

(11) "Usual and customary rate" means the average of:

(A) The eightieth percentile of all billed charges for the particular healthcare service performed by a provider in the same or similar specialty that are provided in the same 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, a health carrier or healthcare provider; and

(B) The ninetieth percentile of all contracted rates for the particular healthcare service performed by a provider in the same or similar specialty that are provided in the same geographical area.

56-33-103. Applicability.

(a) Except as provided in subsection (b), this chapter applies to health benefit plans, health carriers, out-of-network facility-based physicians, and healthcare facilities.

This chapter does not apply to:

(1) Coverage only for a specified disease; specified accident or accident-only coverage; credit, dental, or disability income; hospital indemnity; long-term care insurance, as defined in § 56-42-103; vision care; any other limited supplemental benefit; or to a medicare supplement policy of insurance;

(2) Coverage under a plan through medicare or the Federal Employees Health Benefits Program (FEHB);

(3) TennCare or any successor program; the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; or the Access Tennessee Act of 2006, compiled in chapter 7, part 29 of this title;

(4) Any coverage issued under 10 U.S.C. §§ 1071-1110b, and any coverage issued as a supplement to that coverage; and

(5) Any self-funded employee welfare plan regulated under the federal Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C § 1001 et seq.).

(b) With respect to an entity providing or administering an ERISA self-funded employee welfare plan, this chapter only applies if the plan voluntarily elects to opt-in to the protections afforded by this chapter and be subject to this chapter.

56-33-104. Independent dispute resolution criteria.

The commissioner shall establish an independent dispute resolution process by which a dispute for a bill for out-of-network emergency services or a balance bill may be resolved. The commissioner has the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The commissioner shall promulgate rules establishing standards for the independent dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing

the service that is subject to the dispute resolution process of this section. The physician must be licensed and in good standing in this state.

56-33-105. Criteria for determining a reasonable fee in an independent dispute resolution.

(a) In determining the appropriate amount to pay for a healthcare service, an independent dispute resolution entity shall consider all relevant factors, including:

(1) Whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:

(A) Fees paid to the involved physician for the same services rendered by the physician to other patients in health carrier networks in which the physician is not participating, and

(B) In the case of a dispute involving a health carrier, fees paid by the health carrier to reimburse physicians in the same or similar specialty for the same services in the same region who are not participating with the health carrier's network;

(2) The level of training, education, and experience of the physician;

(3) The physician's usual charge for comparable services with regard to patients covered by health carrier networks in which the physician is not participating;

(4) The circumstances and complexity of the particular case, including time and place of the service;

(5) Individual patient characteristics;

(6) The usual and customary rate of the service;

(7) The fiftieth percentile of rates for the service or supply paid to participating physicians in the same or similar specialty and provided in the same geographical area as reported to the 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;
and

(8) The recent history of network contracting between the parties.

(b) In determining the appropriate amount to pay for a healthcare service, an independent dispute resolution entity shall not consider:

(1) Any benchmarking database that includes medicare or medicaid reimbursement rates; or

(2) Medicare or medicaid reimbursement rates.

56-33-106. Independent dispute resolution for emergency services.

(a)

(1) When a health carrier receives a bill for emergency services from an out-of-network facility-based physician or an out-of-network healthcare facility, the health carrier shall pay an amount that it determines is reasonable for the emergency services rendered by the out-of-network facility-based physician or healthcare facility, in accordance with § 56-7-109, except for the enrollee's co-payment, coinsurance, or deductible, if any, and shall ensure that the enrollee incurs no greater out-of-pocket costs for the emergency services than the enrollee would have incurred had emergency services been performed by a participating physician or healthcare facility. Any amount paid by the enrollee must be added to the in-network deductible, coinsurance, or other deductible as applicable.

(2) An out-of-network facility-based physician, healthcare facility, or health carrier may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity.

(3) The independent dispute resolution entity shall make a determination of a reasonable fee for the services rendered within thirty (30) days of receipt of the dispute for review.

(4) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health carrier's payment or the out-of-network facility-based physician's or healthcare facility's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in § 56-33-105. If an independent dispute resolution entity determines, based on the health carrier's payment and the out-of-network facility-based physician's or facility's fee, that a settlement between the health carrier and out-of-network facility-based physician or the healthcare facility is reasonably likely, or that both the health carrier payment and the out-of-network facility-based physician's fee or healthcare facility's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health carrier and out-of-network facility-based physician or healthcare facility may be granted up to ten (10) business days for this negotiation, and the ten-day period runs concurrently with the thirty-day period for dispute resolution.

(b)

(1) A patient that is not insured may submit a dispute regarding a fee for emergency services for review to an independent dispute resolution entity upon approval of the commissioner.

(2) An independent dispute resolution entity shall determine a reasonable fee for the services based upon the same conditions and factors set forth in § 56-33-105.

(3) A patient that is not insured is not required to have paid the physician's fee in order to be eligible to submit the dispute for review to an independent dispute resolution entity.

(c) The determination of an independent dispute resolution entity is binding on the health carrier, physician, and patient.

56-33-107. Independent dispute resolution for balance bills.

(a) If benefits are assigned in a non-emergency as set forth in § 56-33-109(a), then:

(1) The health carrier shall pay the out-of-network facility-based physician in accordance with subdivisions (a)(2) and (3) and § 56-7-109 if benefits are assigned to an out-of-network facility-based physician. The out-of-network facility-based physician may bill the health carrier for the healthcare services rendered, and the health carrier shall pay the out-of-network facility-based physician the billed amount or attempt to negotiate reimbursement with the out-of-network facility-based physician;

(2) The health carrier shall attempt to negotiate reimbursement for healthcare services provided by an out-of-network facility-based physician;

(3)

(A) If the negotiation does not result in a resolution of the payment dispute between the out-of-network facility-based physician and the health carrier, then the health carrier shall pay the out-of-network facility-based physician an amount the health carrier determines is reasonable for the healthcare services rendered, except for the enrollee's co-payment, coinsurance, or deductible, in accordance with § 56-7-109, and any amount paid by the enrollee must be added to the in-network deductible, coinsurance, or other deductible, as applicable; or

(B) If the negotiation does result in an agreement, then the health carrier shall pay the out-of-network facility-based physician the negotiated amount, except for the enrollee's co-payment, coinsurance, or deductible in accordance with § 56-7-109;

(4) Either the health carrier or the out-of-network facility-based physician may submit the dispute regarding the balance bill for review to an independent dispute resolution entity, except that the health carrier shall not submit the dispute unless it has complied with subdivisions (a)(1)-(3); and

(5) The independent dispute resolution entity shall make a determination within thirty (30) days of receipt of the dispute for review in accordance with the following:

(A) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health carrier payment or the out-of-network facility-based physician's fee, and shall choose the amount based upon the conditions and factors set forth in § 56-33-105;

(B) If an independent dispute resolution entity determines, based on the health carrier's payment and the out-of-network facility-based physician's fee, that a settlement between the health carrier and out-of-network facility-based physician is reasonably likely, or that both the health carrier's payment and the out-of-network facility-based physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement, and in that case the health carrier and non-participating physician may be granted up to ten (10) business days for negotiation, which runs concurrently with the thirty-day period for dispute resolution; and

(C) An out-of-network facility-based physician may request, and the independent dispute resolution entity may permit, that claims of a physician involving the same health carrier be aggregated and submitted for simultaneous review by an independent dispute resolution entity when

the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law.

(b) If a balance bill is received by an enrollee who is not experiencing an emergency as set forth in § 56-33-109(b) and who does not assign benefits in accordance with subsection (a), then:

(1) The enrollee may submit a dispute regarding the balance bill for review to an independent dispute resolution entity that shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in § 56-33-105; and

(2) The enrollee is not required to have paid the physician's fee or a healthcare facility's fee to be eligible to submit the dispute for review to the independent dispute entity.

(c) If a balance bill is received by a patient who is not insured and who is not experiencing an emergency as set forth in § 56-33-106, then:

(1) The patient may submit a dispute regarding the balance bill for review to an independent dispute resolution entity that shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in § 56-33-105;

(2) The patient is not required to have paid the physician's fee to be eligible to submit the dispute for review to the independent dispute entity; and

(3) The determination of an independent dispute resolution entity is binding on the patient, physician, and health carrier.

56-33-108. Payment for independent dispute resolution of a balance bill.

(a) For disputes involving an enrollee:

(1) When the independent dispute resolution entity determines the health carrier's payment is reasonable, payment for the dispute resolution process is the responsibility of the out-of-network facility-based physician or healthcare facility;

(2) When the independent dispute resolution entity determines the out-of-network facility-based physician's or healthcare facility's fee is reasonable, payment for the dispute resolution process is the responsibility of the health carrier; and

(3) When a good faith negotiation directed by the independent dispute resolution entity pursuant to § 56-33-106(a) or § 56-33-107(a) results in a settlement between the health carrier and out-of-network facility-based physician or healthcare facility, the health carrier and the out-of-network facility-based physician or healthcare facility shall evenly divide and share the prorated cost of the dispute resolution.

(b) For disputes involving a patient that is not insured:

(1) When the independent dispute resolution entity determines the physician's or facility's fee is reasonable, payment for the dispute resolution process is the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient; and

(2) When the independent dispute resolution entity determines the physician's or facility's fee is unreasonable, payment for the dispute resolution process is the responsibility of the physician or facility.

(c) The commissioner shall promulgate rules to determine payment for a dispute resolution process in cases where payment for the dispute resolution process would pose a hardship to the patient under subdivision (b)(1).

56-33-109. Hold harmless and assignment of benefits for balance bills for insured persons.

(a) When an enrollee assigns benefits to an out-of-network facility-based physician in writing and the out-of-network facility-based physician knows the patient is an enrollee in a health benefit plan with an out-of-network benefit, the enrollee is only

responsible for any applicable co-payment, coinsurance, or deductible that would be owed if the enrollee utilized a participating physician.

(b) When an enrollee receives emergency services from an out-of-network facility and assigns benefits to an out-of-network facility for an emergency medical condition and the out-of-network facility knows the patient is an enrollee in a health benefit plan with an out-of-network benefit, the enrollee is only responsible for any applicable co-payment, coinsurance, or deductible that would be owed if the enrollee utilized a participating facility.

(c) Subsections (a) and (b) do not apply to:

(1) Coinsurance, co-payments, or deductibles for services provided by an in-network facility or physician; and

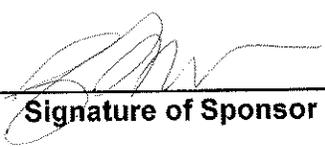
(2) Services, other than emergency services, provided to enrollees who choose to receive services from an out-of-network facility or out-of-network facility-based physician.

SECTION 2. The headings to sections in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 3. For the purpose of promulgating rules, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect January 1, 2022, the public welfare requiring it.

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

Amendment No. _____



Signature of Sponsor

AMEND Senate Bill No. 2786

House Bill No. 2575*

by deleting all language after the caption and substituting instead the following:

WHEREAS, it is the intent of the Tennessee General Assembly to work on behalf of all citizens in this State to reduce the cost of prescription drugs; and

WHEREAS, out-of-pocket costs for prescription drugs, including insulin, continue to increase at unsustainable rates, putting patients at greater risk for adverse health outcomes due to lack of access to affordable and essential medication therapies; and

WHEREAS, the Tennessee General Assembly has enacted several laws to provide greater oversight and transparency with regard to pharmacy benefits managers; and

WHEREAS, the Tennessee General Assembly recognizes that the citizens of Tennessee deserve access to affordable and essential medication therapies; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 32, is amended by adding the following as a new section:

(a) Notwithstanding any law to the contrary, a pharmacy benefits manager or a covered entity shall base the calculation of any coinsurance for a prescription drug or device on the allowed amount of the drug or device. For purposes of this section, "allowed amount" means the cost of a prescription drug or device after applying all pharmacy benefits manager or covered entity discounts.

(b) Notwithstanding any law to the contrary, a pharmacy benefits manager shall not charge a covered entity an amount greater than the reimbursement paid by a



pharmacy benefits manager to a contracted pharmacy for the prescription drug or device.

(c) This section applies to a self-funded employee welfare plan regulated under the federal Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.) only if the plan voluntarily elects to be subject to this section.

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