

HOUSE BILL 1701

By Hall

AN ACT to amend Tennessee Code Annotated, Title 4;
Title 8; Title 56 and Title 71, relative to insurance.

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

SECTION 1. Tennessee Code Annotated, Section 56-7-101(a), is amended by deleting the subsection and substituting the following:

(a)

(1) A contract of insurance is an agreement by which one (1) party, for a consideration, promises to pay money or its equivalent, or to do some act of value to the assured, upon the destruction, injury, loss, or damage of something in which the other party has an insurable interest. The agreement must limit the risk to the assured and offer the best outcome for the assured based on the assured's informed choice given full disclosure to the assured of cost information by the other party.

(2) It is unlawful for any company to make a contract of insurance upon or concerning any property or interests or lives in this state, or with a resident of this state, or for any person, as insurance agent or insurance broker, to make, negotiate, solicit, or in any manner aid in the transaction of the insurance, except as authorized under this title.

(3) Nothing in this chapter and chapters 1-4 and 6 of this title, with the exception of the Easy to Read Life and Health Insurance Policy Act, compiled in part 16 of this chapter, affect the rights and powers of corporations engaged in the transaction of life and casualty insurance upon the assessment plan.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 6, Part 7, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Gold card program" means a method by which a health insurance carrier waives all prior authorization requirements or processes for providers of record that meet defined selection standards; and

(2) "Health insurance carrier" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts with healthcare providers in connection with a plan of health insurance, health benefits, or health care services.

(b) Notwithstanding this part, every entity that uses utilization review agents in this state shall implement a gold card program. A provider of record that participates in a health insurance carrier's gold card program is considered to have gold card status with that health insurance carrier.

(c) The gold card program must:

(1) Require a utilization review agent to automatically grant a determination to certify a health care service:

(A) If the health care service has been approved by utilization review agents utilized by the entity at a rate of at least ninety-five percent (95%) in the three (3) years preceding the request for the health care service; or

(B) If the health care service is provided by a provider of record who has been approved to provide the same health care service by utilization review agents utilized by the entity at a rate of at least ninety-five percent (95%) in the three (3) years preceding the request;

(2) Hold all providers of record to the same selection standards for the gold card program, which selection standards must ensure that providers of

record have staff who are properly qualified, trained, supervised, and able to meet the requirements of the gold card program and which selection standards must be made available to the commissioner upon request;

(3) Require providers of record with gold card status to follow the health insurance carrier's requirements related to prior authorization and utilization management, including documentation to support the provider's or facility's utilization management program;

(4) Require that the provider's clinical review criteria and management practices be evidence-based;

(5) Require providers with gold card status to maintain enrollee records related to the gold card program and provide the records to the health insurance carrier upon request;

(6) Review the performance of a provider with gold card status on an ongoing basis to determine if they still meet the selection standards;

(7) Hold an enrollee harmless if it is determined that the provider has filed a claim for a service covered by the gold card program that is not medically necessary or otherwise in compliance with the medical policies of the plan of health insurance and if the enrollee has no knowledge that the service is not medically necessary;

(8) Be included in the provider contract, which must specify the responsibilities of each party as it pertains to prior authorization, including all the requirements of this section, and specify the services and prescription drugs that the provider is allowed to deliver under the terms of the agreement;

(9) Provide notification to a provider before a health insurance carrier terminates the provider's gold card status or the health insurance carrier's gold

card program. A health insurance carrier and a provider must agree to the status termination notification period;

(10) Upon the termination of a provider's gold card status, not impact the provider's underlying contract with the health insurance carrier. The health insurance carrier must submit a provider agreement to the commissioner if the gold card status of a provider has been modified;

(11) Not include a financial incentive for the provider to deny medically necessary care; and

(12) Be described on the health insurance carrier's website, as well as be described in writing upon written request of an enrollee. The descriptions must include any prior authorization standards, criteria, or information used by providers or facilities. This includes clinical review criteria.

SECTION 3. This act shall take effect upon becoming a law, the public welfare requiring it, and applies to all policies issued, renewed, amended, or altered on or after January 1, 2021.