House Insurance Subcommittee Am. #1

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Amendment No.________________

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Signature of Sponsor

AMEND Senate Bill No. 725 House Bill No. 766*

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 2, is amended by adding the following as a new part:

56-2-1001. Short title.

This part is known and may be cited as the "Insurance Data Security Law."

56-2-1002. Purpose and intent.

(a) This part establishes the exclusive standards for data security, licensees' investigations of cybersecurity events, and licensees' notification of cybersecurity events to the commissioner and affected consumers.

(b) This part does not create or imply a private cause of action for a violation of this part, nor does this part limit a private cause of action that otherwise exists.

56-2-1003. Part definitions.

As used in this part:

(1) "Authorized individual" means an individual known to and screened by the licensee and determined to be necessary and appropriate to have access to the nonpublic information held by the licensee and the licensee's information systems;

(2) "Commissioner" means the commissioner of commerce and insurance, or the commissioner's designee;

(3) "Consumer" means an individual, including an applicant, policyholder, insured, beneficiary, claimant, or certificate holder, who is a resident of this state

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and whose nonpublic information is in a licensee's possession, custody, or control;

(4) "Cybersecurity event":

(A) Means an event resulting in unauthorized access to, or disruption or misuse of, an information system or nonpublic information stored on an information system; and

(B) Does not include:

(i) The unauthorized acquisition of encrypted nonpublic information if the encryption, process, or key is not also acquired, released, or used without authorization; or

(ii) An event in which the licensee determines that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed;

(5) "Department" means the department of commerce and insurance;

(6) "Encrypted" means the transformation of data into a form that results in a low probability that its meaning is discernible without the use of a protective process or key;

(7) "Immediate family" means a spouse; child or grandchild by blood, adoption, or marriage; sibling; parent; or grandparent;

(8) "Information security program" means the administrative, technical, and physical safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle nonpublic information;

(9) "Information system" means:

(A) A discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic nonpublic information; or

(B) A specialized system, including an industrial or process control system, a telephone switching and private branch exchange system, and an environmental control system;

(10) "Licensee":

(A) Means a person:

(i) Licensed, authorized to operate, or registered pursuant to this title; or

(ii) Required to be licensed, authorized to operate, or registered pursuant to this title; and

(B) Does not include a purchasing group or risk retention group chartered and licensed in another state or a person acting as an assuming insurer and domiciled in another state or jurisdiction;

(11) "Multi-factor authentication" means authentication through verification of at least two (2) of the following types of authentication factors:

(A) Knowledge factors, such as by a password;

(B) Possession factors, such as by a token or text message on a mobile phone; or

(C) Inherence factors, such as by a biometric characteristic;

(12) "Nonpublic information" means information that is not publicly available and that is:

(A) Business-related information of a licensee, in which the tampering with, unauthorized disclosure of, access to, or use of, would cause a material adverse impact to the business, operations, or security of the licensee;

(B) Information concerning a consumer that, because of a name, number, personal mark, or other identifier, can be used to identify that consumer, in combination with the following:

(i) A social security number;

(ii) A driver license number or non-driver identification card number;

(iii) A financial account number or credit or debit card number;

(iv) A security code, access code, or password that would permit access to the consumer's financial accounts; or

(v) Biometric records; or

(C) Information or data, except a person's age or sex, created by or derived from a healthcare provider or a consumer that relates to:

(i) The past, present, or future physical, mental, or behavioral health or health condition of a consumer or a member of a consumer's immediate family;

(ii) The provision of health care to a consumer; or

(iii) Payment for the provision of health care to a consumer;

(13) "Person" means an individual or non-governmental entity, including a sole proprietorship, corporation, limited liability company, partnership, trust, religious organization, association, nonprofit organization described in § 501(c) of the Internal Revenue Code that is exempt from federal income taxation under § 501(a) of the Internal Revenue Code (26 U.S.C. § 501(a)), or another legal entity, whether formed as a for-profit or not-for-profit entity;

(14) "Publicly available information" means information that a licensee has a reasonable basis to believe is lawfully made available to the public. For purposes of this subdivision (14), a licensee has a reasonable basis to believe that information is lawfully made available to the public if the licensee has taken steps reasonably necessary to determine:

(A) That the information is of a type that is available to the public through government records, widely distributed media, or public disclosures required by law; or

(B) That a consumer can direct that the information not be made available to the public and, if so, that the consumer has not made that direction;

(15) "Risk assessment" means the risk assessment that each licensee must conduct under § 56-2-1004(3); and

(16) "Third-party service provider" means a person, not otherwise defined as a licensee, that contracts with a licensee to maintain, process, or store, or is otherwise permitted access to maintain, process, or store, nonpublic information through its provision of services to the licensee.

56-2-1004. Information security program.

By July 1, 2022, unless provided otherwise in this section:

(1) Commensurate with the size and complexity of the licensee and the nature and scope of its activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by or in the possession, custody, or control of the licensee, each licensee shall develop, implement, and maintain a comprehensive, written information security program based on the licensee's risk assessment that contains administrative, technical, and physical safeguards for the protection of the nonpublic information and the licensee's information system;

(2) A licensee's information security program must be designed to:

(A) Protect the security and confidentiality of nonpublic information and the security of the information system;

(B) Protect against threats or hazards to the security or integrity of nonpublic information and the information system;

(C) Protect against unauthorized access to or use of nonpublic information and minimize the likelihood of harm to a consumer as a result of unauthorized access or use; and

(D) Define and periodically reevaluate a schedule for retaining nonpublic information and a mechanism for the destruction of nonpublic information when the information is no longer needed;

(3) A licensee shall conduct a risk assessment as follows:

(A) Designate one (1) or more employees, an affiliate, or an outside vendor acting on behalf of the licensee who is responsible for the licensee's information security program;

(B) Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration, or destruction of nonpublic information, including threats to the security of information systems and nonpublic information accessible to or held by third-party service providers;

(C) Assess the likelihood and potential damage of reasonably foreseeable internal or external threats, taking into consideration the sensitivity of the nonpublic information involved;

(D) Assess the sufficiency of policies, procedures, information systems, and other safeguards in place to manage threats throughout the licensee's operations, including in:

(i) Employee training and management;

(ii) Information systems, including network and software design, as well as information classification, governance, processing, storage, transmission, and disposal; and

(iii) Detection, prevention, and response to attacks, intrusions, or other information systems failures; and

(E) Implement information safeguards to manage the threats identified in the licensee's risk assessment and, no less than annually, assess the effectiveness of the safeguards' key controls, systems, and procedures;

(4) Based on a licensee's risk assessment, the licensee shall:

(A) Design an information security program to mitigate the identified risks, commensurate with the size and complexity of the licensee and the nature and scope of its activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by or in the possession, custody, or control of the licensee;

(B) Determine which of the following security measures are appropriate for the licensee and implement those security measures:

(i) Place access controls on information systems, including controls to authenticate and restrict access to authorized individuals to protect against the unauthorized acquisition of nonpublic information;

(ii) Identify and manage the data, personnel, devices, systems, and facilities that enable the licensee to achieve the licensee's business objectives in accordance with the relative importance of the data, personnel, devices, systems, and facilities to the licensee's business objectives and risk strategy;

(iii) Restrict physical access to nonpublic information to authorized individuals;

(iv) Protect by encryption or other appropriate means nonpublic information being transmitted over an external network and nonpublic information stored on a laptop computer or other

portable computing or storage device or media;

(v) Adopt secure development practices for internally developed applications utilized by the licensee and procedures for evaluating, assessing, or testing the security of externally developed applications utilized by the licensee;

(vi) Modify the licensee's information system in accordance with the licensee's information security program;

(vii) Utilize effective controls that may include multi-factor authentication procedures for authorized individuals accessing nonpublic information;

(viii) Regularly test and monitor systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems;

(ix) Include audit trails within the information security program designed to detect and respond to cybersecurity events and to reconstruct material financial transactions sufficient to support normal operations and obligations of the licensee;

(x) Implement measures to protect against destruction, loss, or damage of nonpublic information due to environmental hazards, such as fire and water damage, technological failures, or other catastrophic events; and

(xi) Develop, implement, and maintain procedures for the secure disposal of nonpublic information in any format;

(C) Include cybersecurity risks in the licensee's enterprise risk management process;

(D) Remain informed regarding emerging threats or vulnerabilities to the licensee and utilize reasonable security measures when sharing

information, relative to the nature of the sharing and the type of information being shared; or

(E) Provide personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the licensee in the risk assessment;

(5) If the licensee has a board of directors, then the board or an appropriate committee of the board shall, at a minimum:

(A) Require the licensee's executive management or delegates to develop, implement, and maintain the licensee's information security program;

(B) Require the licensee's executive management or delegates to report in writing, at least annually:

(i) The status of the licensee's information security program and compliance with this part; and

(ii) Material matters related to the licensee's information security program, including risk assessment, risk management and control decisions, third-party service provider arrangements, results of testing, cybersecurity events or violations and the licensee's responses thereto, and recommendations for changes to the information security program; and

(C) If the licensee's executive management delegates any of the executive management's responsibilities under this section, then the executive management must oversee the development, implementation, and maintenance of the licensee's information security program prepared by the delegates and must either prepare the report or receive a copy of the report prepared by the delegates pursuant to subdivision (5)(B);

(6) A licensee shall exercise due diligence in selecting a third-party

service provider and, by July 1, 2023, require that each third-party service provider implement appropriate administrative, technical, and physical measures to protect and secure the information systems and nonpublic information accessible to, or held by, the third-party service provider;

(7) The licensee shall monitor, evaluate, and adjust, as appropriate, its information security program, consistent with relevant changes in technology, the sensitivity of its nonpublic information, internal or external threats to its information, and its changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to information systems;

(8)

(A) As part of a licensee's information security program, a licensee must establish a written incident response plan designed to promptly respond to, and recover from, a cybersecurity event that compromises the confidentiality, integrity, or availability of the licensee's nonpublic information or information systems or the continuing functionality of the licensee's operations;

(B) The incident response plan must address:

(i) The licensee's internal process for responding to a cybersecurity event;

(ii) The goals of the licensee's incident response plan;

(iii) The definition of roles, responsibilities, and levels of decision-making authority relating to a cybersecurity event;

(iv) External and internal communications and information sharing;

(v) The requirements for remediating identified weaknesses in information systems and associated controls;

(vi) Documentation and reporting regarding cybersecurity events and related incident response activities; and

(vii) The evaluation and revision, as necessary, of the incident response plan following a cybersecurity event; and

(9)

(A) Each insurer domiciled in this state shall submit to the commissioner by April 15 of each year written certification that the insurer is in compliance with this section. Each insurer shall maintain for examination by the department all records, schedules, and data supporting the certification for a period of five (5) years from the date of the corresponding certification.

(B) If an insurer identifies areas, systems, or processes requiring material improvement, updating, or redesign, then the insurer must document planned and ongoing remedial efforts to address those areas, systems, or processes, and the documentation must be made available for inspection by the commissioner upon request.

56-2-1005. Investigation of a cybersecurity event.

(a) If a licensee learns that a cybersecurity event has or may have occurred, then the licensee or an outside vendor or service provider designated to act on behalf of the licensee shall conduct a prompt investigation.

(b) During the investigation, the licensee or outside vendor or service provider shall, at a minimum:

(1) Determine whether a cybersecurity event has occurred;

(2) Assess the nature and scope of the cybersecurity event;

(3) Identify nonpublic information that may have been involved in the cybersecurity event; and

(4) Take or oversee reasonable measures to restore the security of the

information systems compromised in the cybersecurity event in order to prevent further unauthorized acquisition, release, or use of nonpublic information in the licensee's possession, custody, or control.

(c) If the licensee learns that a cybersecurity event has or may have occurred in a system maintained by a third-party service provider, then the licensee shall complete, or confirm and document that the third-party service provider has completed, the actions required by subsection (b).

(d) The licensee shall maintain records concerning all cybersecurity events for a period of at least five (5) years from the date of discovery of the cybersecurity event and shall provide those records to the commissioner upon request.

(e) If the licensee conducts an investigation or review of a potential or suspected cybersecurity event and determines that an event is not a cybersecurity event, then the licensee must reduce that determination to writing and maintain that writing for a period of at least five (5) years from the date of discovery of the event. The licensee shall provide the writing to the commissioner upon request.

56-2-1006. Notification of a cybersecurity event.

(a) A licensee shall notify the commissioner as soon as practicable, and in no event more than three (3) business days, following a determination that a cybersecurity event has occurred if:

(1)

(A) The licensee is domiciled in this state, in the case of an insurer, as defined in § 56-6-102, or this state is the licensee's home state, in the case of an insurance producer, as defined in § 56-6-102; and

(B) The cybersecurity event has a reasonable likelihood of materially harming a consumer residing in this state or a material part of the licensee's normal operations; or

(2) The licensee reasonably believes that the nonpublic information of

two hundred fifty (250) or more consumers residing in this state is involved in the cybersecurity event and that the cybersecurity event is:

(A) A cybersecurity event of which notice must be provided to a government body, self-regulatory agency, or other supervisory body pursuant to state or federal law; or

(B) A cybersecurity event with a reasonable likelihood of materially harming a consumer residing in this state or a material part of the licensee's normal operations.

(b)

(1) A licensee that must notify the commissioner under subsection (a) shall provide to the commissioner, in a format directed by the commissioner, as much of the following information as is available:

(A) The date of the cybersecurity event;

(B) A description of how the nonpublic information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of third-party service providers with respect to the nonpublic information, if any;

(C) How the cybersecurity event was discovered;

(D) Whether lost, stolen, or breached nonpublic information has been recovered and, if so, how recovery was accomplished;

(E) The identity of the source of the cybersecurity event;

(F) Whether the licensee has filed a police report or notified regulatory, governmental, or law enforcement agencies and, if so, when the notification was provided;

(G) A description of the specific types of nonpublic information or particular data elements acquired without authorization, which may include types of medical information, types of financial information, or

types of information allowing for consumer identification;

(H) The period during which the licensee's information system was compromised by the cybersecurity event;

(I) The number of total consumers in this state affected by the cybersecurity event. The licensee shall provide its best estimate of this number of consumers in its initial report to the commissioner and update this estimate with each subsequent report to the commissioner pursuant to this subsection (b);

(J) The results of an internal review and whether the review identified whether automated controls or internal procedures were followed or adhered to;

(K) A description of the efforts to remediate the situation that permitted the cybersecurity event to occur;

(L) A copy of the licensee's privacy policy and a statement outlining the steps that the licensee will take to investigate which consumers were affected by the cybersecurity event and to notify affected consumers;

(M) The name of a person who is both knowledgeable regarding the cybersecurity event and authorized to act on behalf of the licensee to serve as a representative of the licensee for contact from the commissioner; and

(N) A copy of the notice sent to affected consumers, if the notice is required under subsection (c).

(2) Licensees shall continually provide material updates or supplements to the information provided under subdivision (b)(1).

(c) Following a determination that a cybersecurity event has occurred, a licensee shall notify consumers affected, or reasonably believed to have been affected, by the

cybersecurity event. The disclosure must be made no later than forty-five (45) days after the determination of the cybersecurity event, unless a longer period of time is required due to the legitimate needs of law enforcement. For purposes of this section, notice may be provided by:

(1) Written notice;

(2) Electronic notice, if the notice provided is consistent with the provisions regarding electronic records and signatures set forth in 15 U.S.C. § 7001, or if the licensee's primary method of communication with the consumer has been by electronic means. Electronic means may include email notification; or

(3) Substitute notice, if the licensee demonstrates that the cost of providing notice would exceed two hundred fifty thousand dollars ($250,000), the affected class of subject persons to be notified exceeds five hundred thousand (500,000) persons, or the licensee does not have sufficient contact information and the notice consists of the following:

(A) Email notice, when the licensee has an email address for the consumer;

(B) Conspicuous posting of the notice on the licensee's website, if the licensee maintains a website page; and

(C) Notification to major statewide media.

(d)

(1) If a licensee becomes aware of a cybersecurity event in the licensee's information system maintained by a third-party service provider, then the licensee must treat the event as if it occurred in an information system maintained by the licensee for purposes of subsection (a).

(2) The licensee's time limitations for purposes of providing notification under subsection (a) begin running when the third-party service provider notifies

the licensee of the cybersecurity event or the licensee otherwise gains actual knowledge of the cybersecurity event, whichever is sooner.

(3) This part does not limit or abrogate an agreement between a licensee and another party to fulfill the investigation requirements imposed under § 56-2-1005 or the notice requirements imposed under this section.

(e)

(1)

(A) In the case of a cybersecurity event involving nonpublic information that is used by, or in the possession, custody, or control of, a licensee acting as an assuming insurer that does not have a direct contractual relationship with the affected consumers, the assuming insurer shall notify the affected ceding insurers and the commissioner of the licensee's state of domicile within three (3) business days of determining that a cybersecurity event has occurred.

(B) The ceding insurers that have a direct contractual relationship with affected consumers must fulfill the consumer notification requirements required under this section.

(2)

(A) In the case of a cybersecurity event involving nonpublic information in the possession, custody, or control of a third-party service provider of a licensee that is an assuming insurer, the assuming insurer shall notify the affected ceding insurers and the commissioner of the licensee's state of domicile within three (3) business days of the third-party service provider notifying the licensee of the cybersecurity event or the licensee otherwise gaining actual knowledge of the cybersecurity event, whichever is sooner.

(B) The ceding insurers that have a direct contractual relationship

with affected consumers shall fulfill the consumer notification requirements required under this section.

(3) Except as provided in this subsection (e), a licensee acting as assuming insurer has no other notice obligations relating to a cybersecurity event under this section.

(f) In the case of a cybersecurity event involving nonpublic information in the possession, custody, or control of a licensee that is an insurer, or the third-party service provider for which a consumer accessed the insurer's services through an independent insurance producer, and for which consumer notice is required under this part, the insurer shall notify the producers of record of all affected consumers, if known, as soon as practicable, but not later than when such notice is provided to the affected consumers. The insurer is excused from this obligation in those instances in which the insurer does not have the current producer of record information for an individual consumer.

56-2-1007. Authority of commissioner.

(a) In addition to authority under chapter 1, part 4 of this title, the commissioner has the authority to examine and investigate a licensee to determine whether the licensee has been or is engaged in conduct in violation of this part. Those examinations or investigations must be conducted in accordance with chapter 1, part 4 of this title.

(b) If the commissioner has reason to believe that a licensee has been or is engaged in conduct in this state that violates this part, then the commissioner may take necessary or appropriate action to enforce this part in accordance with part 3 of this chapter.

56-2-1008. Confidentiality.

(a) Documents, materials, or information in the department's control or possession that are furnished by a licensee, or an employee or agent acting on behalf of the licensee, pursuant to § 56-2-1004(9) or § 56-2-1006(b), or that are obtained by the

commissioner in connection with an investigation or examination pursuant to § 56-2-1007:

(1) Are confidential and not open for inspection by members of the public under title 10, chapter 7 or § 56-1-602; and

(2) Are not subject to subpoena or discovery in a private civil action, except that the commissioner may use the documents, materials, or information in the furtherance of regulatory or legal action by the commissioner.

(b) The commissioner, or a person who received documents, materials, or information while acting under the authority of the commissioner, is not permitted or required to testify in a private civil action concerning documents, materials, or information made confidential under subsection (a).

(c) Notwithstanding subsection (a), to assist in the commissioner's duties under this part, the commissioner may:

(1) Share documents, materials, or information made confidential under subsection (a) with other state, federal, or international regulatory agencies or law enforcement authorities, the national association of insurance commissioners or its affiliates or subsidiaries, or a third-party consultant or vendor of the department, as long as the recipient agrees in writing to maintain the confidential nature of the documents, materials, or information;

(2) Receive documents, materials, or information, including otherwise confidential documents, materials, or information, from the national association of insurance commissioners or its affiliates or subsidiaries, or from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and the commissioner must maintain as confidential any document, material, or information received with notice or the understanding that it is confidential under the laws of the source jurisdiction; and

(3) Enter into agreements governing sharing and use of documents,

materials, or information consistent with this subsection (c).

(d) A waiver of an applicable privilege or confidentiality does not occur as a result of the disclosure of documents, materials, or information by or to the commissioner under subsection (c).

(e) This part does not prohibit the commissioner from releasing final, adjudicated actions open to public inspection under title 10, chapter 7 or § 56-1-602 to a database or other clearinghouse service maintained by the national association of insurance commissioners or its affiliates or subsidiaries.

56-2-1009. Exceptions.

(a)

(1) This part does not apply to:

(A) A licensee who employs less than twenty-five (25) individuals, regardless of whether the individuals are employees or independent contractors;

(B) A licensee with less than five million dollars ($5,000,000) in gross annual revenue; or

(C) A licensee with less than ten million dollars ($10,000,000) in year-end total assets.

(2) A licensee subject to and governed by the privacy, security, and breach notification rules issued by the United States department of health and human services, 45 CFR Parts 160 and 164, established pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et seq.), and the federal Health Information Technology for Economic and Clinical Health (HITECH) Act (42 U.S.C. § 300jj et seq. and 42 U.S.C. § 17901 et seq.), and that maintains nonpublic information in the same manner as protected health information meets the requirements of §§ 56-2-1004 and 56-2-1006(c) if the licensee is compliant with, and submits a written statement certifying its

compliance with, the federal Health Insurance Portability and Accountability Act of 1996 or the federal Health Information Technology for Economic and Clinical Health.

(3) A licensee subject to Title V of the federal Gramm-Leach-Bliley Act of 1999 (15 U.S.C. §§ 6801-6809 and 6821-6827) meets the requirements of § 56-2-1006(c) if the licensee is compliant with, and submits a written statement certifying its compliance with, Title V of the federal Gramm-Leach-Bliley Act of 1999.

(4) An employee, agent, representative, or designee of a licensee, who is also a licensee, is exempt from § 56-2-1004 if the activities of the employee, agent, representative, or designee are covered by the other licensee's information security program.

(b) If a licensee ceases to qualify for an exception under subsection (a), then the licensee has one hundred eighty (180) days from the time the licensee no longer qualifies for the exception to comply with this part.

56-2-1010. Penalties.

The commissioner may seek penalties under § 56-2-305 for a violation of this part.

56-2-1011. Rules.

The commissioner may promulgate rules to effectuate this part. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. If any provision of this act or the application of any provision of this act to any person or circumstance is held invalid, then the invalidity does not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to that end, the provisions of this act are severable.

SECTION 3. 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 4. For the purpose of promulgating rules, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect July 1, 2021, the public welfare requiring it, and applies to breaches that occur or are discovered on or after that date.

House Insurance Subcommittee Am. #1

Amendment No._______________

FILED
Date __________
Time __________
Clerk __________
Comm. Amdt. ______

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Signature of Sponsor

AMEND Senate Bill No. 1248 **House Bill No. 1195***

by deleting all language after the enacting clause and substituting:

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) "Communication" means written or electronic correspondence among a health facility, health insurance entity, or provider concerning a prior authorization;

(2) "Health facility":

(A) Means an institution, place, or building providing healthcare services that is required to be licensed under title 68, chapter 11; and

(B) Excludes emergency room and in-patient services at a hospital, as defined in § 68-11-201;

(3) "Health insurance coverage" has the same meaning as defined in § 56-7-109;

(4) "Health insurance entity" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, 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;

(5) "Healthcare service" means a service for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

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(6) "Minor" means an individual who has not attained eighteen (18) years of age;

(7) "Patient" means an individual who has health insurance coverage and is being treated by a provider for a healthcare service;

(8) "Policyholder" means an individual who has contracted with a health insurance entity for healthcare services coverage; and

(9) "Provider" means an individual or entity performing services regulated pursuant to title 63 or title 68, chapter 11, with whom the health insurance entity has an express and valid network provider agreement or contract.

(b) Except as provided in subsection (d), a health insurance entity shall notify a patient of communication between the health insurance entity and a provider or health facility concerning additional information needed to process a prior authorization request for the patient within two (2) business days after the communication has occurred. The notification must include a brief summary of the communication or a copy of the communication.

(c) The health insurance entity shall notify the patient via electronic means, such as by email or through an online patient portal offered by the health insurance entity, unless the patient requests, in writing, an alternative notification method.

(d) If the patient is a minor, then the health insurance entity must notify the policyholder whose health insurance coverage covers the minor.

(e) This section does not apply to the TennCare program or a successor to the program provided for in the Medical Assistance Act of 1968, compiled in title 71, chapter 5.

SECTION 2. Tennessee Code Annotated, Title 63, Chapter 1, Part 1, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Communication" means written or electronic correspondence among a health facility, health insurance entity, or provider concerning a prior authorization;

(2) "Health facility":

(A) Means an institution, place, or building providing healthcare services that is required to be licensed under title 68, chapter 11; and

(B) Excludes emergency room and in-patient services provided at a hospital, as defined in § 68-11-201;

(3) "Health insurance coverage" has the same meaning as defined in § 56-7-109;

(4) "Health insurance entity" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner of commerce and insurance, 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;

(5) "Healthcare service" means a service for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(6) "Minor" means an individual who has not attained eighteen (18) years of age;

(7) "Patient" means an individual who has health insurance coverage and is being treated by a provider for a healthcare service;

(8) "Policyholder" means an individual who has contracted with a health insurance entity for healthcare services coverage; and

(9) "Provider" means an individual or entity performing services regulated pursuant to this title or title 68, chapter 11, with whom the health insurance entity has an express and valid network provider agreement or contract.

(b) Except as provided in subsection (d), a provider shall notify a patient of communication between the provider and a health insurance entity or health facility concerning additional information needed to process a prior authorization request for the patient within two (2) business days after the communication has occurred. The notification must include a brief summary of the communication or a copy of the communication.

(c) The provider shall notify the patient via electronic means, such as by email or through an online patient portal offered by the provider, unless the patient requests, in writing, an alternative notification method.

(d) If the patient is a minor, then the provider must notify the policyholder whose health insurance coverage covers the minor.

(e) This section does not apply to the TennCare program or a successor to the program provided for in the Medical Assistance Act of 1968, compiled in title 71, chapter 5.

SECTION 3. Tennessee Code Annotated, Title 68, Chapter 11, Part 2, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Communication" means written or electronic correspondence among a health facility, health insurance entity, or provider concerning a prior authorization;

(2) "Health facility":

(A) Means an institution, place, or building providing healthcare services that is required to be licensed under this chapter; and

(B) Excludes emergency room and in-patient services provided at a hospital as defined in § 68-11-201;

(3) "Health insurance coverage" has the same meaning as defined in § 56-7-109;

(4) "Health insurance entity" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, 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;

(5) "Healthcare service" means a service for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(6) "Minor" means an individual who has not attained eighteen (18) years of age;

(7) "Patient" means an individual who has health insurance coverage and is being treated by a provider for a healthcare service;

(8) "Policyholder" means an individual who has contracted with a health insurance entity for healthcare services coverage; and

(9) "Provider" means an individual or entity performing services regulated pursuant to title 63 or this chapter, with whom the health insurance entity has an express and valid network provider agreement or contract.

(b) Except as provided in subsection (d), a health facility shall notify a patient of communication between the health facility and a health insurance entity or provider concerning additional information needed to process a prior authorization request for the patient within two (2) business days after the communication has occurred. The notification must include a brief summary of the communication or a copy of the communication.

(c) The health facility shall notify the patient via electronic means, such as by email or through an online patient portal offered by the health facility, unless the patient requests, in writing, an alternative notification method.

(d) If the patient is a minor, then the health facility must notify the policyholder whose health insurance coverage covers the minor.

(e) This section does not apply to the TennCare program or a successor to the program provided for in the Medical Assistance Act of 1968, compiled in title 71, chapter 5.

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

SECTION 5. For the purpose of rule promulgation, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect January 1, 2022, the public welfare requiring it, and applies to communications made pursuant to insurance policies entered into, issued, renewed, or amended on or after that date.

House Insurance Subcommittee Am. #1

Amendment No._______________

FILED
Date __________
Time __________
Clerk __________
Comm. Amdt. ______

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Signature of Sponsor

AMEND Senate Bill No. 123* **House Bill No. 181**

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 20, is amended by deleting current Part 20 in its entirety and substituting instead a new Part 20 as follows:

71-5-2001. Short title.

This part shall be known and may be cited as the "Annual Coverage Assessment Act of 2021."

71-5-2002. Part definitions.

As used in this part:

(1) "Annual coverage assessment" means the annual assessment imposed on covered hospitals as set forth in this part;

(2) "Annual coverage assessment base" means a covered hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2016, on file with CMS as of September 30, 2018, subject to the following qualifications:

(A) If a covered hospital does not have a full twelve-month medicare cost report for 2016 on file with CMS but has a full twelve-month cost report for a subsequent year, then the first full twelve-month medicare cost report for a year following 2016 on file with CMS is the annual coverage assessment base;

(B) If a covered hospital does not have a full twelve-month medicare cost report for 2016 on file with CMS and does not have a full

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twelve-month cost report for a subsequent year, but has a cost report for 2016 that covers at least nine (9) months of 2016, then the assessment base is calculated by annualizing the 2016 cost report data;

(C) If a covered hospital was first licensed in 2016 or later and did not replace an existing hospital, and if the hospital has a medicare cost report on file with CMS, then the hospital's initial cost report on file with CMS is the base for the hospital assessment. If the hospital does not have an initial cost report on file with CMS but does have a complete twelve-month joint annual report filed with the department of health, then the net patient revenue from the first twelve-month joint annual report is the annual coverage assessment base. If the hospital does not have a medicare cost report or a full twelve-month joint annual report filed with the department of health, then the annual coverage assessment base is the covered hospital's projected net patient revenue for its first full year of operation as shown in its certificate of need application filed with the health services and development agency;

(D) If a covered hospital was first licensed in 2016 or later and replaced an existing hospital, then the annual coverage assessment base is the replacement hospital's initial medicare cost report on file with CMS. If the hospital does not have a medicare cost report on file with CMS, then the hospital's annual coverage assessment base is either the predecessor hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2016, or, if the predecessor hospital does not have a 2016 medicare cost report, then the cost report for the first fiscal year following 2016 on file with CMS;

(E) If a covered hospital is not required to file an annual medicare cost report with CMS, then the hospital's annual coverage assessment

base is its net patient revenue for the fiscal year ending during calendar year 2016 or the first fiscal year that the hospital was in operation after 2016 as shown in the covered hospital's joint annual report filed with the department of health; and

(F) If a covered hospital's fiscal year 2016 medicare cost report is not contained in any of the CMS healthcare cost report information system files and if the hospital does not meet any of the other qualifications listed in subdivisions (2)(A)-(E), then the hospital must submit a copy of the hospital's 2016 medicare cost report to the bureau in order to allow for the determination of the hospital's net patient revenue for the state fiscal year 2021-2022 annual coverage assessment;

(3) "Bureau" means the bureau of TennCare;

(4) "CMS" means the federal centers for medicare and medicaid services;

(5) "Controlling person" means a person who, by ownership, contract, or otherwise, has the authority to control the business operations of a covered hospital. As used in this subdivision (5), "control" means indirect or direct ownership of ten percent (10%) or more of a covered hospital;

(6) "Covered hospital" means a hospital licensed under title 33 or title 68, as of July 1, 2021, but does not include an excluded hospital;

(7) "Excluded hospital" means:

(A) A hospital that has been designated by CMS as a critical access hospital as of July 1, 2021;

(B) A mental health hospital owned by this state;

(C) A hospital providing primarily rehabilitative or long-term acute care services;

(D) A children's research hospital that does not charge patients for services beyond that reimbursed by third-party payers; and

(E) A hospital that is determined by the bureau as eligible to certify public expenditures for the purpose of securing federal medical assistance percentage payments;

(8) "Medicare cost report" means CMS-2552-10 or a subsequent form adopted by CMS for medicare cost reporting, the cost report for electronic filing of hospitals, for the period applicable as set forth in this section; and

(9) "Net patient revenue" from the medicare cost report means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the 2016 medicare cost report excluding long-term care inpatient ancillary and other non-hospital revenues, or, in the case of a hospital that did not file a 2016 medicare cost report, comparable data from the first complete cost report filed after 2016 by the hospital.

71-5-2003. Annual coverage assessment on covered hospitals.

(a) There is imposed on each covered hospital licensed as of July 1, 2021, an annual coverage assessment for fiscal year (FY) 2021-2022 as set forth in this part.

(b) The annual coverage assessment imposed by this part is not effective and validly imposed until the bureau has provided the Tennessee Hospital Association with written notice that includes:

(1) A determination from CMS that the annual coverage assessment is a permissible source of revenue that must not adversely affect the amount of federal financial participation in the TennCare program;

(2)

(A) Approval from CMS for the distribution of the full amount of directed payments to hospitals to offset unreimbursed TennCare costs as

described in § 71-5-2005(d)(2) as long as no assessment installment is collected prior to the distribution of the installment of the directed payments; or

(B) The rules promulgated by the bureau pursuant to § 71-5-2004(j)(2); and

(3) Confirmation that all contracts between hospitals and managed care organizations comply with the hospital rate variation corridors set forth in § 71-5-161.

(c) The general assembly intends that the proceeds of the annual coverage assessment not be used as a justification to reduce or eliminate state funding to the TennCare program. The annual coverage assessment is not effective and validly imposed if the coverage or the amount of revenue available for expenditure by the TennCare program in FY 2021-2022 is less than:

(1) The governor's FY 2021-2022 recommended budget level; plus

(2) Additional appropriations made by the general assembly to the TennCare program for FY 2021-2022, except to the extent new federal funding is available to replace funds that are appropriated as described in subdivision (c)(1) and that are above the amount that the state receives from CMS under the regular federal matching assistance percentage.

(d)

(1)

(A) The general assembly intends that the proceeds of the annual coverage assessment not be used as justification for a TennCare managed care organization to implement across-the-board rate reductions to negotiated rates with covered or excluded hospitals or physicians in existence on July 1, 2021. For those rates in effect on July 1, 2021, the bureau shall include provisions in the managed care

organizations' contractor risk agreements that prohibit the managed care organizations from implementing across-the-board rate reductions to covered or excluded network hospitals or physicians by specific service, category, or type of provider. The requirements of the preceding sentence also apply to services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician, but do not apply to reductions in benefits or reimbursement for the ancillary services if the reductions:

(i) Are different from those items being funded in § 71-5-2005(d); and

(ii) Have been communicated in advance of implementation to the general assembly and the Tennessee Hospital Association.

(B) For purposes of this subsection (d):

(i) "Physician" includes a physician licensed under title 63, chapter 6 or chapter 9, and a group practice of physicians that hold a contract with a managed care organization;

(ii) "Services or settings of care that are ancillary" includes ambulatory surgical facilities, free standing emergency departments, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation, or skilled nursing services; and

(iii) "Services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician" includes services where the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate

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of a covered or excluded hospital or hospital system, holds more than a fifty percent (50%) controlling interest in the ancillary services or settings of care, but does not include other ancillary services or settings of care. For across-the-board rate reductions to ancillary services or settings of care, the bureau shall include appropriate requirements for notice to providers in the managed care organizations' contractor risk agreements.

(2) This subsection (d) does not preclude good faith negotiations between managed care organizations and covered or excluded hospitals, hospital systems, and physicians on an individualized, case-by-case basis, nor is this subsection (d) intended by the general assembly to serve as justification for managed care organizations in this state, covered or excluded hospitals, hospital systems, or physicians to unreasonably deny any party the ability to enter into the individualized, case-by-case good faith negotiations. Good faith negotiation necessarily implies mutual cooperation between the negotiating parties and may include, but is not limited to, the right to terminate contractual agreements, the ability to modify negotiated rates, pricing, or units of service, the ability to alter payment methodologies, and the ability to enforce existing managed care techniques or to implement new managed care techniques.

(3) This subsection (d) does not preclude the full implementation of the requirements set forth in § 71-5-161.

(4) Notwithstanding this subsection (d), if CMS mandates a TennCare program change or a change is required by state or federal law that impacts rates, and that change is required to be implemented by the managed care organizations in accordance with their contracts, or if the annual coverage assessment becomes invalid, then this part does not prohibit the managed care

organizations from implementing a rate change as may be mandated by the bureau or by state or federal law.

71-5-2004. Amount of annual coverage assessment — Payment — Penalty — Suspension of payments — Civil action.

(a) The annual coverage assessment established for this part is four and eighty-seven hundredths percent (4.87%) of a covered hospital's annual coverage assessment base.

(b) The annual coverage assessment must be paid in installments pursuant to this subsection (b) if the requirements of § 71-5-2003(b) have been satisfied. The bureau shall establish a schedule of four (4) equal installment payments spread as evenly as possible throughout FY 2021-2022 with each installment payment due fifteen (15) days after the FY 2021-2022 directed payments approved by CMS to offset unreimbursed TennCare costs have been made to hospitals.

(c) To facilitate collection of the annual coverage assessment, the bureau shall send each covered hospital, at least thirty (30) days in advance of each installment payment due date, a notice of payment along with a return form developed by the bureau. Failure of a covered hospital to receive a notice and return form, however, does not relieve a covered hospital from the obligation of timely payment. The bureau shall also post the return form on its website.

(d) Failure of a covered hospital to pay an installment of the annual coverage assessment, when due, results in an imposition of a penalty of five hundred dollars ($500) per day until the installment is paid in full. The bureau at its discretion may waive the penalty if the hospital establishes that it attempted to mail or electronically transfer payment to the state on or before the date the payment was due.

(e) If a covered hospital ceases to operate or changes status to be an excluded hospital after July 1, 2021, and before July 1, 2022, the hospital's total annual coverage assessment is equal to its annual coverage assessment base multiplied by a fraction,

the denominator of which is the number of calendar days from July 1, 2021, until July 1, 2022, and the numerator of which is the number of days from July 1, 2021, until the date the board for licensing healthcare facilities has recorded as the date that the hospital changed status or ceased operation.

(f) If a covered hospital ceases operation prior to payment of its full annual coverage assessment, then the person controlling the hospital as of the date the hospital ceased operation is jointly and severally responsible for any remaining annual coverage assessment installments and unpaid penalties associated with previous late payments.

(g) If a covered hospital is sold after July 1, 2021 and before July 1, 2022, the seller is responsible for any annual coverage assessment payments due for the period up to and including the date the sale is final. If the hospital continues to operate in this state and continues to meet the definition of a covered hospital, then the new owner is responsible for paying all coverage assessment amounts due for the period beginning on the day after the date of the sale until July 1, 2022.

(h) If a covered hospital fails to pay an installment of the annual coverage assessment within thirty (30) days of its due date, then the bureau must suspend the payments to the hospital as required by § 71-5-2005(d)(2) or (d)(3) until the installment is paid and report the failure to the department that licenses the covered hospital. Notwithstanding any other law, failure of a covered hospital to pay an installment of the annual coverage assessment or any refund required by this part is considered a license deficiency and grounds for disciplinary action as set forth in the statutes and rules under which the covered hospital is licensed.

(i) In addition to the action required by subsection (h), the bureau is authorized to file a civil action against a covered hospital and its controlling person or persons to collect delinquent annual coverage assessment installments, late penalties, and refund obligations established by this part. Exclusive jurisdiction and venue for a civil action authorized by this subsection (i) is in the chancery court for Davidson County.

(j)

(1) If any federal agency with jurisdiction over this annual coverage assessment determines that the annual coverage assessment is not a valid source of revenue or if there is a reduction of the coverage and funding of the TennCare program contrary to § 71-5-2003(c), or if the requirements of §§ 71-5-161 and 71-5-2003(b) are not fully satisfied, or if one (1) or more managed care organizations impose rate reductions contrary to § 71-5-2003(d), then:

(A) No subsequent installments of the annual coverage assessment are due and payable; and

(B) No further payments must be paid to hospitals pursuant to § 71-5-2005(d)(2) or (d)(3) after the date of the event.

(2)

(A) Notwithstanding this part, if CMS discontinues approval of or otherwise fails to approve the full amount of directed payments to hospitals to offset losses incurred from providing services to TennCare enrollees as authorized under § 71-5-2005(d), then the bureau must suspend any payments from or to covered hospitals otherwise required by this part and must promulgate rules that:

(i) Establish the methodology for determining the amounts, categories, and times of payments to hospitals, if any, instead of the payments that otherwise would have been paid under § 71-5-2005(d)(3) if approved by CMS;

(ii) Prioritize payments to hospitals as set forth in § 71-5-2005(d)(3);

(iii) Identify the benefits and services for which funds will be available in order to mitigate reductions or eliminations that

otherwise would be imposed in the absence of the coverage assessment;

(iv) Determine the amount and timing of payments for benefits and services identified under subdivisions (j)(2)(A)(ii) and (iii) as appropriate;

(v) Reinstitute payments from or to covered hospitals as appropriate; and

(vi) Otherwise achieve the goals of this subdivision (j)(2).

(B) The rules adopted under this subdivision (j)(2) must, to the extent possible, achieve the goals of:

(i) Maximizing the amount of federal matching funds available for the TennCare program; and

(ii) Minimizing the variation between payments hospitals will receive under the rules as compared to payments hospitals would have received if CMS had approved the total payments described in § 71-5-2005(d).

(C) Notwithstanding any other law, the bureau is authorized to exercise emergency rulemaking authority to the extent necessary to meet the objectives of this subdivision (j)(2).

(3) Upon occurrence of any of the events set forth in subdivision (j)(1) or (j)(2), the bureau shall then have authority to make necessary changes to the TennCare budget to account for the loss of annual coverage assessment revenue.

(k) A covered hospital or an association representing covered hospitals, the membership of which includes thirty (30) or more covered hospitals, has the right to file a petition for declaratory order pursuant to § 4-5-223 to determine if there has been a failure to meet any of the requirements of this part. A covered hospital may not increase

charges or add a surcharge based on, or as a result of, the annual coverage assessment.

71-5-2005. Deposits in Maintenance of Coverage Trust Fund — Expenditures — Quarterly Reports.

(a) The funds generated as a result of this part must be deposited in the maintenance of coverage trust fund created by § 71-5-160, the existence of which is continued as provided in subsection (b). The fund must not be used to replace any monies otherwise appropriated to the TennCare program by the general assembly or to replace any monies appropriated outside of the TennCare program.

(b) The maintenance of coverage trust fund must continue without interruption and must be operated in accordance with § 71-5-160 and this section.

(c) The maintenance of coverage trust fund consists of:

(1) The balance of the trust fund remaining as of June 30, 2021;

(2) All annual coverage assessments received by the bureau;

(3) Investment earnings credited to the assets of the maintenance of coverage trust fund; and

(4) Penalties paid by covered hospitals for late payment of assessment installments imposed by this part or a prior statute authorizing an annual coverage assessment.

(d) Monies credited or deposited to the maintenance of coverage trust fund, together with all federal matching funds, must be available to and used by the bureau only for expenditures in the TennCare program and include the following purposes:

(1) Expenditure for benefits and services under the TennCare program, including those that would have been subject to reduction or elimination from TennCare funding for FY 2021-2022, except for the availability of one-time funding for that year only, as follows:

(A) Replacement of across-the-board reductions in covered and excluded hospital and professional reimbursement rates described in the governor's recommended budgets since FY 2011 except for any reductions that were included on a list for a given year but then funded in a subsequent year with recurring state dollars;

(B) Funding virtual DSH payments, funding payments to hospitals for uncompensated care to charity patients, and funding payments to hospitals for quality incentive arrangements, with all of those payments being made in accordance with, and as those categories of payments are defined in, the TennCare 1115 demonstration waiver from the centers for medicare and medicaid services to the maximum amount permitted for each category under that waiver;

(C) Maintenance of payments for graduate medical education of at least fifty million dollars ($50,000,000), or a successor program as approved by CMS;

(D) Maintenance of reimbursement for medicare part A crossover claims at the lesser of one hundred percent (100%) of medicare allowable or the billed amount;

(E) Avoidance of any coverage limitations relative to the number of hospital inpatient days per year or the annual cost of hospital services for a TennCare enrollee;

(F) Avoidance of any coverage limitations relative to the number of nonemergency outpatient visits per year for a TennCare enrollee;

(G) Avoidance of any coverage limitations relative to the number of physician office visits per year for a TennCare enrollee;

(H) Avoidance of coverage limitations relative to the number of laboratory and diagnostic imaging encounters per year for a TennCare enrollee;

(I) Maintenance of coverage for occupational therapy, physical therapy, and speech therapy services;

(J) In the total amount of five hundred sixty-five thousand eight hundred forty dollars ($565,840) to maintain reimbursement at the same emergency care rate as in FY 2020-2021 for nonemergent care to children twelve (12) to twenty-four (24) months of age;

(K) In the total amount of two million twenty-two thousand three hundred dollars ($2,022,300) to the bureau to offset the elimination of the provision in the TennCare managed care contractor risk agreements for hospitals as follows:

CRA 2.12.9.60-Specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing;

(L) In the total amount of two hundred seventy-five thousand dollars ($275,000) to offset a portion of the hospital cost of providing admissions, discharge, and transfer (ADT) messages to the TennCare bureau to support the TennCare Patient Centered Medical Home initiative;

(M) In the total amount of seven hundred fifty thousand dollars ($750,000) to provide funding for stipends for physicians and other healthcare providers who commit to work in designated medically underserved areas in this state; and

(N) In the amount of three million dollars ($3,000,000) to offset the unreimbursed cost of charity care for critical access hospitals to be funded from funds remaining in the trust fund as of June 30, 2021.

(2) Directed payments to hospitals to reduce unreimbursed costs incurred by covered hospitals in providing services to TennCare patients, as approved by CMS and as directed in subdivision (d)(3)(B).

(3)

(A) If CMS does not approve directed payments to hospitals to offset unreimbursed costs incurred in serving TennCare patients, but instead approves hospital supplemental pools in the TennCare waiver for that purpose, then payments required by this subdivision (d)(3) must be made from the allocated pools to covered hospitals to offset losses incurred in providing services to TennCare enrollees as set forth in this subdivision (d)(3) as first priority before any other supplemental payments authorized in the TennCare waiver are distributed;

(B) Directed payments to hospitals must be based on the amounts paid to covered hospitals during each quarter of FY 2021-2022. Each covered hospital is entitled to payments for FY 2021-2022 of a portion of its unreimbursed TennCare costs of providing services to TennCare enrollees. As used in this subdivision (d)(3)(B), "unreimbursed TennCare costs" means the excess of TennCare costs over TennCare net revenue. TennCare charges and net revenue are calculated using data from Schedule E, items (A)(1)(e) and (A)(1)(f) from the hospital's 2019 joint annual report (JAR) filed with the department of health. As used in this subdivision (d)(3)(B), "TennCare costs" means the quotient of a facility's cost-to-charge ratio, calculated as B(3) (total expenses) divided by A(3)(e) (total gross patient charges) from Schedule E of the 2019 JAR,

times TennCare charges. The amount of the payment to covered hospitals must be no less than forty and two tenths percent (40.20%) of unreimbursed TennCare costs for all hospitals licensed by the state that reported TennCare charges and revenue and total expenses on the 2019 joint annual report (JAR), excluding state-owned hospitals;

(C) The payments required by this subdivision (d)(3) must be made in four (4) equal installments. The bureau shall provide to the Tennessee Hospital Association a schedule showing the payments to each hospital at least seven (7) days in advance of the payments; and

(D) The payments required by this subdivision (d)(3) may be made by the bureau directly or by the TennCare managed care organizations with the direction to make payments to hospitals as required by this subsection (d). The payments to a hospital pursuant to this subdivision (d)(3) are not part of the reimbursement to which a hospital is entitled under its contract with a TennCare managed care organization;

(4) In addition to the items and expenditures set forth in subdivisions (d)(1)-(3), other programs and initiatives developed by the bureau, in consultation with the Tennessee Hospital Association, to offset the unreimbursed costs of providing services to TennCare enrollees and the financial consequences of the public health emergency caused by the COVID-19 pandemic;

(5) Refunds, in proportion to the amount paid in, to covered hospitals based on:

(A) The payment of annual coverage assessments or penalties to the bureau through error, mistake, or a determination that the annual coverage assessment was invalidly imposed; or

(B) Circumstances where the bureau, in consultation with the Tennessee Hospital Association, has determined a lower coverage assessment would have been required to carry out the purposes of subdivisions (d)(1)-(4); and

(6) Payments authorized under rules promulgated by the bureau pursuant to § 71-5-2004(j)(2).

(e) The bureau shall modify the contracts with TennCare managed care organizations and otherwise take action necessary to assure the use and application of the assets of the maintenance of coverage trust fund, as described in subsection (d).

(f) The bureau shall submit requests to CMS to modify the medicaid state plan, the contractor risk agreements, and an applicable Section 1115 demonstration project, as necessary, to implement the requirements of this part.

(g) At quarterly intervals beginning September 1, 2021, the bureau shall submit a report to the finance, ways and means committees of the senate and the house of representatives, to the health and welfare committee of the senate, and to the health committee of the house of representatives, which report must include:

(1) The status, if applicable, of the determination and approval by CMS set forth in § 71-5-2003(b) of the annual coverage assessment;

(2) The balance of funds in the maintenance of coverage trust fund; and

(3) The extent to which the maintenance of coverage trust fund has been used to carry out this part.

(h) Notwithstanding another provision of law, no part of the maintenance of coverage trust fund must be diverted to the general fund or used for a purpose other than as set forth in this part.

71-5-2006. Expiration of part — Survival of certain rights and obligations.

This part expires on July 1, 2022. However, the following rights and obligations survive the expiration:

(1) The authority of the bureau to impose late payment penalties and to collect unpaid annual coverage assessments and required refunds;

(2) The rights of a covered hospital or an association of covered hospitals to file a petition for declaratory order to determine compliance with this part;

(3) The existence of the maintenance of coverage trust fund and the obligation of the bureau to use and apply the assets of the maintenance of coverage trust fund; and

(4) The obligation of the bureau to implement and maintain the requirements of § 71-5-161.

71-5-2007. Audit of expenditure of funds from maintenance of coverage trust fund.

The comptroller of the treasury may audit the expenditure of funds pursuant to this part from the maintenance of coverage trust fund. At the discretion of the comptroller of the treasury, the audit may be prepared by a certified public accountant, a public accountant, or the department of audit. Notwithstanding § 71-5-2005, the bureau of TennCare and the maintenance of coverage trust fund must bear the full costs of the audit.

SECTION 2. Tennessee Code Annotated, Section 71-5-2005(d), is amended by adding the following as a new subdivision:

(6) Other programs and initiatives developed by the bureau in consultation with the Tennessee Hospital Association to offset the unreimbursed costs of providing services to TennCare enrollees and the financial consequences of the public health emergency caused by the COVID-19 pandemic.

SECTION 3. 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 4. SECTION 2 of this act takes effect upon becoming a law, the public welfare requiring it. SECTION 1 and SECTION 3 of this act takes effect June 30, 2021, at 11:59 p.m., the public welfare requiring it.

House Insurance Subcommittee Am. #1

FILED
Date ________
Time ________
Clerk ________
Comm. Amdt. ______
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Amendment No.________________

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Signature of Sponsor

AMEND Senate Bill No. 425* **House Bill No. 1379**

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. Short title.

This part is known and may be cited as the "Tennessee Pro-Family Building Act."

56-7-3502. Part definitions.

As used in this part:

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

(2) "Diagnosis of infertility" means the services, procedures, testing, or medications recommended by a licensed physician that are consistent with established, published, or approved medical practices or professional standards or guidelines from the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology for diagnosing and treating infertility;

(3) "Fertility treatment" means healthcare services, procedures, testing, medications, treatments, and/or products, including genetic testing and assisted reproductive technologies such as oocyte retrievals, in vitro fertilization, and fresh and frozen embryo transfers, provided with the intent to achieve a pregnancy that results in a live birth with healthy outcomes;

(4) "Health carrier" means an entity subject to the insurance laws this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to

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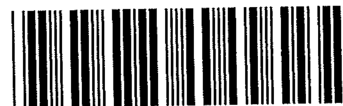
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provide, deliver, arrange for, pay for, or reimburse the costs of healthcare services, including an insurance company, a health maintenance organization, a health service corporation, or another entity providing a plan of health insurance, health benefits, or health services;

(5) "Infertility" means a disease or condition characterized by:

(A) The failure to conceive a pregnancy or to carry a pregnancy to live birth;

(B) A person's inability to cause pregnancy and live birth either as an individual or with the person's partner; or

(C) A licensed physician's findings and statement based on a patient's medical history, sexual and reproductive history, age, physical findings, or diagnostic testing;

(6) "Medically necessary" means healthcare services or products that are provided in a manner that is:

(A) Consistent with the findings and recommendations of a licensed physician, based on a patient's medical history, sexual and reproductive history, age, partner, physical findings, and/or diagnostic testing;

(B) Consistent with generally accepted standards of medical practice as set forth by a professional medical organization with a specialization in an aspect of reproductive health, including, but not limited to, the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists; or

(C) Clinically appropriate in terms of type, frequency, extent, site, and duration;

(7) "Monitoring" includes ultrasounds, laboratory testing, and other diagnostic tests;

(8) "Standard fertility preservation services" means services, procedures, testing, medications, treatments, and products that are consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility; and

(9) "Third-party reproductive care for the benefit of the enrollee" means the use of eggs, sperm, or embryos that are donated to the enrollee or partner by a donor, or the use of a gestational carrier, to achieve a live birth with healthy outcomes.

56-7-3503. Diagnosis of infertility, fertility treatment, and fertility preservation.

(a) On or after January 1, 2023, a health carrier that issues or renews a health insurance policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide coverage for the expenses of the diagnosis of infertility, fertility treatment, and standard fertility preservation services.

(b) Coverage must include:

(1) Three (3) completed cycles of intrauterine insemination, in accordance with the standards and guidelines of the American Society for Reproductive Medicine, when recommended by a physician as medically necessary;

(2) Fertility treatment and standard fertility preservation services, necessary to achieve two (2) live births, or a maximum of four (4) completed egg retrievals with unlimited fresh and frozen embryo transfers, in accordance with the guidelines of the American Society for Reproductive Medicine, and using no more than two (2) embryos per transfer, when recommended by a physician as medically necessary;

(3) Diagnosis of infertility, fertility treatment, and standard fertility preservation services, including third-party reproductive care for the benefit of the enrollee or partner;

(4) Fertility treatment consisting of a method of causing pregnancy other than sexual intercourse that is provided with the intent to create a legal parent-child relationship between the enrollee and the resulting child;

(5) Standard fertility preservation services, including the procurement, cryopreservation, and storage of gametes, embryos, or other reproductive tissue, and standard fertility preservation services when the enrollee has a diagnosed medical condition, or genetic condition, that may directly or indirectly cause impairment of fertility now or in the future by affecting reproductive organs or processes. For the purposes of this subdivision (5), "may directly or indirectly cause" means that the disease itself, or the necessary treatment, has a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology; and

(6) Medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with an individual's religious or ethical beliefs.

(c) This section shall not be construed to deny the included coverage in this section to any enrollee who foregoes a particular fertility treatment or standard fertility preservation service if the enrollee's physician determines that such fertility treatment or standard fertility preservation service is likely to be unsuccessful.

56-7-3504. Prohibited and permissible limitations on coverage.

(a) The diagnosis of infertility, fertility treatment, and standard fertility preservation services covered by the health carrier must be performed at facilities that conform to the standards and guidelines developed by the American Society for

Reproductive Medicine, the American College of Obstetricians and Gynecologists, the American Society of Clinical Oncology, or other reputable professional medical organizations.

(b) A health carrier shall make coverage for the diagnosis of infertility, fertility treatment, and standard fertility preservation services available to all individuals, including, but not limited to, those who enter coverage during special enrollment or open enrollment periods.

(c) Coverage for the diagnosis of infertility, fertility treatment, and standard fertility preservation services shall be in accordance with the standards or guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology, when recommended by a physician as medically necessary. Making, issuing, circulating, or causing to be made, issued, or circulated, clinical guidelines that are based upon data that are not reasonably current or do not cite with specificity shall constitute unfair and deceptive act and practice in the business of insurance, subject to the Tennessee Consumer Protection Act of 1977, compiled in title 47, chapter 18.

(d) Coverage for fertility treatment and fertility preservation services is limited to persons who are forty-four (44) years of age or less;

(e) This section's coverage requirements do not apply to:

(1) The TennCare program or any successor program; and

(2) A managed care organization's TennCare health plan.

(f) A health carrier shall not limit benefits under this section based upon:

(1) Co-payments, deductibles, coinsurances, benefit maximums, waiting periods, or other limitations on coverage that are different than maternity benefits provided by the health carrier;

(2) Exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on other prescription medications by the health carrier;

(3) A requirement that provides different benefits to, or imposes different requirements upon, a class protected under title 4, chapter 21, than that provided to or required of other patients; or

(4) A pre-existing condition exclusion, pre-existing condition waiting periods on coverage for required benefits, or prior diagnosis of infertility, fertility treatment, or standard fertility preservation services.

SECTION 2. Tennessee Code Annotated, Section 47-18-104(b), is amended by adding the following as a new subdivision:

(53) Violating § 56-7-3504(c).

SECTION 3. For the purpose of promulgating rules, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect January 1, 2023, the public welfare requiring it, and applies to plans entered into, issued, amended, or renewed on or after that date.

House Insurance Subcommittee Am. #1

Amendment No._______________

FILED
Date ________
Time ________
Clerk ________
Comm. Amdt. ______
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Signature of Sponsor

AMEND Senate Bill No. 1271 **House Bill No. 1015***

by deleting all language after the enacting clause and substituting:

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

56-62-101. Chapter definitions.

As used in this chapter:

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

(2) "Department" means the department of commerce and insurance;

(3) "Discount plan":

(A) Means a card, or other purchasing mechanism or device, that is not insurance and purports to offer discounts or access to discounts to a member for dental services, vision services, or retail purchases of prescription drugs from licensed pharmacies; and

(B) Does not include:

(i) A discount card or drug benefit plan provided by a self-insured employer's group health benefits plan;

(ii) A discount plan offered by an insurer licensed under this title in conjunction with health insurance;

(iii) A dental service plan regulated by the Dental Service Plan Law, 1961, compiled in chapter 30 of this title; or

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(iv) A vision service plan regulated by the Vision Service Plan Law, compiled in chapter 31 of this title;

(4) "Marketer" means a person or entity that offers, sells, markets, advertises, or otherwise distributes a discount plan, including a private label entity that places its name on, and markets or distributes, a discount plan pursuant to a marketing agreement with a discount plan operator;

(5) "Member" means an individual who pays fees, dues, charges, or other consideration for the right to enroll to receive the purported benefits of a discount plan;

(6) "Operator":

(A) Means a person that engages as principal in the business of offering, selling, marketing, advertising, or otherwise distributing a discount plan within this state; and

(B) Does not include discount cards offered by a nonprofit association to its members as an incidental benefit to membership in the association as long as that membership in the association entitles members to apply for insurance or other health benefits that are available only to members of the association;

(7) "Person" means an individual, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, limited liability company, similar entity, or combination of these entities; and

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

56-62-102. Certificate of registration required by operator of discount plan — Application.

(a) An operator of a discount plan must obtain a valid certificate of registration from the commissioner. A certificate of registration is not required for a marketer. A certificate of registration is valid for one (1) year from the date of issuance. In order to

receive a valid certificate of registration, an operator must file an application on a form adopted by the commissioner and provide, or demonstrate, to the commissioner the following:

(1) The name and principal place of business of the operator; and

(2) The name and address of the agent in this state for service of process.

(b) Notwithstanding any law to the contrary, it is a violation of this chapter for an operator, on or after August 1, 2022, to sell, market, promote, advertise, or otherwise distribute a discount plan in this state without first complying with the registration provisions of this chapter and complying with §§ 47-18-2701 and 47-18-2702.

56-62-103. Information required to be provided to members.

(a) A discount card or materials distributed on behalf of a discount plan covered under this chapter must expressly provide, in bold and reasonably prominent type, that the card or plan does not constitute insurance. The card or distributed materials must also contain a toll-free number for customer service and provide the operator's corporate name and a website address, if applicable.

(b) The operator must provide a prospective member, prior to becoming a member, with a complete description of the fees that a member of the plan could be assessed, including one-time non-refundable processing fees, upfront fees, or membership fees associated with the plan, along with the estimated average savings typically associated with the plan's general terms and conditions.

(c) An operator must provide a member with:

(1) An annually updated network directory of participating pharmacies, dentists, and vision care providers or access to the information online or by a toll-free number;

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(2) An annually updated list of the prescription drugs covered by the card or plan or access to the information online, by a toll-free number, or by way of a notation that the plan is an open formulary; and

(3) A toll-free number for customer service.

56-62-104. Cancellation by members.

(a) A member has the right to cancel membership in a plan within thirty (30) days of joining the plan and has the right to have refunded membership fees paid during that initial membership, except for a one-time nominal processing fee.

(b) After the initial thirty-day membership period, a member has the right to cancel membership, in accordance with the policies established by the operator. An operator must provide information concerning the cancellation policy to the member at the time of the initial membership and cannot change the cancellation policy unless the operator provides the member with written notice at least thirty (30) days prior to the date the change takes effect.

56-62-105. Additional consumer protections.

(a) An operator or marketer shall not:

(1) Describe or characterize the discount plan as being insurance;

(2) Use or approve for use in its cards or distributed materials the terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead an individual into believing that the discount plan is health insurance;

(3) Make misleading, deceptive, or fraudulent representations regarding the discount or range of discounts offered by the discount plan; or

(4) Pay pharmacies, dentists, or vision care providers fees for healthcare services or collect or accept money from a member to pay a pharmacy, dentist, or vision care provider for healthcare services provided under the discount

medical plan, unless the operator or marketer has an active certificate of authority to act as a third-party administrator.

(b) An operator shall approve in writing, prior to the marketer's use, all cards and distributed materials used by marketers to offer, sell, market, advertise, or otherwise distribute the discount plan.

56-62-106. Violations — Penalties.

(a) As part of an examination or investigation, the commissioner may request, and the operator or marketer shall provide, copies of materials that are distributed to prospective members.

(b) After notice and hearing, the commissioner may levy an administrative penalty, in an amount up to ten thousand dollars ($10,000), for each violation of this chapter. Each day of a continuing violation constitutes a separate violation for purposes of this chapter.

SECTION 2. Tennessee Code Annotated, Sections 56-57-103, 56-57-104, 56-57-105, and 56-57-106, are amended by deleting the sections and substituting:

56-57-103.

A prescription drug discount plan issued pursuant to § 56-57-102 is subject to regulation by the department and compliance with laws applicable to pharmacy discount cards, including, but not limited to, chapter 62 of this title.

SECTION 3. 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 4. For the purpose of promulgating rules, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect July 1, 2021, the public welfare requiring it.

House Insurance Subcommittee Am. #1

Amendment No._______________

FILED
Date __________
Time __________
Clerk __________
Comm. Amdt. ______
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Signature of Sponsor

AMEND Senate Bill No. 429* **House Bill No. 620**

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 56-7-1003(a)(6), is amended by adding the following as a new subdivision:

(C) Notwithstanding subdivisions (a)(6)(A) and (B), includes Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) compliant audio-only conversation for the provision of behavioral health services when the means described in subdivision (a)(6)(A) are unavailable;

SECTION 2. Tennessee Code Annotated, Section 56-7-1003(a)(6)(A), is amended by deleting the word "Accessibility" and substituting the word "Accountability".

SECTION 3. This act takes effect upon becoming a law, the public welfare requiring it, and applies to services delivered on or after the effective date of this act.

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