House Insurance Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

AMEND Senate Bill No. 1276 **House Bill No. 556***

by deleting SECTION 2 and substituting:

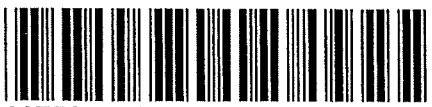
SECTION 2. Tennessee Code Annotated, Section 71-5-1003(c), is amended by deleting:

The total aggregated amount of assessments for all nursing facilities from July 1, 2020, through June 30, 2021, shall equal four and three-quarters percent (4.75%) of the net patient service revenue. The total aggregated amount of assessment for all nursing facilities, and the annual assessment determined for each nursing facility, shall be established on July 1 of each year. Once established, neither amount shall vary during each fiscal year. Each nursing facility shall have an annual assessment amount that shall be determined as follows:

and substituting:

The total aggregated amount of assessments for all nursing facilities from July 1, 2021, through June 30, 2022, is equal to four and three-quarters percent (4.75%) of the net patient service revenue. The total aggregated amount of assessment for all nursing facilities, and the annual assessment determined for each nursing facility, must be established on July 1 of each year. The bureau may allow for one (1) mid-year adjustment to be established prior to January 1. Once established, neither amount must vary during the fiscal year. Each nursing facility has an annual assessment amount that is determined as follows:

AND FURTHER AMEND by adding the following as a new SECTION 8 and renumbering the existing SECTION 8 and subsequent sections accordingly:



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SECTION 8. Tennessee Code Annotated, Section 71-5-1006(a), is amended by deleting the subsection and substituting:

(a) If a part of a quarterly assessment fee imposed by § 71-5-1003 is not paid on or before the due date, then a penalty of five percent (5%) of the unpaid fee balance accrues immediately and is added to the quarterly assessment fee. Thereafter, on the first day of each month during which a part of a quarterly assessment fee remains unpaid, an additional penalty of five percent (5%) of the original quarterly assessment fee balance is imposed. Payment is deemed to have been made upon date of deposit in the United States mail.

House Insurance Subcommittee Am. #1

Amendment No._____

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Date _____
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Comm. Amdt. _____

Signature of Sponsor

AMEND Senate Bill No. 1617* House Bill No. 1398

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 31, is amended by adding the following as a new section:

(a) A health insurance issuer, managed health insurance issuer as defined in § 56-32-128(a), pharmacy benefits manager, or other third-party payer shall not:

(1) Reimburse a 340B entity for pharmacy-dispensed drugs at a rate lower than the rate paid for the same drug by national drug code number to pharmacies that are not 340B entities;

(2) Assess a fee, chargeback, or adjustment upon a 340B entity that is not equally assessed on non-340B entities;

(3) Exclude 340B entities from its network of participating pharmacies based on criteria that is not applied to non-340B entities; or

(4) Require a claim for a drug by national drug code number to include a modifier to identify that the drug is a 340B drug.

(b) With respect to a patient eligible to receive drugs subject to an agreement under 42 U.S.C. § 256b, a pharmacy benefits manager, or third party that makes payment for those drugs, shall not discriminate against a 340B entity in a manner that violates § 56-7-2359 or otherwise prevents or interferes with the patient's choice to receive those drugs from the 340B entity.

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

(1) The TennCare program administered under the Medical Assistance Act of 1968, compiled in title 71, chapter 5, part 1, or a successor Medicaid program;

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

(3) The prescription drug program described in chapter 57 of this title, or a successor program.

(d) As used in this section:

(1) "340B entity" means a covered entity participating in the federal 340B drug discount program, as defined in section 340B of the Public Health Service Act, 42 U.S.C. § 256b, including the entity's pharmacy or pharmacies, or any pharmacy or pharmacies under contract with the 340B covered entity to dispense drugs on behalf of the 340B covered entity; and

(2) "National drug code number" means the unique national drug code number that identifies a specific approved drug, its manufacturer, and its package presentation.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 31, is amended by adding the following as a new section:

(a) A pharmacy benefits manager or a covered entity shall not require a person covered under a pharmacy benefit contract, that provides coverage for prescription drugs, including specialty drugs, to pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or other penalty when obtaining prescription drugs, including specialty drugs from a contracted pharmacy.

(b) A pharmacy benefits manager or a covered entity shall not interfere with the patient's right to choose a contracted pharmacy or contracted provider of choice in a manner that violates § 56-7-2359 or by other means, including inducement, steering, or offering financial or other incentives.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, Part 32, is amended by adding the following as a new section:

(a) Notwithstanding a law to the contrary, a pharmacy benefits manager or a covered entity shall base the calculation of any coinsurance or deductible for a prescription drug or device on the allowed amount of the drug or device. For purposes of this section, coinsurance or deductible does not mean or include copayments.

(b) Notwithstanding a law to the contrary, a pharmacy benefits manager shall not charge a covered entity an amount greater than the reimbursement paid by a pharmacy benefits manager to a contracted pharmacy for the prescription drug or device.

(c) Notwithstanding a law to the contrary, a pharmacy benefits manager shall not reimburse a contracted pharmacy for a prescription drug or device an amount that is less than the actual cost to that pharmacy for the prescription drug or device.

(d) As used in this section, "allowed amount" means the cost of a prescription drug or device after applying pharmacy benefits manager or covered entity pricing discounts available at the time of the prescription claim transaction.

SECTION 4. Tennessee Code Annotated, Title 56, Chapter 7, Part 32, is amended by adding the following as a new section:

A pharmacy benefits manager has a responsibility to report to the plan and the patient any benefit percentage that either are entitled to as a benefit as a covered person.

SECTION 5. Tennessee Code Annotated, Title 56, Chapter 7, Part 32, is amended by adding the following as a new section:

(a) A covered entity shall, upon request of an enrollee, enrollee's healthcare provider, or authorized third party, furnish the cost, benefit, and coverage data described in subsection (b) to the enrollee, the enrollee's healthcare provider, or an authorized third party, and shall ensure that the data is:

(1) Accurate as of the most recent change to the data that was made prior to the date of request;

(2) Provided in real time; and

(3) Provided in the format designated by the requesting party.

(b) A covered entity that receives a request for data that complies with subsection (a) shall provide the following data for each drug covered under the enrollee's health plan:

(1) The enrollee's eligibility information for the drug;

(2) A list of any clinically appropriate alternatives to drugs covered under the enrollee's health plan;

(3) Cost-sharing information for the drugs and the clinically appropriate alternatives; and

(4) Applicable utilization management requirements for the drugs or clinically appropriate alternatives, including prior authorization, step therapy, quantity limits, and site-of-service restrictions.

(c) A covered entity that furnishes data as provided in subsection (b) shall not:

(1) Restrict, prohibit, or otherwise hinder a healthcare provider from communicating or sharing with the enrollee or enrollee's authorized representative:

(A) The data set forth in subsection (b);

(B) Additional information on lower-cost or clinically appropriate alternative drugs, whether or not the drugs are covered under the enrollee's plan; or

(C) Additional payment or cost-sharing information that may reduce the patient's out-of-pocket costs, such as cash price or patient assistance, and support programs sponsored by a manufacturer, foundation, or other entity;

(2) Except as may be required by law, interfere with, prevent, or materially discourage access to, exchange of, or the use of the data set forth in subsection (b), including:

(A) Charging fees;

(B) Failing to respond to a request at the time made when such a response is reasonably possible;

(C) Implementing technology in nonstandard ways; or

(D) Instituting requirements, processes, policies, procedures, or renewals that are likely to substantially increase the complexity or burden of accessing, exchanging, or using the data; or

(3) Penalize a healthcare provider for:

(A) Disclosing the information described in subdivision (c)(1) to an enrollee; or

(B) Prescribing, administering, or ordering a clinically appropriate or lower-cost alternative drug.

SECTION 6. Sections 1–4 of this act take effect July 1, 2021, the public welfare requiring it. Section 5 of this act takes effect January 1, 2022, the public welfare requiring it, and applies to contracts entered into, executed, issued, amended, delivered, or renewed on or after those effective dates.

House Insurance Subcommittee Am. #1

Amendment No._____

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Date _____
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Comm. Amdt. _____
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Signature of Sponsor

AMEND Senate Bill No. 663* **House Bill No. 979**

by deleting all language after the enacting clause and substituting:

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

56-7-3501.

As used in this part:

(1) "Group disability income protection policy" means a short-term or long-term group disability income protection policy instituted by an employer that:

(A) Provides income replacement benefits to an employee who is limited from working, or unable to work, for an extended period of time because of an injury or sickness; and

(B) Requires an employee covered under the policy to pay a premium; and

(2) "Reasonable time period" means at least thirty (30) days prior to, and again at least ten (10) days prior to, the initial payroll deduction of an employee's premium.

56-7-3502.

(a) An employer, as defined in § 50-1-702, may pre-enroll an employee in a group disability income protection policy and commence payroll deductions to pay a premium without obtaining affirmative agreement from an employee, if:

(1) The employer discloses to the employee the terms of the group disability income protection policy, including the benefits, exclusions, and premiums payable under the policy; and

(2) The employer provides the employee with notice of the pre-enrollment and a reasonable time period for declining coverage under the policy.

(b) The information provided in accordance with subsection (a) must:

(1) Be in clear and conspicuous language; and

(2) Describe the process by which an employee may exercise the employee's right to decline coverage.

SECTION 2. Tennessee Code Annotated, Section 67-4-2009, is amended by designating the existing language as subsection (a) and adding the following as a new subsection (b):

(1) Except as provided in subdivision (b)(2), for tax years beginning on or after the effective date of this act, there is allowed to a taxpayer doing business in this state who has tax liability under this part a tax credit against the excise tax imposed by this part that is equal to:

(A) Thirty dollars ($30.00) per employee who is pre-enrolled in a long-term group disability income protection policy; plus

(B) Thirty dollars ($30.00) per employee who is pre-enrolled in a short-term group disability income protection policy.

(2) In no event may the tax credit described in subdivision (b)(1) equal more than sixty dollars ($60.00) per pre-enrolled employee.

(3) The credit provided in this subsection (b) is allowed:

(A) On the annual tax for the year in which an employee first enrolls in a group disability income protection policy as defined in § 56-7-3501; and

(B) On the annual tax for up to two (2) subsequent years, as long as the employee maintains enrollment in the group disability income protection policy for

at least six (6) months of the year for which the credit is claimed, or, if maintained for a period shorter than six (6) months, is maintained as of the last day of the tax year for which the credit is claimed.

(4) The commissioner may conduct an audit or require the filing of additional information necessary to substantiate or adjust the amount of credit taken by a taxpayer under this subsection (b).

SECTION 3. This act takes effect upon becoming a law, the public welfare requiring it.

House Insurance Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

AMEND Senate Bill No. 1038 House Bill No. 988*

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:

56-38-101. Chapter definitions.

As used in this chapter:

(1) "Air ambulance membership" or "air ambulance subscription" means a contract in which a consumer pays a fee to an entity in exchange for the entity either paying or waiving the out-of-pocket expenses that would otherwise be incurred by the consumer in connection with an air ambulance transport;

(2) "Air ambulance service" means ambulance services provided by a rotor or fixed-wing aircraft that is specifically designed for transporting a sick or injured person; and

(3) "Air carrier" means a person or entity that undertakes, by lease or other agreement, to directly engage in air transportation.

56-38-102. Air ambulance services.

(a) An air ambulance service or other entity engages in the business of insurance as an insurer if the air ambulance service or other entity directly or indirectly, whether acting through an affiliated entity, an agreement with a third-party entity, or otherwise:

(1) Solicits air ambulance memberships or air ambulance subscriptions;

(2) Accepts air ambulance membership or air ambulance subscription applications; or

(3) Charges air ambulance subscription or air ambulance membership fees for the purpose of covering the copayments, deductibles, post-service payments of costs incurred by third parties, or other cost-sharing amounts of a patient.

(b)

(1) An air ambulance membership or air ambulance subscription that covers the copayments, deductibles, post-service payments of costs incurred by third parties, or other cost-sharing amounts of a patient:

(A) Is insurance and an insurance product; and

(B) May be considered secondary insurance coverage or a supplement to insurance coverage.

(2) The department of commerce and insurance shall regulate as insurance an air ambulance membership or air ambulance subscription described in subdivision (b)(1).

SECTION 2. The commissioner of commerce and insurance is 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 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. This act takes effect upon becoming a law, the public welfare requiring it.

House Insurance Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

AMEND Senate Bill No. 1278 **House Bill No. 1258***

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 68, Chapter 11, Part 16, is amended by adding the following as a new section:

(a)

(1) There is created a health information committee for the purposes of:

(A) Facilitating data-driven, evidence-based improvements in access, quality, and cost of health care;

(B) Promoting and improving the public health through improved understanding of healthcare expenditure patterns and the operation and performance of the healthcare system; and

(C) Issuing reports based upon aggregated all payer claims database data to describe patterns of incidence and variation of targeted medical conditions, state and regional cost patterns, and the utilization of services.

(2) The powers and duties of the health information committee include:

(A) Establishing and operating the all payer claims database as described in § 56-2-125; and

(B) Promulgating rules necessary to effectuate this section and § 56-2-125, which must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5;

(b) The health information committee consists of eleven (11) members, as follows:

(1) The following individuals, who are voting members:

(A) The executive director of the health services and development agency, who serves as chair of the advisory committee;

(B) The commissioner of finance and administration, or the commissioner's designee;

(C) The comptroller of the treasury, or the comptroller's designee;

(D) One (1) representative of the hospital industry, appointed by the governor, who may be chosen from a list of eligible nominees from the Tennessee Hospital Association;

(E) One (1) physician, appointed by the governor, who may be chosen from a list of eligible nominees from the Tennessee Medical Association;

(F) One (1) representative of the health insurance industry, appointed by the speaker of the senate;

(G) One (1) representative of the health insurance industry, appointed by the speaker of the house of representatives;

(H) One (1) consumer representative, appointed by the speaker of the house of representatives; and

(I) One (1) consumer representative, appointed by the speaker of the senate; and

(2) The following individuals, who are non-voting members:

(A) One (1) member of the senate, appointed by the speaker of the senate; and

(B) One (1) member of the house of representatives, appointed by the speaker of the house of representatives.

(c)

(1) Initial members of the committee are appointed to staggered terms, as follows:

(A) The members appointed under subdivisions (b)(1)(D), (b)(1)(F), and (b)(1)(H) are appointed to serve initial terms of three (3) years; and

(B) The members appointed under subdivisions (b)(1)(E), (b)(1)(G), and (b)(1)(I) are appointed to serve initial terms of two (2) years.

(2) The terms of initial appointees to the committee commence on July 1, 2021. Subsequent appointments are for two-year terms that begin on July 1 and end on June 30.

(3)

(A) Legislative members of the committee appointed under subdivision (b)(2) are eligible for reappointment, and are eligible to serve only so long as they remain members of the general assembly.

(B) Members of the committee appointed under subdivisions (b)(1)(D)-(I) are eligible for reappointment, and each member appointed under subdivisions (b)(1)(D)-(I) may serve a maximum of three (3) two-year terms.

(4) The appointing authority designated in subsection (b) may remove a committee member for good cause.

(5)

(A) The appointing authority designated in subsection (b) shall fill a vacancy that occurs prior to the expiration of a committee member's unexpired term.

(B) A person appointed to fill a vacancy is appointed for the remainder of the predecessor's unexpired term.

(C) A person who serves a partial term as an appointee to fill a vacancy for a member described in subdivisions (b)(1)(D)-(I) remains eligible to serve three (3) two-year terms in addition to the unexpired term.

(6) A committee member shall not serve on the committee beyond the expiration of the member's term, regardless of whether a successor has been appointed.

(7) A majority of the members of the committee constitutes a quorum for the purpose of conducting business.

(8)

(A) The committee shall meet as frequently as the executive director deems necessary, but not less than once each year.

(B) Committee meetings may be conducted by electronic or telephonic means, as long as members have the ability to communicate via real-time audio during the meeting.

(9)

(A) Except as provided in subdivision (c)(9)(B), committee members serve without compensation, but are eligible for reimbursement for travel expenses in accordance with the comprehensive travel regulations as promulgated by the department of finance and administration and approved by the attorney general and reporter.

(B) The legislative members of the committee appointed under subdivision (b)(2) are eligible for reimbursement as members of the general assembly are paid for attending legislative meetings as provided in § 3-1-106.

(d) The health information committee is attached to the health services and development agency for administrative purposes.

(e) The health services and development agency is authorized, subject to the availability of federal funds, to develop, implement, and administer an all payer claims database according to rules and policies established by the health information committee. In developing the all payer claims database, the agency shall:

(1) Ensure uniform data collection by adopting the reporting format for self-insured group health plans established by the secretary of the United States department of labor;

(2) Ensure the privacy and security of data;

(3) Set clear standards for who may be authorized to access data, how the data may be requested, and how the data may be used; and

(4) Work with other state all payer claims databases to establish a single application process for access to data by authorized users across multiple state lines.

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

(a) As used in this section:

(1) "Agency" means the health services and development agency;

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

(3) "Executive director" or "director" means the executive director of the health services and development agency;

(4) "Group health plan":

(A) Means an employee welfare benefit plan, as defined in § 3(1) of the federal Employee Retirement Income Security Act of 1974 (ERISA)

(29 U.S.C. § 1002(1)), to the extent that the plan provides medical care to employees or their dependents, as defined under the terms of the plan, or an administrator of the plan; and

(B) Does not include:

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

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

(5) "Health information committee" or "committee" means the health information committee created by SECTION 1;

(6) "Health insurance coverage"

(A) Means a hospital and medical expense incurred policy, nonprofit healthcare service plan contract, health maintenance organization subscriber contract, or another healthcare plan or arrangement that pays for or furnishes medical or healthcare services, whether by insurance or otherwise;

(B) Includes, but is not limited to:

(i) Individual health benefit plans;

(ii) Fully insured, employer-sponsored insurance plans;

(iii) Workers' compensation insurance;

(iv) Pharmacy benefits;

(v) Dental insurance;

(vi) Vision insurance;

(vii) A state or local insurance program, under title 8, chapter 27;

(viii) Medicare Part C; and

(ix) Medicare supplemental health insurance; and

(C) Does not include:

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

(ii) Medicare Part A, B, or D; and

(7) "Health insurance issuer":

(i) Means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the department of commerce and insurance, that contracts or offers to contract to provide health insurance coverage; and

(ii) Includes, but is not limited to, an insurance company, a health maintenance organization, a nonprofit hospital and medical service corporation, a pharmacy benefits manager, a third-party administrator, the state medicaid program, a managed care organization that contracts with the state medicaid program to administer enrollee benefits, and an entity described in § 56-2-121.

(b)

(1) The health information committee shall establish and maintain an all payer claims database to carry out the following duties:

(A) Improving the accessibility, adequacy, and affordability of patient health care and healthcare coverage;

(B) Identifying health and healthcare needs and informing health and healthcare policy;

(C) Determining the capacity and distribution of existing health care resources;

(D) Evaluating the effectiveness of intervention programs on improving patient outcomes;

(E) Reviewing costs among various treatment settings, providers, and approaches; and

(F) Providing publicly available information on healthcare providers' quality of care.

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

(c)

(1) As required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d et seq.), the all payer claims database shall not publicly disclose individually identifiable health information as defined in 45 CFR 160.103. Use of the all payer claims database is subject to restrictions required by HIPAA and other applicable privacy laws and policies. The all payer claims database may only be accessed by health information committee members, the executive director, authorized agency staff, and designated entities authorized in writing by the executive director to perform the analyses contemplated by this section. The health information committee shall develop procedures and safeguards to protect the integrity and confidentiality of data contained in the all payer claims database.

(2)

(A)

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

10-7-503. The information contained in the all payer claims database is confidential and not subject to subpoena.

(ii) The health information committee may promulgate rules to authorize the public release of reports derived from the information contained in the all payer claims database. The release of a report does not result in the information losing its confidentiality or cause it to be admissible in a legal proceeding, except in administrative proceedings authorized under the rules adopted by the health information committee.

(B) The health information committee shall, through memoranda of understanding, allow the use of the all payer claims database by the department of finance and administration, the department of health, the department of mental health and substance abuse services, the department of intellectual and developmental disabilities, the bureau of TennCare, the department of labor and workforce development, other departments of state government, and other entities authorized by this part for the purposes listed in subsection (b) and SECTION 1(a).

(C) Except for the health information committee, executive director, authorized agency staff, and authorized vendors permitted by subdivision (c)(1), this part does not permit access to or discovery of the source or draft information used to construct or populate the all payer claims database.

(d)

(1)

(A) No later than January 1, 2023, and thereafter on a quarterly basis, group health plans and health insurance issuers shall provide electronic health insurance claims data for state residents to the

executive director or a designated entity authorized by the executive director, in accordance with standards and procedures recommended by the health information committee pursuant to SECTION 1 and adopted by the health information committee by rule.

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

(C) The health information committee shall strive to establish standards and procedures that are the least burdensome for data submitters. The health information committee has the authority to delegate the establishment of these standards and procedures to the executive director, and it is the intent of the general assembly that the committee exercise that delegation authority.

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

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

(4) If a group health plan or health insurance issuer fails to submit required data to the executive director on a timely basis, then the executive director may impose a civil penalty of up to one thousand dollars ($1,000) for each day of delay.

(5) A self-funded or self-insured plan that uses a health insurance issuer to administer plan benefits may provide electronic health insurance claims data

for state residents to the executive director or a designated entity authorized by the executive director for inclusion in the all payer claims database.

(6) The health information committee shall obtain data for Medicare Part A, B, and D for inclusion in the all payer claims database.

(e)

(1) The health information committee, in the committee's discretion, may allow some group health plans and health insurance issuers to submit data on a biannual basis. The health information committee has authority to delegate the exercise of this discretion to the executive director, and it is the intent of the general assembly that the committee exercise that delegation authority.

(2) The health information committee may establish by rule exceptions to the reporting requirements of this section for entities based upon an entity's size or amount of claims or other relevant factors deemed appropriate, which may include that reporting would pose an unreasonable burden on the entity. The committee shall annually review an exception that has been granted to an entity for a determination of whether the entity still qualifies for the exception.

(f) Beginning January 1, 2024, and no later than January 1 each year thereafter, the health information committee shall submit a report to the commerce and labor committee of the senate, the health and welfare committee of the senate, the insurance committee of the house of representatives, and the health committee of the house of representatives on the status of the all payer claims database, including observed trends in healthcare costs and quality, and any recommendations for improvements to the database.

(g) A health plan or health insurance issuer that submits data to the all payer claims database pursuant to this section is not liable for a release of that data from the all payer claims database due to a data breach by a vendor or entity of this state.

(h) The health information committee shall ensure that a contract with a vendor requires that at the conclusion or termination of the contract the vendor shall:

(1) Provide to the committee a copy of the final version of all data collected by the vendor from the all payer claims database;

(2) Delete all data from the vendor's systems; and

(3) Provide the committee with certification that all of the data obtained from the all payer claims database has been removed from the vendor's systems.

(i)

(1) The health information committee shall adopt a nationally recognized, common data layout for purposes of data submission to the all payer claims database.

(2) The committee shall not adopt a new data submission layout format more often than once every two (2) years.

(3) Following the adoption of a new data submission layout format by the committee, the entities required to submit data to the all payer claims database under this section shall begin using the new data submission layout format within one hundred twenty (120) days of the date the committee provides notice to the entities of the change.

(j) Data submitted to and contained in the all payer claims database is the exclusive property of this state. The committee shall ensure that data in the all payer claims database is not sold to another party.

(k) The health information committee may, in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, promulgate rules for the purpose of implementing this section. The committee may promulgate initial rules as emergency rules pursuant to § 4-5-208, prior to July 1, 2021, for the purpose of establishing the all payer claims database.

SECTION 3. Tennessee Code Annotated, Section 4-29-244(a), is amended by adding the following as a new subdivision:

( ) Health information committee, created by SECTION 1;

SECTION 4. If any provision of this act or its application 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 5. For the purposes of promulgating rules, making appointments, and initiating the procurement process, 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._____

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Date _____
Time _____
Clerk _____
Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 151* **House Bill No. 360**

by deleting all language after the caption and substituting:

WHEREAS, mental health parity remains a challenging compliance effort; and

WHEREAS, in March 2019, the United States District Court of Northern California issued its findings of facts and conclusions of law in the class action *Wit v. United Behavioral Health*; and

WHEREAS, the United States District Court of Northern California determined United Behavioral Health had prioritized financial considerations over patients' needs by wrongfully denying coverage to over 50,000 patients, half of whom were children and adolescents, using flawed utilization review criteria that were inconsistent with generally accepted standards of care in order to "mitigate" against the federal Mental Health Parity and Addiction Equity Act of 2008; and

WHEREAS, medical necessity and utilization review criteria should not put financial considerations ahead of patients' needs; and

WHEREAS, it is important for the health of the citizens of the State of Tennessee to receive mental health insurance coverage that is consistent with generally accepted standards of care; now, therefore,

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

SECTION 1. Tennessee Code Annotated, Section 56-7-2360, is amended by deleting the section and substituting:

(a)

(1) As used in this section:

(A) "Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits under a health plan with respect to an individual or other coverage unit;

(B) "Annual limit" means a dollar limitation on the total amount that may be paid for benefits in a twelve-month period under a health plan with respect to an individual or other coverage unit;

(C) "Classification of benefits" means:

(i) Inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drug benefits, and emergency care benefits; and

(ii) The only classifications that may be used, except that there may be sub-classifications within both outpatient classifications differentiating office visits from other outpatient items and services, including outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items;

(D) "Financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit;

(E) "Health benefit plan" means a hospital or medical expense policy, health, hospital, or medical service corporation contract, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer, other plans administered by the state government, or a certificate issued under the policies, contracts, or plans;

(F) "Health insurance carrier" means an entity subject to this title, or subject to the jurisdiction of the commissioner of commerce and insurance, that contracts with healthcare providers in connection with a plan of health insurance, health benefits, or health services;

(G) "Mental health or alcoholism or drug dependency benefits" means benefits for the treatment of a condition or disorder that involves a mental health condition or substance use disorder that:

(i) Falls under the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Disease; or

(ii) Is listed in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;

(H) "Non-quantitative treatment limitations" or "NQTLs":

(i) Means limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. For purposes of this subdivision (a)(1)(H), fail-first or step therapy protocols do not include formulary designs that require the prescription, use, and a showing of ineffectiveness of generic drugs prior to approval of payment for the prescription of higher cost drugs; and

(ii) Include:

(a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(b) Formulary design for prescription drugs;

(c) Tier design for plans with multiple network tiers, including preferred providers and participating providers, and network tier design;

(d) Standards for provider admission to participate in a network, including reimbursement rates;

(e) Plan methods for determining usual, customary, and reasonable charges;

(f) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective, that are also known as fail-first policies or step therapy protocols;

(g) Exclusions based on failure to complete a course of treatment;

(h) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(i) In- and out-of-network geographic limitations;

(j) Standards for providing access to out-of-network providers;

(k) Limitations on inpatient services for situations where the participant is a threat to self or others;

(l) Exclusions for court-ordered and involuntary holds;

(m) Experimental treatment limitations;

(n) Service coding; and

(o) Exclusions for services provided by clinical social workers;

(I) "Predominant" means application to more than one-half (1/2) of such type of limit or requirement;

(J) "Substantially all" means application to at least two-thirds (2/3) of all medical or surgical benefits in a classification; and

(K) "Treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(2) In addition to any other requirement of law concerning coverage of mental health or mental illness benefits or alcoholism or drug dependency benefits, including, but not limited to, §§ 56-7-2601 and 56-7-2602, an individual or group health benefit plan issued by a health insurance carrier regulated pursuant to this title shall provide coverage for mental health or alcoholism or drug dependency services in compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (42 U.S.C. § 300gg-26) and 45 CFR § 146.136 and 45 CFR § 147.160.

(b) Subsection (a) does not prohibit an employee health benefit plan, or a plan issuer offering an individual or group health plan from utilizing managed care practices for the delivery of benefits required under this section, as long as that for an utilization review or benefit determination for the treatment of alcoholism or drug dependence the clinical review criteria is the most recent Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine or other evidence-based clinical guidelines, such as those referenced by the federal substance abuse and mental health services administration (SAMHSA). Additional criteria, other than in this subsection (b), must not be used during utilization review or benefit determination for treatment of substance use disorders.

(c) The mandate to provide coverage for mental health services does not apply with respect to a group health plan if the application of the mandate to the plan results in an increase in the cost under the plan of more than one percent (1%). Documentation of the increase in cost must be filed with the department after twelve (12) months of experience. If the commissioner determines that the increase in cost is a result of the requirements of this section, then the commissioner or the commissioner's designee shall issue a letter to the issuer of the plan stating that the plan does not have to comply with the mandate set out in this section. The issuer may appeal the letter as final agency action pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(d) The department of commerce and insurance shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, this section, and §§ 56-7-2601 and 56-7-2602, that include:

(1) Ensuring compliance by individual and group health benefit plans;

(2) Detecting possible violations of the law by individual and group health benefit plans;

(3) Accepting, evaluating, and responding to complaints regarding such violations; and

(4) Maintaining and regularly reviewing for possible parity violations a publicly available consumer complaint log regarding mental health or alcoholism or drug dependency coverage as long as individually identifiable information is excluded.

(e) Not later than January 31, 2022, and each year thereafter, the department shall issue a report to the general assembly and provide an educational presentation to the general assembly. The department shall request from the United States department of labor and the United States department of health and human services copies of the

NQTL analyses submitted to the departments the previous year in compliance with the federal Consolidated Appropriations Act of 2021 (Pub.L. 116–260) and incorporate these analyses into the report. The report and presentation must:

(1) List health plans sold in this state and over which of these plans the department has jurisdiction;

(2) Discuss the methodology the department is using to check for compliance with the MHPAEA, and any federal regulations or guidance relating to the compliance and oversight of the MHPAEA, including 45 CFR 146.136;

(3) Discuss the methodology the department uses to check for compliance with this section and §§ 56-7-2601 and 56-7-2602;

(4) Identify market conduct examinations and full scope examinations conducted or completed during the preceding twelve-month period and summarize the results of the examinations. Individually identifiable information must be excluded from the reports consistent with federal privacy protections, including, but not limited to, 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67. This discussion must include:

(A) The number of full scope examinations and market conduct examinations initiated and completed;

(B) The benefit classifications examined by each market conduct examination and full scope examination;

(C) The subject matter of each market conduct examination, including quantitative and non-quantitative treatment limitations;

(D) A summary of the basis for the final decision rendered in each market conduct examination; and

(E) Any examination regarding compliance with parity in mental health or alcoholism or drug dependency benefits under state and federal laws;

(5) Detail educational or corrective actions the department of commerce and insurance has taken to ensure health benefit plan compliance with this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-7-2602;

(6) Detail the department's educational approaches relating to informing the public about mental health or alcoholism or drug dependence parity protections under state and federal law; and

(7) Describe how the department examines any provider or consumer complaints related to denials or restrictions for possible violations of this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-7-2602, including complaints regarding, but not limited to:

(A) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary;

(B) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested;

(C) Denials of requests, authorizations, pre-authorizations, prior authorizations, concurrent reviews, or claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication;

(D) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary;

(E) Step therapy requirements imposed before buprenorphine or naltrexone are approved;

(F) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine; and

(G) Denial of in-network authorization or denials of out-of-network services or claims where there is not an in-network provider within seventy-five (75) miles of the insured patient's home.

(f) The report issued pursuant to subsection (e) must be written in non-technical, readily understandable language and be made available to the public by posting the report on the department's website and by other means as the department finds appropriate. The name and identity of the health insurance carrier must be given confidential treatment, may not be made public by the commissioner or another person, and are not subject to public inspection pursuant to § 10-7-503.

(g) Benefits under this section shall not be denied for care for confinement provided in a hospital owned or operated by this state that is especially intended for use in the diagnosis, care, and treatment of psychiatric, mental, or nervous disorders.

(h) This section does not apply to accident-only, specified disease, hospital indemnity, medicare supplement, long-term care, or other limited benefit hospital insurance policies.

(i) The commissioner is authorized to promulgate rules to effectuate the purposes of this section. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(j) This section does not require the disclosure of information that would violate 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it, and applies to plans entered into, issued, renewed, or amended on or after the effective date of this act.