House Insurance Subcommittee Am. #1

Amendment No._____

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

Signature of Sponsor

AMEND Senate Bill No. 1351 House Bill No. 875*

by deleting all language after the enacting clause and substituting:

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

56-7-3501.

As used in this part:

(1) "Catastrophic health plan" means an individual health benefit plan that provides coverage through a reinsurance pool established under this part and that does not provide a bronze, silver, gold, or platinum level of coverage under the federal act;

(2) "Federal act" means the federal Patient Protection and Affordable Care Act (42 U.S.C. § 18011 et seq.);

(3) "Secretary" means the secretary of the United States department of health and human services; and

(4) "State innovation waiver" means a waiver of one (1) or more requirements of the federal act as authorized by § 1332 of the federal act.

56-7-3502.

(a) The commissioner shall, no later than one hundred eighty (180) days after the effective date of this act, apply to the secretary for a five-year state innovation waiver in accordance with § 1332 of the federal act and 45 C.F.R. 155 to waive § 1303(e) of the federal act and 45 C.F.R. 156.155 to enable insurance carriers in this state to offer catastrophic health plans through a reinsurance pool to an individual residing in this

state for plan years starting on or after January 1, 2023. The waiver application must clearly state that:

(1) Offering catastrophic health plans to individuals who do not meet a hardship requirement is contingent on approval of the waiver request;

(2) Health benefit plans issued in accordance with the waiver may only be offered and sold through qualified health insurance carriers in this state as determined by the commissioner; and

(3) Health benefit plans issued in accordance with the waiver are not eligible for advanced premium tax credits.

(b) The commissioner shall ensure that the waiver application submitted pursuant to this part complies with the requirements specified in § 1332 of the federal act and 45 C.F.R. 155.1308.

56-7-3503.

(a) The commissioner shall make the draft waiver application available for public review by posting a copy on the department's website on or before December 1, 2021. The commissioner shall submit the waiver application to the secretary on or before January 1, 2022.

(b) The commissioner shall notify the following of federal actions regarding the waiver request:

(1) The chair of the health committee of the house of representatives and the chair of the health and welfare committee of the senate;

(2) The chairs of the finance, ways and means committees of the house of representatives and the senate;

(3) The speakers of the house of representatives and the senate; and

(4) The governor.

(c) Notwithstanding a law to the contrary, if the secretary approves the waiver requested in accordance with this part, then insurance carriers may offer catastrophic

health plans to individuals residing in this state in accordance with rules adopted pursuant to § 56-7-3504.

56-7-3504.

If the secretary approves the waiver requested in accordance with this part, then the commissioner shall promulgate rules:

(1) Creating a reinsurance pool to be funded by the fund created under § 56-7-3505;

(2) Establishing the manner in which insurance carriers may offer catastrophic health plans consistent with the waiver and this part to residents of this state; and

(3) Providing for the administration of the fund.

56-7-3505.

(a) If the secretary approves the waiver requested in accordance with this part, then a revolving fund is created in the general fund to be accounted for separately, beginning on the date on which the waiver is approved by the secretary. The fund is funded by grants, contributions, appropriations, and other moneys made available for the purpose of the fund.

(b) The fund must be administered in accordance with rules adopted pursuant to § 56-7-3504.

56-7-3506.

If the secretary denies the waiver requested under this part or, after approval, denies an application to extend the waiver, then this part is repealed effective on the date of the denial of the waiver or application to extend the waiver.

SECTION 2. The commissioner of commerce and insurance shall transmit to the executive secretary of the Tennessee Code Commission a copy of a denial of a waiver or extension issued by the secretary of health and human services.

SECTION 3. 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. 603 **House Bill No. 636***

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 "Health Benefit Plan Network Access and Adequacy Act."

56-7-3502. Purpose.

The purpose of this part is to:

(1) Establish standards for the creation and maintenance of networks by health carriers; and

(2) Assure the adequacy, accessibility, transparency, and quality of healthcare services offered under a network plan by:

(A) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide covered services to covered persons; and

(B) Requiring health carriers to maintain and follow access plans that consist of policies and procedures for assuring the ongoing sufficiency of provider networks consistent with § 56-7-3505, including requirements in § 56-7-3505(e) related to its availability to the public.

56-7-3503. Part definitions.

As used in this part:

(1) "Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person;

(B) A person authorized by law to provide substituted consent for a covered person; or

(C) If the covered person is unable to provide consent:

(i) The covered person's treating healthcare professional; or

(ii) A family member of the covered person;

(2) "Balance billing" means the practice of a provider billing for the difference between the provider's charge and the health carrier's allowed amount;

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

(4) "Covered benefit" or "benefit" means those healthcare services to which a covered person is entitled under the terms of a health benefit plan;

(5) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(6) "Emergency medical condition" means a physical, mental, or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(A) Placing the individual's physical, mental, or behavioral health or, with respect to a pregnant woman, the woman's or her unborn child's health in serious jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious impairment of a bodily organ or part; or

(D) With respect to a pregnant woman who is having contractions:

(i) That there is inadequate time to effectuate a safe transfer to another hospital before delivery; or

(ii) That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(7) "Emergency services" means, with respect to an emergency condition:

(A) A medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(B) Further medical or mental health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient;

(8) "Essential community provider" or "ECP" means a provider that:

(A) Serves predominantly low-income, medically underserved individuals, including a healthcare provider that falls within the definition of a covered entity as defined in § 340B(a)(4) of the Public Health Service Act (PHSA) (42 U.S.C. § 256b(a)(4)); or

(B) Is described in § 1927(c)(1)(D)(i)(IV) of the Social Security Act (42 U.S.C. § 1396r-8(c)(1)(D)(i)(IV));

(9) "Facility" means an institution providing physical, mental, or behavioral healthcare services or a healthcare setting, including, but not limited to, hospitals and other licensed inpatient centers; ambulatory surgical treatment centers; skilled nursing centers; residential treatment centers; urgent care centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings;

(10) "Family member" means a spouse, parent, grandparent, stepmother, stepfather, child, grandchild, brother, sister, half-brother, half-sister, adopted child, or the spouse's parents;

(11) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse the costs of physical, mental, or behavioral healthcare services;

(12) "Healthcare professional" means a physician or other healthcare practitioner licensed, accredited, or certified pursuant to title 63 or title 68, chapter 24, part 6, to perform specified physical, mental, or behavioral healthcare services consistent with their scope of practice under state law;

(13) "Healthcare provider" or "provider" means a healthcare professional, a pharmacy, or a facility;

(14) "Healthcare services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental, or behavioral health condition, illness, injury, or disease, including mental health and substance use disorders;

(15) "Health carrier" or "carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse the costs of healthcare services, including a health insurance company, a health maintenance organization, a hospital and

health service corporation, or another entity providing a plan of health insurance, health benefits, or healthcare services;

(16) "Intermediary":

(A) Means a person authorized to negotiate and execute provider contracts with health carriers on behalf of healthcare providers or on behalf of a network; and

(B) Includes a pharmacy benefits manager;

(17) "Limited scope dental plan" means a plan that provides coverage substantially all of which is for treatment of the mouth, including an organ or structure within the mouth, which is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan;

(18) "Limited scope vision plan" means a plan that provides coverage substantially all of which is for treatment of the eye that is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan;

(19) "Network" means the group or groups of participating providers providing services under a network plan;

(20) "Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, healthcare providers managed, owned, under contract with, or employed by the health carrier;

(21) "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide healthcare services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(22) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, a similar entity, or a combination of the foregoing;

(23) "Primary care" means healthcare services for a range of common physical, mental, or behavioral health conditions provided by a physician or non-physician primary care professional;

(24) "Primary care professional" means a participating healthcare professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of healthcare services rendered to the covered person;

(25) "Specialist":

(A) Means a physician or non-physician healthcare professional who:

(i) Focuses on a specific area of physical, mental, or behavioral health or a group of patients; and

(ii) Has successfully completed required training and is recognized by the state in which the physician or non-physician healthcare professional practices to provide specialty care; and

(B) Includes a subspecialist who has additional training and recognition above and beyond the subspecialist's specialty training;

(26) "Specialty care" means advanced medically necessary care and treatment of specific physical, mental, or behavioral health conditions or those health conditions that may manifest in particular ages or subpopulations and that are provided by a specialist, preferably in coordination with a primary care professional or other healthcare professional;

(27) "Telemedicine" or "telehealth" means the use of real time audio, video, or other electronic media and telecommunication technology that enables interaction between a healthcare provider and a patient, or also store-and-forward telemedicine services as defined in § 56-7-1002, for the purpose of diagnosis, consultation, or treatment of a patient at a distant site where there may be no in-person exchange between a healthcare provider and a patient;

(28) "To stabilize" means, with respect to an emergency medical condition, to provide medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth, with no complications resulting in a continued emergency, to deliver the child and the placenta;

(29) "Transfer" means, for purposes of subdivision (28), the movement, including the discharge, of an individual outside a hospital's facilities at the direction of a person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(A) Has been declared dead; or

(B) Leaves the facility without the permission of such person; and

(30) "Without unreasonable travel or delay" means within not more than thirty-miles distance or thirty-minutes travel time at a reasonable speed.

56-7-3504. Applicability.

(a) Except as provided in subsections (b) and (c), this part applies to health carriers that offer network plans.

(b) The following do not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) Section 56-7-3505(a)(2);

(2) Section 56-7-3505(f)(7)(E), (f)(8)(B), and (f)(11);

(3) Section 56-7-3506(l)(2)(A)(i)*(a)* and (*b*) and (l)(2)(C)(iii)*(c)*;

(4) Section 56-7-3507;

(5) Section 56-7-3508(b)(2) and (3); and

(6) Section 56-7-3508(c)(1)(A) and (B), (c)(2), and (c)(3).

(c) This part does not apply to:

(1) The TennCare program or a successor to the program provided for in the Medical Assistance Act of 1968, compiled in title 71, chapter 5; and

(2) The CoverKids or a successor to the program provided for in the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11.

56-7-3505. Network adequacy.

(a)

(1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) Covered persons must have access to emergency services twenty-four (24) hours per day, seven (7) days per week.

(b) The commissioner shall determine sufficiency in accordance with this section and may establish sufficiency by reference to reasonable criteria, including:

(1) Provider-covered person ratios by specialty;

(2) Primary care professional-covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons; children and adults with serious, chronic, or complex health conditions or physical or mental disabilities; or persons with limited English proficiency;

(8) Other healthcare service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering care;

(9) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services;

(10) The extent to which participating providers are accepting new patients;

(11) The degree to which participating physicians are authorized to admit patients to participating hospitals and hospital-based providers are participating providers; and

(12) The regionalization of specialty care, which may require some children and adults to cross state lines for care.

(c)

(1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

(A) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(B) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2)

(A) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider as provided in subdivision (c)(1) when:

(i) The covered person is diagnosed with a condition or disease that requires specialized healthcare services or medical services; and

(ii) The health carrier:

(a) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide healthcare services for the condition or disease; or

(b) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide healthcare services for the condition or disease without unreasonable travel or delay.

(B) For purposes of this subdivision (c)(2):

(i) "Disability" means, with respect to a person:

(*a*) A physical or mental impairment that substantially limits one (1) or more of such person's major life activities;

(*b*) A record of having such an impairment; or

(c) Being regarded as having such an impairment; and

(ii) "Specialized healthcare services or medical services" includes the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.

(3) The health carrier shall treat the healthcare services the covered person receives from a non-participating provider pursuant to subdivision (c)(2) as if the services were provided by a participating provider, including counting the covered person's cost-sharing for the services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described under subdivisions (c)(1) and (2) must ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person's condition.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-participating provider under this subsection (c) and shall provide this information:

(A) Upon request, to the commissioner; and

(B) In an annual report to the commerce and labor committee of the senate, the insurance committee of the house of representatives, and the legislative librarian.

(6) The process established in this subsection (c) must not be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with this part, and must not be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) This section does not prevent a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

(8) A health carrier shall make its process under this subsection (c) available in writing to covered persons and to the commissioner, in a form and manner the commissioner may specify by rule.

(d)

(1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this subdivision (d)(1), the commissioner shall give due consideration to the relative availability of healthcare providers with the requisite expertise and training in the service area under consideration.

(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

(3) If the commissioner determines that there is a deficiency in access to care for a limited scope dental or vision plan, then the commissioner may work with the health carrier for approval of in-network reimbursements to covered persons.

(e)

(1) Beginning July 1, 2021, a health carrier shall file with the commissioner for review and approval prior to or at the time it files a newly offered network, in a manner and form defined by rule of the commissioner, an access plan in compliance with this part.

(2)

(A) The health carrier may request the commissioner to deem sections of the access plan, but not the entire plan, as proprietary, competitive, or trade secret information that must not be made public. The health carrier shall make the access plans, absent proprietary, competitive, or trade secret information, available online, at its business premises, and to a person upon request. The access plans must be annually updated and kept current of changes.

(B) For the purposes of this subdivision (e)(2), information is proprietary, competitive, or trade secret information if revealing the information would cause the health carrier's competitors to obtain valuable business information.

(3)

(A) The health carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of a material change to an existing network plan within fifteen (15) business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which the carrier will submit to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.

(B) For purposes of subdivision (e)(3)(A), "material change" includes:

(i) A fifteen-percent or more reduction in the number of primary or specialty care physicians available in a network;

(ii) A reduction in a specific type of provider such that a specific covered service is no longer available;

(iii) A change to the tiered, multi-tiered, layered or multi-level network plan structure; or

(iv) A change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased.

(f) The access plan must describe or contain at least the following:

(1) The health carrier's network, including how the use of telemedicine, telehealth, or other technology may be used to meet network access standards, if applicable;

(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the healthcare needs of populations that enroll in network plans;

(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select or tier providers;

(5) The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy; diverse cultural or ethnic backgrounds; physical or mental disabilities; and serious, chronic, or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;

(6) The health carrier's methods for assessing the healthcare needs of covered persons and their satisfaction with services;

(7) The health carrier's method of informing covered persons of the plan's covered services and features, including, but not limited to:

(A) The plan's grievance and appeals procedures;

(B) The plan's process for choosing and changing providers;

(C) The plan's process for updating its provider directories for each of its network plans;

(D) A statement of healthcare services offered, including those services offered through the preventive care benefit, if applicable; and

(E) The plan' procedures for covering and approving emergency, urgent, and specialty care, if applicable;

(8) The health carrier's system for ensuring the coordination and continuity of care:

(A) For covered persons referred to specialty physicians; and

(B) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

(10) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner;

(11) The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology and laboratory services at their participating hospitals;

(12) Information on the health carrier's efforts to ensure that its participating providers meet available and appropriate quality of care standards

and health outcomes for network plans that the health carrier has designed to include providers that have high quality of care and health outcomes; and

(13) Other information required by the commissioner to determine compliance with this part.

56-7-3506. Requirements for health carriers and participating providers.

(a) A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered healthcare services for which the provider will be responsible, including limitations or conditions on services.

(b) A contract between a health carrier and a participating provider must set forth a hold harmless provision and adhere to federal and state law concerning the negotiation of out-of-network services rendered for health benefit plans not covered by the Employee Retirement Income Security Act (ERISA)(29 U.S.C. § 1001 et seq.).

(c) A contract between a health carrier and a participating provider must set forth that if a health carrier or intermediary insolvency or other cessation of operations occurs, then the provider shall:

(1) Offer similar services to the formerly covered persons by entering into a direct medical care agreement to offer direct medical services to the formerly covered persons in accordance with the Health Care Empowerment Act, compiled in title 63, chapter 1, part 5; and

(2) Notify the formerly covered persons of any change to out-of-network status that would occur pursuant to federal law or state law concerning surprise billing.

(d)

(1) The contract provisions that satisfy subsections (b) and (c) must be construed in favor of the covered person; must survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier or intermediary; and must supersede an oral or written contrary

agreement between a provider and a covered person, or the representative of a covered person, if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by subsections (b) and (c).

(2) The hold harmless obligation and continuation of covered services provisions under subsections (b) and (c) do not apply to services rendered after the termination of the provider contract, except to the extent that the network relationship is extended to provide continuity of care under subsection (l).

(e) A participating provider shall not collect or attempt to collect from a covered person money owed to the provider by the health carrier.

(f)

(1) Health carrier selection standards for selecting and tiering, as applicable, of participating providers must be developed for providers and each health care professional specialty.

(2)

(A) The standards must be used in determining the selection and tiering of participating providers by the health carrier and its intermediaries with which it contracts.

(B) The standards must meet the requirements of § 56-7-1001.

(3)

(A) A health carrier shall not establish selection and tiering criteria in a manner:

(i) That would allow a health carrier to discriminate against high-risk populations by excluding and tiering providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses, or healthcare services utilization; or

(ii) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses, or healthcare services utilization.

(B)

(i) In addition to subdivision (f)(3)(A), a health carrier's selection criteria must not discriminate with respect to participation under the health benefit plan against a provider who is acting within the scope of the provider's license or certification under applicable state law or rules.

(ii) Subdivision (f)(3)(B)(i) does not require a health carrier to contract with a provider willing to abide by the terms and conditions for participation established by the carrier.

(4) Subdivision (f)(3) does prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this part.

(5) This part does not require a health carrier, its intermediaries, or the provider networks with which they contract to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under § 56-7-3505.

(g) A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review and approval by the commissioner. A health carrier shall make a description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, available to the general public.

(h) A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including, but not limited to, payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and applicable federal or state programs.

(i) A health carrier shall not offer an inducement to a provider that would encourage or otherwise incent the provider to deliver less than medically necessary services to a covered person.

(j) A health carrier shall not prohibit a participating provider from discussing specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier or in accordance with rights or remedies available under applicable state or federal law.

(k) A contract between a health carrier and a participating provider must require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of, or amend their medical and health records.

(l)

(1)

(A) A health carrier and participating provider shall provide written notice at least sixty (60) days in advance to each other before the provider is removed or leaves the network without cause.

(B) The health carrier shall make a good faith effort to provide written notice of a provider's removal or leaving the network within thirty (30) days of receipt or issuance of a notice provided in accordance with subdivision (l)(1)(A) to covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause.

(C) If the provider being removed or leaving the network is a primary care professional, then covered persons who are patients of that primary care professional must also be notified.

(2)

(A) As used in this subdivision (l)(2):

(i) "Active course of treatment" means:

(a) An ongoing course of treatment for a life-threatening condition;

(b) An ongoing course of treatment for a serious acute condition;

(c) The second or third trimester of pregnancy; or

(d) An ongoing course of treatment for a health condition for which a treating physician or healthcare provider attests that discontinuing care by that physician or healthcare provider would worsen the condition or interfere with anticipated outcomes;

(ii) "Life-threatening health condition" means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; and

(iii) "Serious acute condition" means a disease or condition requiring complex on-going care that the covered person

is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy.

(B) For purposes of subdivision (l)(2)(A)(i), a covered person must have been treated by the provider being removed or leaving the network on a regular basis to be considered in an active course of treatment.

(C)

(i) If a covered person's provider leaves or is removed from the network, then a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

(ii) The health carrier shall provide the notice required under subdivision (l)(1), and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered person may request continuity of care as provided under this subdivision (l)(2).

(iii) The procedures must provide that:

(a) A request for continuity of care must be made to the health carrier by the covered person or the covered person's authorized representative;

(b) Requests for continuity of care must be reviewed by the health carrier's medical director after consultation with the treating provider for patients who meet the criteria listed in this subdivision (l)(2) and are under the care of a provider who has not been removed or leaving the network for cause. Decisions made with

respect to a request for continuity of care are subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law, rules, or regulations;

(c) The continuity of care period for covered persons who are in their second or third trimester of pregnancy extend through the postpartum period; and

(d) The continuity of care period for covered persons who are undergoing an active course of treatment extend to the earlier of:

(1) The termination of the course of treatment by the covered person or the treating provider;

(2) Ninety (90) days, unless the medical director determines that a longer period is necessary;

(3) The date that care is successfully transitioned to a participating provider;

(4) Benefit limitations under the plan are met or exceeded; or

(5) Care is not medically necessary.

(iv) In addition to subdivision (l)(2)(C)(iii)*(d)*, a continuity of care request shall only be granted if the provider agrees in writing not to seek payment from the covered person for an amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

(m) The rights and responsibilities under a contract between a health carrier and a participating provider must not be assigned or delegated by either party without the prior written consent of the other party.

(n) A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of healthcare services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(o) A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

(p) A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities an act or practice by the health carrier that jeopardizes patient health or welfare.

(q)

(1) A health carrier shall establish a mechanism by which participating providers may determine at the time services are provided whether or not an individual is a covered person or is within a grace period for payment of health insurance premium.

(2) If the provider relies on the health carrier's network participation mechanism and the mechanism represents that the individual is a covered person, then the provider shall bill the health carrier for the services provided, except for a co-pay, deductible, or co-insurance that is the responsibility of the individual receiving the service.

(3) If the provider relies on the health carrier's network participation mechanism and the mechanism represents that the individual is within a grace period for payment of the individual's health insurance premium, then the provider may, at the provider's discretion:

(A) Bill the individual's health carrier for the services provided, except for a co-pay, deductible, or co-insurance that is the responsibility of the individual receiving the service, in which case any timely filing requirement imposed by the health carrier is tolled for ninety (90) days after payment of the premium; or

(B) Bill the individual directly for the services provided, including a co-pay, deductible, or co-insurance that is the responsibility of the individual receiving the service, and any balance owed for the service capped at the contracted rate. If the individual pays the premium within the grace period, then the health carrier is authorized to recoup the amount owed to it from the individual.

(r) A health carrier shall establish procedures for resolution of administrative, payment, or other disputes between providers and the health carrier.

(s) A contract between a health carrier and a provider must not contain provisions that conflict with the provisions contained in the network plan or with this part.

(t)

(1)

(A) At the time the contract is signed, a health carrier and, if appropriate, an intermediary, shall notify a participating provider of provisions and other documents incorporated by reference in the contract and provide instructions as to how to access them.

(B) While the contract is in force, the carrier shall notify a participating provider of changes to those provisions or documents that

would result in material changes in the contract at least ninety (90) days prior to the effective date of the change.

(2) A health carrier shall inform a provider of the provider's network participation status within five (5) days of approval.

(u) A health carrier offering a network plan shall satisfy the requirements contained in this section.

56-7-3507. Disclosure and notice requirements.

(a)

(1) A health carrier shall develop a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification, if applicable, for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network, or twenty-four (24) hours before the medical service is rendered, whichever is longer, that there is the possibility that the covered person could be treated by a healthcare professional that is not in the same network.

(2)

(A) The disclosure or notice must indicate that:

(i) The covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a healthcare professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility; and

(ii) Information on what the covered person's plan will pay for the covered services provided by a non-participating

healthcare professional is available on request from the health carrier.

(B) The disclosure or notice also must inform the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

(b) For non-emergency services, as a requirement of its provider contract with a health carrier, a facility shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment, but not more than one (1) business day before an appointment, for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist, or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network.

56-7-3508. Provider directories.

(a)

(1)

(A) A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described in subsection (c).

(B) In making the directory available electronically, the carrier shall ensure that the general public is able to view the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2)

(A) The health carrier shall update each network plan provider directory at least monthly.

(B) The health carrier shall periodically audit at least a reasonable sample size of its provider directories, in accordance with department rules, for accuracy and retain documentation of that audit to be made available to the commissioner upon request.

(3) A health carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in subsection (b) upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following:

(A) A description of the criteria the carrier has used to build its provider network;

(B) If applicable, a description of the criteria the carrier has used to tier providers;

(C) If applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(D) If applicable, note that authorization or referral may be required to access some providers.

(5)

(A) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(B) The health carrier shall include in both its electronic and print directories a customer service email address, telephone number, and electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

(6) For the pieces of information required pursuant to subsections (b), (c), and (d) in a provider directory pertaining to a healthcare professional, a hospital, or a facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, must accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) The health carrier shall make available through an electronic provider directory, for each network plan, the following information in a searchable format:

(1) For healthcare professionals:

(A) Name;

(B) Gender;

(C) Participating office locations;

(D) Specialty, if applicable;

(E) Medical group affiliations, if applicable;

(F) Facility affiliations, if applicable;

(G) Participating facility affiliations, if applicable;

(H) Languages spoken other than English, if applicable; and

(I) Whether accepting new patients;

(2) For hospitals:

(A) Hospital name;

(B) Hospital type, such as acute, rehabilitation, children's, or cancer;

(C) Participating hospital location; and

(D) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:

(A) Facility name;

(B) Facility type;

(C) Types of services performed; and

(D) Participating facility locations.

(c) For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to the information available under subsection (b):

(1) For healthcare professionals:

(A) Contact information;

(B) Board certifications; and

(C) Languages spoken other than English by clinical staff, if applicable;

(2) For hospitals: telephone number; and

(3) For facilities other than hospitals: telephone number.

(d)

(1) The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

(A) For healthcare professionals:

(i) Name;

(ii) Contact information;

(iii) Participating office locations;

(iv) Specialty, if applicable;

(v) Languages spoken other than English, if applicable; and

(vi) Whether accepting new patients;

(B) For hospitals:

(i) Hospital name;

(ii) Hospital type, such as acute, rehabilitation, children's, or cancer; and

(iii) Participating hospital location and telephone number; and

(C) For facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility locations and telephone number.

(2) The health carrier shall include a disclosure in the directory that the information in subdivision (d)(1) included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website or call its customer service telephone number to obtain current provider directory information.

56-7-3509. Intermediaries.

(a) Intermediaries and participating providers with whom they contract shall comply with the applicable requirements of § 56-7-3506.

(b) A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

(c) A health carrier has the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

(d) A health carrier shall maintain copies of intermediary healthcare subcontracts at its principal place of business in this state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

(e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and healthcare services received by covered persons.

(f) If applicable, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in this state and preserve them in a manner that facilitates statutorily required regulatory review.

(g) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information, and documentation of services provided to covered persons, as necessary to determine compliance with this part.

(h) A health carrier has the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier shall remain obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

(i) Notwithstanding this section, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier retains full responsibility for the intermediary's compliance with this part.

(j) A contract between a health carrier and an intermediary must satisfy the requirements contained in this section.

56-7-3510. Filing requirements and state administration.

(a) At the time a health carrier files its access plan, the health carrier shall file for approval with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

(b) A health carrier shall submit material changes to a contract that would affect a provision required under this part or implementing rules to the commissioner for approval prior to use.

(c) If the commissioner takes no action within sixty (60) days after submission of a contract or a material change to a contract by a health carrier, then the contract or change is deemed approved.

(d) The health carrier shall maintain provider and intermediary contracts at its principal place of business in this state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

56-7-3511. Contracting.

(a) The execution of a contract by a health carrier does not relieve the health carrier of its liability to a person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable rules.

(b) Contracts must be in writing and subject to review by the department and the contracting party.

(c) Contracts must comply with applicable requirements of the law and applicable rules.

56-7-3512. Enforcement.

(a) If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have

accessible healthcare services in a geographic area, or that a health carrier's network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this part, or that a health carrier has not complied with this part, then the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that the health carrier shall follow, or may use the commissioner's other enforcement powers to obtain the health carrier's compliance with this part.

(b) The commissioner shall not act to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding another dispute between a health carrier, its intermediaries, or one (1) or more providers arising under or by reason of a provider contract or its termination.

56-7-3513. Rules.

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

56-7-3514. Penalties.

A violation of this part is a Class A misdemeanor, subject only to a fine not less than five hundred dollars ($500) nor more than five thousand dollars ($5,000).

SECTION 2. Tennessee Code Annotated, Section 56-7-122, is amended by deleting the section.

SECTION 3. Tennessee Code Annotated, Section 56-7-2356, is amended by deleting the section.

SECTION 4. Tennessee Code Annotated, Section 56-32-103(e), is amended by deleting "§ 56-7-2356" and substituting "the Health Benefit Plan Network Access and Adequacy Act, compiled in chapter 7, part 35 of this title".

SECTION 5. Tennessee Code Annotated, Section 56-51-106(b), is amended by deleting "§ 56-7-2356" and substituting "the Health Benefit Plan Network Access and Adequacy Act, compiled in chapter 7, part 35 of this title".

SECTION 6. 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 7. For the promulgation of rules and § 56-7-3505(e) in SECTION 1, 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 plans and contracts entered into, issued, amended, or renewed on or after that date.

House Insurance Subcommittee Am. #1

Amendment No._____

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

_____

Signature of Sponsor

AMEND Senate Bill No. 1* **House Bill No. 2**

by deleting all language after the enacting clause and substituting:

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

56-33-101. Purpose.

The purpose of this chapter is to alleviate the effects of a "balance bill" received by a patient for healthcare services performed by out-of-network healthcare providers.

56-33-102. Adoption of no surprises act.

(a) To hold patients harmless from incurring an unanticipated balance medical bill, this chapter adopts the process established by the federal No Surprises Act (26 U.S.C. § 9816), as set out in the federal Consolidated Appropriations Act, 2021 (Pub. L 116-260), for this state in order to address a patient who receives an unexpected medical bill that arises from receiving care from certain out-of-network providers.

(b) This chapter constitutes the "specified state law" as the term is used in the federal Consolidated Appropriations Act, 2021.

56-33-103. Applicability.

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

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

(c) This chapter does not apply to:

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

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

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

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

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

56-33-104. Qualifying payment amount.

(a) The department of commerce and insurance shall ensure verification of the median of the contracted rates recognized by the plan based on data for commercial health plans compiled in the state's all payer claims database established pursuant to § 56-2-125.

(b) Notwithstanding § 56-2-125, the rates described in subsection (a) must be made available upon request to healthcare providers receiving payment for claims covered by this chapter and to health benefit plans and health carriers that make payment to healthcare providers covered by this chapter.

56-33-105. Additional IDR consideration.

In addition to the considerations set out in 26 U.S.C.A. § 9816(c)(5)(C)(ii), the certified IDR entity shall consider the fact that the amount of the qualified payment to the

healthcare provider does not include benefits and remuneration afforded to in-network providers, such as patient volume and steerage.

SECTION 2. Tennessee Code Annotated, Section 56-2-125(d)(2)(A), is amended by adding the following as a new subdivision:

(iii) Prior to January 1, 2022, the commissioner shall promulgate rules to authorize the release of reports on the median of the contracted rates recognized by a health plan pursuant to § 53-33-104 derived from the information. A release of reports does not result in the information losing its confidentiality or cause the information to be admissible in proceedings, except for those authorized in chapter 33, part 1 of this title.

SECTION 3. The headings 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 purposes of Section 1, this act takes effect January 1, 2022, the public welfare requiring it. For all other purposes, this act takes effect upon becoming a law, the public welfare requiring it.