Amendment No. 1 to HB1503

Kumar
Signature of Sponsor

AMEND Senate Bill No. 1345 House Bill No. 1503*

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:

56-34-101. Short title.

This chapter is known and may be cited as the "Surprise Billing Consumer Protection Act."

56-34-102. Chapter definitions.

As used in this chapter:

(1) "Balance bill" means the amount that:

(A) A nonparticipating provider charges for services provided to a covered person; and

(B) Equals the difference between the amount paid or offered by the insurer and the amount of the nonparticipating provider's bill charge, excluding any amount for coinsurance, copayments, or deductibles due by the covered person;

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

(3) "Contracted amount" means:

(A) Before July 1, 2024, the median in-network amount paid during the 2019 calendar year by an insurer for the emergency or nonemergency services provided by in-network providers engaged in the

same or similar specialties and provided in the same or nearest geographical area; and

(B) On or after July 1, 2024, the median in-network amount as described in subdivision (3)(A) as annually adjusted by the department for inflation, which may be based on the consumer price index, but must not include medicare or medicaid rates;

(4) "Covered person" means an individual who is insured under a healthcare plan;

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

(6) "Emergency medical provider" means:

(A) A physician who is licensed pursuant to title 63, chapter 6 or 9, and who provides emergency medical services; or

(B) A healthcare provider licensed or otherwise authorized in this state to render emergency medical services;

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

(8) "Facility" means a hospital, an ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution;

(9) "Geographic area" means a specific portion of this state that consists of one (1) or more zip codes as defined by the commissioner pursuant to rule;

(10) "Healthcare plan":

(A) Means a hospital or medical insurance policy or certificate, healthcare plan contract or certificate, qualified higher deductible health plan, health maintenance organization or other managed care subscriber contract, or state healthcare plan; and

(B) Does not include limited benefit insurance policies or plans; air ambulance insurance; policies issued relating to workers'

compensation; Part A, B, C, or D of Title XVIII of the Social Security Act (Medicare); or a plan or program not described in this subdivision (10)(B) over which the commissioner does not have regulatory authority;

(11) "Healthcare provider" or "provider" means a healthcare professional licensed, authorized, certified, or permitted under title 63, chapter 6 or 9;

(12) "Healthcare services" means emergency or nonemergency medical services;

(13) "Insurer" means an entity subject to this title, or subject to the jurisdiction of the commissioner, that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including those of an accident and sickness insurance company, a health maintenance organization, a healthcare plan, a managed care plan, or any other entity providing a health insurance plan, a health benefit plan, or healthcare services;

(14) "Nonemergency medical services":

(A) Means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from an illness, injury, or other human physical problem that does not qualify as an emergency medical service; and

(B) Includes:

(i) Hospital services that include the general and usual care, services, supplies, and equipment furnished by hospitals;

(ii) Medical services that include the general and usual care and services rendered and administered by doctors of medicine, dentistry, optometry, and other providers; and

(iii) Other medical services that, by way of illustration only and without limiting the scope of this chapter, include the provision

of appliances and supplies; nursing care by a registered nurse; institutional services, including the general and usual care, services, supplies, and equipment furnished by healthcare institutions and agencies or entities other than hospitals; physiotherapy; drugs and medications; therapeutic services and equipment, including oxygen and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and appliances, including wheelchairs, trusses, braces, crutches, and prosthetic devices, including artificial limbs and eyes; and any other appliance, supply, or service related to health care which does not qualify as an emergency medical service;

(15) "Nonparticipating provider" means a healthcare provider who has not entered into a contract with a healthcare plan for the delivery of medical services;

(16) "Out-of-network" refers to healthcare services provided to a covered person by providers or facilities that do not belong to the provider network in the healthcare plan;

(17) "Participating provider" means a healthcare provider that has entered into a contract with an insurer for the delivery of healthcare services to covered persons under a healthcare plan;

(18) "Resolution organization" means a qualified, independent, third-party claim dispute resolution entity selected by and contracted with the department;

(19) "State healthcare plan" means an insurance plan established pursuant to title 8, chapters 34-37; and

(20) "Surprise bill" means a bill resulting from an occurrence in which charges arise from a covered person receiving healthcare services from an out-of-network provider at an in-network facility.

56-34-103. Application of chapter.

(a) This chapter applies to all insurers providing a healthcare plan that pays for the provision of healthcare services to covered persons.

(b) This chapter is not applicable to healthcare plans that are subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.).

(c) This chapter applies to healthcare plans and state healthcare plans.

(d) This chapter does not apply to:

(1) A policy of insurance issued pursuant to a contract with the bureau of TennCare;

(2) TennCare or a successor program provided for in title 71, chapter 5;

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

(4) Ground or air ambulance services.

56-34-104. Emergency medical services; participating and nonparticipating providers.

(a) An insurer that provides benefits to covered persons with respect to emergency medical services shall pay for those emergency medical services:

(1) Without the need for a prior authorization determination and without retrospective payment denial for medically necessary services;

(2) Regardless of whether the healthcare provider or facility furnishing emergency medical services is a participating provider or facility with respect to emergency medical services; and

(3) In accordance with this chapter.

(b)

(1) If a covered person receives the provision of emergency medical services from a nonparticipating emergency medical provider, then the nonparticipating provider shall collect or bill no more than the person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by the person's policy directly, and the insurer shall directly pay the provider the greater of:

(A) The verifiable contracted amount paid by all eligible insurers subject to this chapter for the provision of the same or similar services as determined by the commissioner by rule;

(B) The most recent verifiable amount agreed to by the insurer and the nonparticipating emergency medical provider for the provision of the same services during such time as the provider was in-network with the insurer; or

(C) A higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

(2) An amount that the insurer pays the nonparticipating provider under this subsection (b) is not required to include any amount of coinsurance, copayment, or deductible owed by the covered person or already paid by the covered person.

(c) A healthcare plan shall not deny benefits for emergency medical services previously rendered based upon a covered person's failure to provide subsequent notification in accordance with plan provisions, where the covered person's medical condition prevented timely notification.

(d) For purposes of the covered person's financial responsibilities, the healthcare plan must treat the emergency medical services received by the covered person from a nonparticipating provider or nonparticipating facility pursuant to this section as if the

services were provided by a participating provider or participating facility, and must include applying the covered person's cost-sharing for the services toward the covered person's deductible and maximum out-of-pocket limit applicable to services obtained from a participating provider or a participating facility under the healthcare plan.

(e) If a covered person receives emergency medical services from a nonparticipating facility, then the nonparticipating facility shall bill the covered person no more than the covered person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by the person's policy directly.

(f) All insurer payments made to providers pursuant to this section must accompany notification to the provider from the insurer disclosing whether the healthcare plan is subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.).

56-34-105. Nonemergency medical services.

(a) In accordance with this chapter, an insurer that provides benefits to covered persons with respect to nonemergency medical services shall pay for the services in the event that the services resulted in a surprise bill regardless of whether the healthcare provider furnishing nonemergency medical services is a participating provider with respect to nonemergency medical services.

(b)

(1) If a covered person receives a surprise bill for the provision of nonemergency medical services from a nonparticipating medical provider, then the nonparticipating provider shall collect or bill the covered person no more than the person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by the person's policy directly, and the insurer shall directly pay the provider the greater of:

(A) The verifiable contracted amount paid by all eligible insurers subject to this chapter for the provision of the same or similar services as determined by the department;

(B) The most recent verifiable amount agreed to by the insurer and the nonparticipating provider for the provision of the same services during such time as the provider was in-network with the insurer; or

(C) A higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

(2) An amount that the insurer pays the nonparticipating provider under this subsection (b) is not required to include any amount of coinsurance, copayment, or deductible owed by the covered person or already paid by the covered person.

(c) For purposes of the covered person's financial responsibilities, the healthcare plan must treat the nonemergency medical services received by the covered person from a nonparticipating provider pursuant to this section as if the services were provided by a participating provider, and must include applying the covered person's cost-sharing for the services toward the covered person's deductible and maximum out-of-pocket limit applicable to services obtained from a participating provider under the healthcare plan.

(d) All insurer payments made to providers pursuant to this section must accompany notification to the provider from the insurer disclosing whether the healthcare plan is subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001, et seq.).

(e) Notwithstanding other law to the contrary, this section does not affect a covered person's financial responsibilities or a nonparticipating facility's rights with respect to nonemergency medical services received from a nonparticipating facility.

56-34-106. Denial or restriction of covered benefits due to balance bill from treatment from a nonparticipating provider.

A healthcare plan must not deny or restrict the provision of covered benefits from a participating provider to a covered person solely because the covered person obtained treatment from a nonparticipating provider leading to a balance bill. The insurer shall provide notice of such protection in writing to the covered person.

56-34-107. Financial responsibilities – nonemergency medical services from an out-of-network provider.

(a) This chapter does not reduce a covered person's financial responsibilities in the event that the covered person chose to receive nonemergency medical services from an out-of-network provider. Those services are not considered a surprise bill for purposes of this chapter.

(b) The covered person's choice as described in subsection (a) must:

(1) Be documented through the covered person's written and oral consent in advance of the provision of the services; and

(2) Occur only after the covered person has been provided with an estimate of the potential charges.

(c) If, during the provision of nonemergency medical services, a covered person requests that the attending provider refer the covered person to another provider for the immediate provision of additional nonemergency medical services, then the referred provider is exempt from the requirements in subsection (b) if the following requirements are satisfied:

(1) The covered person orally and in writing acknowledges being aware that the referred provider may be a nonparticipating provider and may charge higher fees than a participating provider; and

(2) The written acknowledgment referenced in subdivision (c)(1) is on a document separate from other documents provided by the referring provider and includes language to be determined by the commissioner by rule.

56-34-108. All-payer health claims database; records.

(a) Subject to appropriation, the department shall provide for the maintenance of an all-payer health claims database that maintains records of insurer payments and tracks the payments by a wide variety of healthcare services and by geographic areas of this state. The appropriation must specifically reference this act. The department shall update information in the all-payer health claims database on no less than an annual basis and shall maintain the information on the department's website.

(b) If the appropriation described in subsection (a) is not made, then the department has the authority to acquire, receive, or collect all such data necessary to determine the contracted amounts for specific services from an independent benchmarking database not affiliated with or owned by an insurance carrier or healthcare provider. The department shall update information as the commissioner determines appropriate and shall maintain the information on the department's website. The department has the authority to promulgate rules as necessary to comply with this section.

56-34-109. Request for arbitration.

(a) If an out-of-network provider or out-of-network facility concludes that payment received from an insurer is not sufficient given the complexity and circumstances of the services provided, then the provider or facility may initiate a request for arbitration with the commissioner. The provider or facility shall submit the request within sixty (60) days of receipt of payment for the claim and concurrently provide the insurer with a copy of the request.

(b) A request for arbitration may involve a single patient and a single type of healthcare service, a single patient and multiple types of healthcare services, multiple patients and a single type of healthcare service, or multiple substantially similar healthcare services in the same specialty on multiple patients.

56-34-110. Dismissal of requests for arbitration.

The commissioner shall dismiss a request for arbitration if the disputed claim is:

(1) Related to a healthcare plan that is not regulated by this state;

(2) The basis for an action pending in state or federal court at the time of the request for arbitration;

(3) Subject to a binding claims resolution process entered into prior to July 1, 2023;

(4) Made against a healthcare plan subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.); or

(5) In accord with other circumstances as may be determined by the commissioner by rule.

56-34-111. Submission of data; arbitration.

Within thirty (30) days of the insurer's receipt of the provider's or facility's request for arbitration, the insurer shall submit to the commissioner all data necessary for the commissioner to determine whether the insurer's payment to the provider or facility was in compliance with this chapter. The commissioner is not required to make a determination prior to referring the dispute to a resolution organization for arbitration.

56-34-112. Referral to dispute resolution organization.

The commissioner shall promulgate rules in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, implementing an arbitration process requiring the commissioner to select one (1) or more resolution organizations to arbitrate certain claim disputes between insurers and out-of-network providers or out-of-network facilities. Prior to proceeding with arbitration, the commissioner shall allow the parties thirty (30) days from the date the commissioner received the request for arbitration to negotiate a settlement. The parties shall timely notify the commissioner of the result of the negotiation. If the parties have not notified the commissioner of the result within thirty (30) days of the date that the commissioner received the request for arbitration, then the commissioner shall refer the dispute to a resolution organization within five (5) days. The department shall contract with one (1) or more resolution

organizations by October 1, 2023, to review and consider claim disputes between insurers and out-of-network providers or out-of-network facilities as disputes are referred by the commissioner.

56-34-113. Selection of arbitrator.

Upon the commissioner's referral of a dispute to a resolution organization, the parties have five (5) days to select an arbitrator by mutual agreement. If the parties have not notified the resolution organization of their mutual selection before the fifth day, then the resolution organization shall select an arbitrator from among its members. A selected arbitrator shall be independent of the parties and shall not have a personal, professional, or financial conflict with any party to the arbitration. The arbitrator shall have experience or knowledge in healthcare billing and reimbursement rates and shall not communicate ex parte with either party.

56-34-114. Submission of final offer and supporting documents; initial arguments.

The parties have ten (10) days after the selection of the arbitrator to submit in writing to the resolution organization each party's final offer and each party's argument in support of the offer. The parties' initial arguments are limited to written form and must consist of no more than twenty (20) pages per party. The parties may submit documents in support of their arguments. The arbitrator may require the parties to submit additional written argument and documentation as the arbitrator determines necessary, but the arbitrator may require additional filing no more than once. The additional written argument is limited to no more than ten (10) pages per party and must be submitted not later than ten (10) days after the arbitrator's request for additional documentation. The arbitrator may set filing times and extend the filing times, as appropriate, with the mutual agreement of the parties. Failure of either party to timely submit the supportive documentation described in this section may result in a default against the party failing to make timely submission.

56-34-115. Proposed payment amounts; modification; decision.

Each party shall submit one (1) proposed payment amount to the arbitrator. The arbitrator shall pick one (1) of the two (2) amounts submitted and shall reveal that amount in the arbitrator's final decision. The arbitrator shall not modify the selected amount. In making such a decision, the arbitrator shall consider the complexity and circumstances of each case, including the level of training, education, and experience of the relevant physicians or other individuals at the facility who are licensed or otherwise authorized in this state to furnish healthcare services and other factors as determined by the commissioner through rule. The arbitrator shall put the final decision in writing and describe the basis for the decision, including citations to documents relied upon. The arbitrator shall make the final decision within thirty (30) days of the commissioner's referral. A default or final decision issued by the arbitrator is binding upon the parties and is not appealable through the court system.

56-34-116. Fees and expenses.

(a) Except as provided in this section, the party whose final offer amount is not selected by the arbitrator shall pay the amount of the award, the arbitrator's expenses and fees, and other fees assessed by the resolution organization, directly to the resolution organization.

(b) If the parties reach an agreement to settle a dispute after referral to an arbitrator and prior to a final determination by the arbitrator, then the fees and expenses must be split equally between the parties.

(c)

(1) If a party defaults and the defaulting party is:

(A) An insurer, then the insurer shall pay the provider's or facility's offer, plus expenses and fees of arbitration, within fifteen (15) days of the arbitrator's final decision; or

(B) A facility or provider, then the facility or provider shall pay the expenses and fees of arbitration within fifteen (15) days of the arbitrator's final decision.

(2) If both parties default, then the fees and expenses must be split equally between the parties.

(d) Parties shall pay moneys due under this section in full to the resolution organization within fifteen (15) days of the arbitrator's final decision. Within three (3) days of the organization's receipt of moneys due to the party whose final offer was selected, the organization shall distribute the moneys to such party.

(e) The department may promulgate rules to carry out this section.

56-34-117. Pattern of acting in violation of this chapter; referral to governing entity; investigation.

Following the resolution of arbitration, the commissioner may refer the decision of the arbitrator to the appropriate state agency or the governing entity with governing authority over the payer, provider, or facility if the commissioner concludes that a payer, provider, or facility has either displayed a pattern of acting in violation of this chapter or has failed to comply with a lawful order of the commissioner or the arbitrator. The referral must include a description of the violations and the commissioner's recommendation for enforcement action. The state agency or governing entity shall initiate an investigation regarding the referral within thirty (30) days of receiving the referral and shall conclude the investigation within ninety (90) days of receiving the referral.

56-34-118. Litigation.

Once a request for arbitration has been filed with the commissioner by a provider or facility under this chapter, neither the provider, the facility, nor the insurer in the dispute shall file a lawsuit in court regarding the same out-of-network claim.

56-34-119. Resolution organizations; quarterly reports.

Each resolution organization contracted by the department shall report to the department on a quarterly basis the results of all disputes referred to the organization as follows:

(1) The number of arbitrations filed, settled, arbitrated, defaulted, or dismissed during the previous calendar year; and

(2) Whether the arbitrators' decisions were in favor of the insurer or the provider or facility.

56-34-120. Written report of commissioner to the committees; posting.

On or before July 1, 2024, and each July 1 thereafter, the commissioner shall:

(1) Provide a written report to the commerce and labor committee of the senate and the insurance committee of the house of representatives; and

(2) Post the report on the department's website summarizing the number of arbitrations filed, settled, arbitrated, defaulted, and dismissed during the previous calendar year and a description of whether the arbitration decisions were in favor of the insurer or the provider or facility.

56-34-121. Arbitration not subject to the Uniform Administrative Procedures Act.

The arbitration conducted under this chapter is not subject to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

56-34-122. Credit report; surprise bills.

A nonparticipating provider shall not report to a credit reporting agency a covered person who receives a surprise bill for the receipt of healthcare services from the provider and does not pay the provider any copay, coinsurance, deductible, or other cost-sharing amount beyond what the covered person would pay if the nonparticipating provider had been a participating provider.

SECTION 2. Tennessee Code Annotated, Section 56-7-2356(a)(2), is amended by deleting the subdivision and substituting:

(2)

(A) Each managed health insurance issuer shall:

(i) File a network adequacy standards description with the commissioner, review the description for adequacy and compliance with this section, and update the description annually; and

(ii) Report to the commissioner each material change to an approved network plan at least fifteen (15) days before such change, including each change that would result in a failure to satisfy the requirements of this section. Upon receiving the report, the commissioner shall reevaluate the issuer's network plan for compliance with the network adequacy standards of this section.

(B) As used in this subdivision (a)(2), "material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of ten percent (10%) or more of a specific type of provider in a geographic market, the removal of a major health system that causes a network to be significantly different from the network when the beneficiary enrolled in the network plan, or a change that would cause the network to no longer satisfy the requirements of this section or the commissioner's rules for network adequacy.

(3) In an effort to ensure that consumers within a geographic region have an adequate opportunity to select an in-network provider, including specialty providers and facilities, and to avoid unanticipated out-of-network costs, the network adequacy standards description must include a report for each network hospital that provides the percentage of providers in each of the specialties of emergency medicine, anesthesiology, radiology, radiation oncology, pathology, and hospitalists practicing in the hospital who are in the health benefit plan's network.

SECTION 3. Tennessee Code Annotated, Section 56-7-2356(b)(4), is amended by deleting "annually" and substituting "quarterly".

SECTION 4. Tennessee Code Annotated, Section 56-7-2356(b)(9), is amended by deleting the subdivision and substituting:

(9) A sufficient number of contracted providers practicing at the same in-network facilities with which the managed health insurance issuer has contracted to reasonably ensure enrollees have complete and comprehensive in-network access for covered services delivered at those in-network facilities; and

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

SECTION 5. Tennessee Code Annotated, Section 56-7-2356, is amended by adding the following as new subsections:

(g) If the commissioner determines that a managed health insurance issuer has not met the sufficiency standards established by this section, then the commissioner shall require a modification to the network or may institute a corrective action plan to ensure access for enrollees. The commissioner may take other disciplinary action for violations of this section as permitted pursuant to § 56-2-305, and in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(h) The commissioner shall develop an appeals procedure and forms where an enrollee of the managed health insurance issuer, contractor of a managed health insurance issuer, or a healthcare provider or facility may file a request for review of network adequacy and sufficiency of the managed health insurance issuer network. The department shall complete such review within ninety (90) days of submission to the department.

SECTION 6. The commissioner of commerce and insurance is authorized to promulgate rules to effectuate this act. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 7. 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 8. For purposes of promulgating rules and carrying out administrative duties necessary to effectuate this act, this act takes effect July 1, 2023, the public welfare requiring it. This act takes effect on January 1, 2024, for all other purposes, the public welfare requiring it.