TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

FISCAL MEMORANDUM

SB 1120 - HB 1342

March 24, 2019

SUMMARY OF ORIGINAL BILL: Requires that currently required written notices be provided to the insured at least three days before the insured receives services from an out-of-network facility-based physician.

FISCAL IMPACT OF ORIGINAL BILL:

NOT SIGNIFICANT

IMPACT TO COMMERCE OF ORIGINAL BILL:

NOT SIGNIFICANT

SUMMARY OF AMENDMENTS (004800, 006212): Amendment 004800 deletes all language after the enacting clause. Adds language to Tenn. Code Ann. § 56-7-120(c)(2)(B)(i)(*b*) that requires a healthcare facility to provide written notice to an insured, or the insured's representative, that agrees to receive medical services by an out-of-network provider that includes a bill for 100 percent of billed charges for the amount unpaid by the insured's insurer. The written notice is to include the estimated amount of copay, deductible, or coinsurance, or range of estimates that the facility will charge the insured for scheduled items or services provided by the facility in accordance with the insured's health benefit coverage for the items and services or as estimated by the insurance company on its website for its insured or through the available information to the facility at the time of prior authorization; and a listing of anesthesiologists, radiologists, emergency room physicians, and pathologists or the groups of such healthcare providers with which the facility has contracted, including the healthcare provider or group name, phone number, and website.

Requires the healthcare facility, if the insured or the insured's personal representative refuses to sign the written notice, to put the document in the patient's medical record and make note the notice was provided and the patient refused to sign.

Declares that an in-network healthcare facility does not need to provide an insured with the written notice if the facility employs all facility-based physicians and requires all facility-based physicians to participate in all of the insurance networks in which the healthcare facility is a participating provider, or if the healthcare facility contractually prohibits all facility-based physicians from balance billing patients.

Prohibits healthcare facilities from collecting out-of-network charges from an insured, or the insurer on behalf of the insured, in excess of the cost sharing amount required in accordance with the insured's health benefits coverage for the items and services unless the written notice includes certain detailed information.

Amendment 006212 removes the provision that requires an insurer, if a property and casualty insurance policy includes a specified medical expense benefit payable without regard to fault, but does not permit assignment of benefit, to establish a process to disburse funds in the names of the insured and the healthcare provider as joint payees.

Clarifies that balance billing must be in excess of the cost sharing amount required in accordance with the insured's health benefits coverage for the times and services provided in order for the healthcare facility that contractually prohibits all facility-based physicians from balance billing patients to be exempt from providing notice.

FISCAL IMPACT OF BILL WITH PROPOSED AMENDMENTS:

Unchanged from the original fiscal note.

Assumptions for the bill as amended:

- This legislation will allow a health insurance company to deny an assignment of benefits to an out-of-network facility-based physician if certain notification requirements are not met.
- This legislation will prevent an out-of-network facility-based physician from balance billing an insured if such physician fails to provide a written notice, as required by this legislation, and prior to providing healthcare services.
- According to Benefits Administration, under current practice, the state plan, local education plan, and local government plans pay billed charges when an out-of-network physician renders service to a member at an in-network facility.
- Benefits Administration is unaware how often an out-of-network facility-based physician will fail to provide a notice to a member of either the state plan, local education plan, or local government plans; however, due to the fact that Benefits Administration currently pays for such services, it is assumed that physicians will generally seek to provide the required notice.
- To the extent out-of-network facility-based physicians fail to provide the notice required in this legislation, Benefits Administration may experience a decrease in expenditures as a result of being able to deny a member's assignment of benefits. Due to numerous unknown factors, an exact fiscal impact to Benefits Administration cannot be determined but is reasonably estimated to be not significant.
- According to the Division of TennCare, the proposed legislation is estimated to have no significant impact on Medicaid plans administered through the Division.

IMPACT TO COMMERCE WITH PROPOSED AMENDMENT:

Other Commerce Impact – To the extent providers fail to provide the written notice and follow other requirements established by this legislation, there could be decreases in business revenue to out-of-network facility-based physicians. Any other impact to commerce or jobs in Tennessee is considered not significant.

Assumptions for the bill as amended:

- To the extent providers fail to adhere to the required notification requirements created by the proposed legislation, there could be decreases in revenue to out-of-network facility-based physicians in this state.
- Any other impact to commerce or jobs in this Tennessee is estimated to be not significant.

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.

Krista Lee Carsner

Krista Lee Carsner, Executive Director

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