

HOUSE BILL 2

By Hawk

AN ACT to amend Tennessee Code Annotated, Title 33;
Title 56; Title 63 and Title 68, relative to health
care.

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

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 providers. To hold the patient harmless from incurring an unanticipated balance bill, this chapter establishes an independent dispute resolution process that ensures a fair reimbursement for out-of-network services; implements a balance bill prohibition for emergency services in an out-of-network facility and for facility-based non-emergency services; and creates opportunities for transparency and notice to a patient of unexpected medical bills that arise from receiving care from out-of-network providers.

56-33-102. Chapter definitions.

As used in this chapter:

(1) "Balance bill" means a bill for healthcare services, other than emergency services, received by:

(A) An enrollee for services rendered by an out-of-network facility-based physician at a participating hospital or ambulatory surgical treatment center, where a participating physician is unavailable or an out-

of-network facility-based physician renders services without the enrollee's knowledge, or unforeseen medical services arise at the time the healthcare services are rendered. However, "balance bill" does not mean a bill received for healthcare services when a participating physician is available and the enrollee has elected to obtain services from an out-of-network facility-based physician;

(B) An enrollee for services rendered by an out-of-network facility-based physician, where the services were referred by a participating physician to an out-of-network facility-based physician without explicit written consent of the enrollee acknowledging that the participating physician is referring the enrollee to an out-of-network facility-based physician and that the referral may result in costs not covered by the health benefit plan; or

(C) A patient who is not insured for services rendered by a physician at a hospital or ambulatory surgical treatment center;

(2) "Carrier" or "health carrier" means a health insurance entity as defined in § 56-7-109;

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

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

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

(6) "Enrollee" means an individual who is eligible to receive medical care through a health benefit plan;

(7) "Health benefit plan" means health insurance coverage as defined in § 56-7-109;

(8) "Healthcare facility" or "facility" means an institution licensed under title 33 or 68;

(9) "Network" means the providers and healthcare facilities that have contracted to provide healthcare services to the enrollees of a health benefit plan, including a network operated by a carrier or a network with which a carrier has contracted;

(10) "Out-of-network facility-based physician" means a physician:

(A) To whom a participating healthcare facility has granted clinical privileges;

(B) Who provides services to patients of the participating healthcare facility pursuant to those clinical privileges;

(C) Who does not have a current contract or provider agreement with the enrollee's health carrier; and

(D) Who is licensed under title 63, chapter 6 or 9; and

(11) "Usual and customary rate" means the average of:

(A) The eightieth percentile of all billed charges for the particular healthcare service performed by a provider in the same or similar specialty that are provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization that is specified by the commissioner and not affiliated with, or has ownership interest by, a health carrier or healthcare provider; and

(B) The ninetieth percentile of all contracted rates for the particular healthcare service performed by a provider in the same or similar specialty that are provided in the same geographical area.

56-33-103. Applicability.

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

This chapter does not apply to:

(1) Coverage only for a specified disease; specified accident or accident-only coverage; credit, dental, or disability income; 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 any 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) Any coverage issued under 10 U.S.C. §§ 1071-1110b, and any coverage issued as a supplement to that coverage; and

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

(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.

56-33-104. Independent dispute resolution criteria.

The commissioner shall establish an independent dispute resolution process by which a dispute for a bill for out-of-network emergency services or a balance bill may be resolved. The commissioner has the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The commissioner shall promulgate rules establishing standards for the independent dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process of this section. The physician must be licensed and in good standing in this state.

56-33-105. Criteria for determining a reasonable fee in an independent dispute resolution.

(a) In determining the appropriate amount to pay for a healthcare service, an independent dispute resolution entity shall consider all relevant factors, including:

(1) Whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:

(A) Fees paid to the involved physician for the same services rendered by the physician to other patients in health carrier networks in which the physician is not participating, and

(B) In the case of a dispute involving a health carrier, fees paid by the health carrier to reimburse physicians in the same or similar specialty for the same services in the same region who are not participating with the health carrier's network;

(2) The level of training, education, and experience of the physician;

(3) The physician's usual charge for comparable services with regard to patients covered by health carrier networks in which the physician is not participating;

(4) The circumstances and complexity of the particular case, including time and place of the service;

(5) Individual patient characteristics;

(6) The usual and customary rate of the service;

(7) The fiftieth percentile of rates for the service or supply paid to participating physicians in the same or similar specialty and provided in the same geographical area as reported to the benchmarking database maintained by a nonprofit organization that is specified by the commissioner and not affiliated with, or has ownership interest by, an insurance carrier or healthcare provider; and

(8) The recent history of network contracting between the parties.

(b) In determining the appropriate amount to pay for a healthcare service, an independent dispute resolution entity shall not consider:

(1) Any benchmarking database that includes medicare or medicaid reimbursement rates; or

(2) Medicare or medicaid reimbursement rates.

56-33-106. Independent dispute resolution for emergency services.

(a)

(1) When a health carrier receives a bill for emergency services from an out-of-network facility-based physician or an out-of-network healthcare facility, the health carrier shall pay an amount that it determines is reasonable for the emergency services rendered by the out-of-network facility-based physician or

healthcare facility, in accordance with § 56-7-109, except for the enrollee's co-payment, coinsurance, or deductible, if any, and shall ensure that the enrollee incurs no greater out-of-pocket costs for the emergency services than the enrollee would have incurred had the emergency services been performed by a participating physician or healthcare facility. Any amount paid by the enrollee must be added to the in-network deductible, coinsurance, or other deductible as applicable.

(2) An out-of-network facility-based physician, healthcare facility, or health carrier may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity.

(3) The independent dispute resolution entity shall make a determination of a reasonable fee for the services rendered within thirty (30) days of receipt of the dispute for review.

(4) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health carrier's payment or the out-of-network facility-based physician's or healthcare facility's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in § 56-33-105. If an independent dispute resolution entity determines, based on the health carrier's payment and the out-of-network facility-based physician's or facility's fee, that a settlement between the health carrier and out-of-network facility-based physician or the healthcare facility is reasonably likely, or that both the health carrier payment and the out-of-network facility-based physician's fee or healthcare facility's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for

settlement. The health carrier and out-of-network facility-based physician or healthcare facility may be granted up to ten (10) business days for this negotiation, and the ten-day period runs concurrently with the thirty-day period for dispute resolution.

(b)

(1) A patient who is not insured may submit a dispute regarding a fee for emergency services for review to an independent dispute resolution entity upon approval of the commissioner.

(2) An independent dispute resolution entity shall determine a reasonable fee for the services based upon the same conditions and factors set forth in § 56-33-105.

(3) A patient who is not insured is not required to have paid the physician's fee in order to be eligible to submit the dispute for review to an independent dispute resolution entity.

(c) The determination of an independent dispute resolution entity is binding on the health carrier, physician, and patient.

56-33-107. Independent dispute resolution for balance bills.

(a) If benefits are assigned in a non-emergency as set forth in § 56-33-109(a), then:

(1) The health carrier shall pay the out-of-network facility-based physician in accordance with subdivisions (a)(2) and (3) and § 56-7-109 if benefits are assigned to an out-of-network facility-based physician. The out-of-network facility-based physician may bill the health carrier for the healthcare services rendered, and the health carrier shall pay the out-of-network facility-

based physician the billed amount or attempt to negotiate reimbursement with the out-of-network facility-based physician;

(2) The health carrier shall attempt to negotiate reimbursement for healthcare services provided by an out-of-network facility-based physician;

(3)

(A) If the negotiation does not result in a resolution of the payment dispute between the out-of-network facility-based physician and the health carrier, then the health carrier shall pay the out-of-network facility-based physician an amount the health carrier determines is reasonable for the healthcare services rendered, except for the enrollee's co-payment, coinsurance, or deductible, in accordance with § 56-7-109, and any amount paid by the enrollee must be added to the in-network deductible, coinsurance, or other deductible, as applicable; or

(B) If the negotiation does result in an agreement, then the health carrier shall pay the out-of-network facility-based physician the negotiated amount, except for the enrollee's co-payment, coinsurance, or deductible in accordance with § 56-7-109;

(4) Either the health carrier or the out-of-network facility-based physician may submit the dispute regarding the balance bill for review to an independent dispute resolution entity, except that the health carrier shall not submit the dispute unless it has complied with subdivisions (a)(1)-(3); and

(5) The independent dispute resolution entity shall make a determination within thirty (30) days of receipt of the dispute for review in accordance with the following:

(A) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health carrier payment or the out-of-network facility-based physician's fee, and shall choose the amount based upon the conditions and factors set forth in § 56-33-105;

(B) If an independent dispute resolution entity determines, based on the health carrier's payment and the out-of-network facility-based physician's fee, that a settlement between the health carrier and out-of-network facility-based physician is reasonably likely, or that both the health carrier's payment and the out-of-network facility-based physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement, and in that case the health carrier and non-participating physician may be granted up to ten (10) business days for negotiation, which runs concurrently with the thirty-day period for dispute resolution; and

(C) An out-of-network facility-based physician may request, and the independent dispute resolution entity may permit, that claims of a physician involving the same health carrier be aggregated and submitted for simultaneous review by an independent dispute resolution entity when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law.

(b) If a balance bill is received by an enrollee who is not experiencing an emergency as set forth in § 56-33-109(b) and who does not assign benefits in accordance with subsection (a), then:

(1) The enrollee may submit a dispute regarding the balance bill for review to an independent dispute resolution entity that shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in § 56-33-105; and

(2) The enrollee is not required to have paid the physician's fee or a healthcare facility's fee to be eligible to submit the dispute for review to the independent dispute entity.

(c) If a balance bill is received by a patient who is not insured and who is not experiencing an emergency as set forth in § 56-33-106, then:

(1) The patient may submit a dispute regarding the balance bill for review to an independent dispute resolution entity that shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in § 56-33-105;

(2) The patient is not required to have paid the physician's fee to be eligible to submit the dispute for review to the independent dispute entity; and

(3) The determination of an independent dispute resolution entity is binding on the patient, physician, and health carrier.

56-33-108. Payment for independent dispute resolution of a balance bill.

(a) For disputes involving an enrollee:

(1) When the independent dispute resolution entity determines the health carrier's payment is reasonable, payment for the dispute resolution process is the responsibility of the out-of-network facility-based physician or healthcare facility;

(2) When the independent dispute resolution entity determines the out-of-network facility-based physician's or healthcare facility's fee is reasonable,

payment for the dispute resolution process is the responsibility of the health carrier; and

(3) When a good faith negotiation directed by the independent dispute resolution entity pursuant to § 56-33-106(a) or § 56-33-107(a) results in a settlement between the health carrier and the out-of-network facility-based physician or healthcare facility, the health carrier and the out-of-network facility-based physician or healthcare facility shall evenly divide and share the prorated cost of the dispute resolution.

(b) For disputes involving a patient who is not insured:

(1) When the independent dispute resolution entity determines the physician's or facility's fee is reasonable, payment for the dispute resolution process is the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient; and

(2) When the independent dispute resolution entity determines the physician's or facility's fee is unreasonable, payment for the dispute resolution process is the responsibility of the physician or facility.

(c) The commissioner shall promulgate rules to determine payment for a dispute resolution process in cases where payment for the dispute resolution process would pose a hardship to the patient under subdivision (b)(1).

56-33-109. Hold harmless and assignment of benefits for balance bills for insured persons.

(a) When an enrollee assigns benefits to an out-of-network facility-based physician in writing and the out-of-network facility-based physician knows the patient is an enrollee in a health benefit plan with an out-of-network benefit, the enrollee is only

responsible for any applicable co-payment, coinsurance, or deductible that would be owed if the enrollee utilized a participating physician.

(b) When an enrollee receives emergency services from an out-of-network facility and assigns benefits to an out-of-network facility for an emergency medical condition and the out-of-network facility knows the patient is an enrollee in a health benefit plan with an out-of-network benefit, the enrollee is only responsible for any applicable co-payment, coinsurance, or deductible that would be owed if the enrollee utilized a participating facility.

(c) Subsections (a) and (b) do not apply to:

(1) Coinsurance, co-payments, or deductibles for services provided by an in-network facility or physician; and

(2) Services, other than emergency services, provided to enrollees who choose to receive services from an out-of-network facility or out-of-network facility-based physician.

SECTION 2. 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 3. For the purpose of promulgating rules, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect January 1, 2023, the public welfare requiring it.