State of Tennessee

PUBLIC CHAPTER NO. 840

SENATE BILL NO. 1869

By Lundberg, Massey

Substituted for: House Bill No. 1935

By Zachary, Moon, Gravitt

AN ACT to amend Tennessee Code Annotated, Title 8; Title 56; Title 63 and Title 68, relative to billing of services.

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

SECTION 1. Tennessee Code Annotated, Section 56-7-120, is amended by deleting the section and substituting instead the following:

(a)(1) Notwithstanding any law to the contrary, if a policy of insurance issued in this state provides for coverage of health care rendered by a healthcare provider covered under title 63, the insured or other persons entitled to benefits under the policy are entitled to assign their benefits to the healthcare provider and such rights must be stated clearly in the policy. Notice of the assignment must be in writing to the insurer in order to be effective unless otherwise stated in the policy.

(2) If a property and casualty insurance policy includes a specified medical expense benefit payable without regard to fault, but does not permit assignment of the benefit, the insurer must establish a process that, when requested by the insured, the insurer must disburse funds in the names of the insured and the healthcare provider as joint payees. Disbursement is subject to the terms and conditions under the issued policy.

(b) As used in this section:

(1) "Emergency medical services" means the services used in responding to the perceived individual need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury;

(2) "Health insurance coverage":

(A) Means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any policy, certificate or agreement offered by a health insurance entity; and

(B) Does not include policies or certificates covering only accident, credit, disability income, long-term care, hospital indemnity, medicare supplement as defined in 42 U.S.C. § 1395ss(g)(1), specified disease, other limited benefit health insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(3) "Healthcare facility" means a hospital as defined in title 68, chapter 11, part 2, or an ambulatory surgical treatment center as defined in title 68, chapter 11, part 2;

(4) "Healthcare provider" means any doctor of medicine, osteopathy, dentistry, chiropractic, podiatry, or optometry; a pharmacist or pharmacy; a hospital; home

health agency; an entity providing infusion therapy services; or an entity providing medical equipment services;

(5) "Insured" or "covered person" means a person on whose behalf a health insurance entity offering health insurance coverage is obligated to pay benefits or provide services; and

(6) "Stabilized" means the insured is no longer in need of emergency medical services.

(c)(1) For purposes of this subsection (c):

(A) "In-network healthcare facility" means a hospital or ambulatory treatment surgical center licensed under title 68, chapter 11, part 2 that has a current contract provider agreement with the insured's insurer; and

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

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

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

(iii) Who does not have a current contract or provider agreement with the insured's insurer.

(2) An insured's assignment of benefits, pursuant to subsection (a), may be disregarded by an insurer if:

(A) The assignment of benefits is to an out-of-network facility-based physician; and

(B) The following conditions are not satisfied:

(i) The healthcare facility provides written notice to the insured, or the insured's personal representative, that includes the following:

(*a*) A statement that the out-of-network facility-based physician may not have a current contract provider agreement with the insured's insurer;

(b) A statement that the insured agrees to receive medical services by an out-of-network healthcare provider and will receive a bill for one hundred percent (100%) of billed charges for the amount unpaid by the insured's insurer;

(c) The estimated amount that the facility will charge the insured for items and services provided by the facility in accordance with the insured's health benefits coverage for the items and services; and

(d) A listing of anesthesiologists, radiologists, emergency room physicians, and pathologists or the groups of such physicians with which the facility has contracted, including the physician or group name, phone number, and website;

(ii) The insured signs the written notice, acknowledging agreement to receive medical services by an out-of-network provider; and

(iii) The written notice includes the following statement:

The physicians and other providers that may treat the patient at this facility may not be employed by this facility and may not participate in the patient's insurance network.

Anesthesiologists, radiologists, emergency room physicians, and pathologists are not employed by this

facility. Services provided by those specialists, among others, will be billed separately.

Before receiving services, the patient should check with his or her insurance carrier to find out if the patient's providers are in-network. Otherwise, the patient may be at risk of higher out-of-network charges.

(d)(1) The written notice required by subdivision (c)(2)(B) must be provided to the insured, or the insured's personal representative, prior to when the insured first receives services from the out-of-network facility-based physician. If the insured is receiving medical services through a hospital emergency department or is incapacitated or unconscious at the time of receiving services, the written notice is not required until the insured is stabilized.

(2) The failure of the healthcare facility to provide the notice required by subdivision (c)(2)(B) does not give rise to any right of indemnification or private cause of action against the healthcare facility by an out-of-network facility-based physician for an insurer's disregard of an insured's assignment of benefits unless:

(A) The healthcare facility's failure to provide the written notice is due to willful or wanton misconduct of an agent of the healthcare facility; and

(B) The out-of-network facility-based physician provides the insured a billing statement that:

(i) Contains an itemized listing of the services and supplies provided along with the dates when the services and supplies were provided;

(ii) Contains a conspicuous, plain language explanation that:

(*a*) The out-of-network facility-based physician does not have a current contract provider agreement with the insured's insurer; and

(*b*) The insurer has paid a rate, as determined by the insurer, that is below the out-of-network facility-based physician's billed amount;

(iii) Contains a telephone number to call to discuss the billing statement; provide an explanation of any acronyms, abbreviations, and numbers used on the statement; or discuss any payment issues;

(iv) Contains a statement that the insured may call the telephone number described in subdivision (d)(2)(B)(iii) to discuss alternative payment arrangements;

(v) For billing statements that total an amount greater than two hundred dollars ($200), over any applicable copayments, coinsurance or deductibles, states, in plain language, that if the insured finalizes a payment plan agreement within forty-five (45) days of receiving the first billing statement and substantially complies with the agreement, the out-of-network facility-based physician shall not furnish adverse information to a consumer reporting agency regarding an amount owed by the insured. For purposes of this subdivision (d)(2)(B)(v), a patient is considered out of substantial compliance with the payment plan agreement if the payments are not made in compliance with the agreement for a period of forty-five (45) days; and

(vi) Contains a telephone number for the department and a clear and concise statement that the insured may call the department to complain about any out-of-network charges.

(3) Nothing in this subsection (d) applies to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, or other limited benefit hospital insurance policies.

SECTION 2. Tennessee Code Annotated, Title 68, Chapter 1, Part 2, is amended by adding the following language as a new section:

(a) For the purposes of this section:

(1) "Emergency medical services" means the services used in responding to the perceived individual need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury;

(2) "Healthcare facility" means a hospital as defined in § 68-11-201, or an ambulatory surgical treatment center as defined in § 68-11-201;

(3) "Healthcare provider" means a physician licensed pursuant to chapter 6 or 9 of title 63, who either is employed by a healthcare facility or contracts with a healthcare facility to provide medical services;

(4) "In-network healthcare facility" means a healthcare facility that has a current contract provider agreement with the insured's insurer;

(5) "Insured" means any person who has health insurance coverage as defined in § 56-7-109 through a health insurance entity as defined in § 56-7-109;

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

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

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

(iii) Who does not have a current contract provider agreement with the insured's insurer;

(7) "Stabilized" means the patient is no longer in need of emergency medical services; and

(8) "Transfer" means transporting a patient from one (1) location to another for medical services.

(b) Healthcare facilities are prohibited from collecting out-of-network charges from an insured, or the insurer on behalf of the insured, unless:

(1) The healthcare facility provides written notice to the insured, prior to medical services being provided, that contains the following:

(A) A statement that the insured agrees to receive medical services by the out-of-network facility and will receive a bill for the amount unpaid by the insured's insurer;

(B) A statement that the nonparticipating out-of-network facility-based physician may not have a current contract provider agreement with the insured's insurer and is an out-of-network provider;

(C) A statement that the insured agrees to receive medical services by an out-of-network provider and will receive a bill for the amount unpaid by the insured's insurer;

(D) If the healthcare facility is not in-network or otherwise a participating provider, the estimated amount that the facility will charge the insured for items and services in excess of any cost sharing obligations that the insured would otherwise have under the insured's health benefits coverage for the items and services if the facility were in-network or otherwise participating in the coverage; and

(E) A listing of anesthesiologists, radiologists, emergency room physicians, and pathologists or the groups of such physicians with which the facility has contracted, including the physician or group name, phone number, and website, along with the following statement:

The physicians and other providers that may treat the patient at this facility may not be employed by this facility and may not participate in the patient's insurance network.

Anesthesiologists, radiologists, emergency room physicians, and pathologists are not employed by this facility. Services provided by those specialists, among others, will be billed separately.

Before receiving services, the patient should check with his or her insurance carrier to find out if the patient's providers are in-network. Otherwise, the patient may be at risk of higher out-of-network charges.

(2) The insured signs the written notice, acknowledging agreement to receive medical services by an out-of-network provider.

(c) Prior to admission or a scheduled medical procedure, a healthcare facility shall provide the insured with informational materials that include the following:

(1) The estimated amount that the facility will charge the insured for items and services provided by the facility in accordance with the insured's health benefits coverage for the items and services;

(2) A listing of anesthesiologists, radiologists, emergency room physicians, and pathologists or the groups of such physicians with which the facility is contracted, including the physician or group name, phone number, and website; and

(3) The following statement:

The patient will be billed for additional charges, including out-of-network charges, if the patient is provided medical services by a healthcare provider that is not in-network. In particular, the patient should ask the facility if he or she will be provided any medical services by anesthesiologists, radiologists, emergency room physicians, or pathologists who are not in the patient's network.

(d)(1) Except as provided in subdivision (d)(2) the notice required by subdivision (b)(1) must be provided to the insured, or the insured's personal representative, at the time of admission.

(2)(A) If the insured is receiving medical services through a hospital emergency department and is incapacitated or unconscious at the time of receiving those services, the notice will not be required at that time.

(B) In circumstances as described in subdivision (d)(2)(A), the written notice required by subdivision (b)(1) must be provided to the insured, or the insured's personal representative, after receiving medical services and within twelve (12) hours following stabilization. Information about a transfer to an in-network facility must also be provided with the written notice.

(e) The insured, or the insured's personal representative, must receive the written notice required by subdivision (b)(1) from the facility before being transferred by an ambulance as defined in § 68-140-302 to another facility or physician for treatment of medical services unless the insured would be at risk of bodily injury by the facility giving the insured the notice. The written notice must provide information about the possibility of a transfer to an in-network facility if the in-network facility has similar treatment available to the insured and will not risk the insured's health.

(f) A bill to an insured from a healthcare provider or healthcare facility must contain a telephone number for the department and a clear and concise statement that the insured may call the department to complain about any out-of-network charges.

SECTION 3. This act shall take effect July 1, 2018, the public welfare requiring it, and shall apply to services rendered on or after that date.

SENATE BILL NO. 1869

PASSED: April 16, 2018

RANDY McNALLY
SPEAKER OF THE SENATE

BETH HARWELL, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 26th day of April 2018

BILL HASLAM, *GOVERNOR*