

HOUSE BILL 2353

By Hill T

AN ACT to amend Tennessee Code Annotated, 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. Short title.**

This chapter shall be known and may be cited as the "Network Adequacy and Out-of-Network Balance Billing Transparency Act."

**56-33-102. Purpose.**

The purpose of this chapter is to alleviate the effects of inadequate and narrow health benefit plan provider networks by establishing the adoption and use of a healthcare provider charge database for ensuring a minimum reimbursement baseline standard for the payment of out-of-network services; implementing a balance billing prohibition for out-of-network emergency services and for certain facility-based non-emergency services when reimbursement is issued in accordance with such minimum reimbursement baseline standards; and creating opportunities for enhanced transparency and notice to consumers of healthcare services resulting from unexpected medical bills that arise from receiving care from out-of-network providers.

**56-33-103. Applicability.**

(a) Except as provided in subsection (b), this chapter applies to health benefit plans, providers, and healthcare facilities.

(b) This chapter does not apply to:

(1) Coverage only for a specified disease; specified accident or accident-only coverage; credit, dental, disability income; hospital indemnity; long-term care insurance, as defined in § 56-42-103; vision care; or 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 title 56, chapter 7, part 29 of this title;

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

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

(c) 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 pursuant to § 56-33-105(f).

**56-33-104. Chapter definitions.**

As used in this chapter:

(1) "Balance billing" means:

(A) The practice by a provider, who does not participate in an enrollee's health benefit plan network, of charging the enrollee the difference between the provider's fee and the sum of what the enrollee's health benefit plan pays and what the enrollee is required to pay in applicable deductibles, co-payments, coinsurance or other cost-sharing amounts required by the health benefit plan; or

(B) Surprise billing, which is the practice as described in subdivision (1)(A) by a facility-based provider who does not participate in an enrollee's health benefit plan network while providing medical services at a facility that participates in the enrollee's health benefit plan network;

(2) "Carrier" or "health carrier":

(A) 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 any of the costs of healthcare services; and

(B) Includes a health insurance company, HMO, a hospital and health services corporation, or any other entity providing a plan of health insurance, health benefits, or healthcare services;

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

(4) "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:

(A) Placing the person's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part;

(5) "Emergency services" means healthcare items and services furnished in a hospital that are required to determine, evaluate, or treat an emergency medical condition, until the condition is stabilized, as directed or ordered by a physician or directed by physician or hospital protocol;

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

(7) "Facility-based provider" means an individual or group of healthcare providers:

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

and

(B) Who provide services to patients treated at the healthcare facility under those clinical privileges;

(8) "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 any of the costs of physical, mental, or behavioral healthcare services;

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

(10) "Healthcare provider" or "provider" means a physician or other healthcare practitioner licensed or certified under title 63 to perform specified healthcare services consistent within their scope of practice under state law;

(11) "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;

(12) "Network plan" means a health benefit plan that uses a network to provide services to enrollees;

(13) "Out-of-network facility" means a healthcare facility that has not contracted with a carrier to provide services to enrollees of a health benefit plan;

(14) "Out-of-network provider" means a healthcare provider who has not contracted with a carrier to provide services to enrollees of a health benefit plan;  
and

(15) "Usual and customary rate" means the eightieth (80th) percentile of all submitted 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, an insurance carrier or healthcare provider.

**56-33-105. Determination of network adequacy.**

(a)

(1) A health benefit plan that contracts with a network of healthcare providers and facilities must ensure that the network is adequate to meet the health needs of enrollees and provide an appropriate choice of providers sufficient to render the services covered by the health benefit plan.

(2) The commissioner shall, in consultation with interested stakeholders, adopt rules to establish quantitative and, if appropriate, non-quantitative criteria to evaluate the network sufficiency of health benefits plans subject to this chapter.

(3) In adopting the rules, the commissioner shall take the following into consideration:

(A) Geographic accessibility of primary care and specialty care providers, with consideration for geographic variation and population dispersion, to establish maximum distance standards;

(B) Waiting times for an appointment with participating primary and specialty care providers to establish maximum wait time standards;

(C) Provider-to-enrollee ratios for primary and specialty care providers to establish provider-to-enrollee ratio standards;

(D) Hours of operation;

(E) The ability of the network to meet the needs of enrollees; and

(F) Providers who are actively accepting new patients and providers who will not accept new patients.

(b) A carrier shall annually submit a network access plan to the commissioner with information necessary to document compliance with this chapter, including:

(1) A report for each network hospital that provides the percentage of providers in each of the specialties of emergency medicine, anesthesiology, radiology and radiation oncology, pathology, and hospitalists practicing in the hospital who are in the health benefit plan's network to ensure enrollees with reasonable and timely access to in-network providers; and

(2) A report on the percentage of primary care and specialty care providers who are in the insurer's network to ensure enrollees with reasonable and timely access to necessary medical care.

(c) The health carrier shall prepare an access plan prior to offering a new network plan, and shall file with the commissioner any material change to any existing network plan at least sixty (60) business days before the change goes into effect or is distributed to potential enrollees. The commissioner shall review the network of

healthcare providers for adequacy at the time of the commissioner's initial approval of a health insurance policy or contract and upon application for expansion of any service area associated with the policy or contract. For purposes of this subsection (c), "material change" means any material or substantive change in the composition of the health carrier's network or network access plan that impacts an enrollee's ability to access or receive in-network healthcare services within a reasonable geographic standard adopted by the commissioner.

(d) When determining the adequacy of a proposed provider network, the commissioner must consider whether the carrier's proposed access plan includes a sufficient number of contracted providers practicing at the same facilities with which the carrier has contracted to reasonably ensure enrollees have complete and comprehensive in-network access for covered services delivered at those in-network facilities.

(e) To the extent that the network has been determined by the commissioner to meet the standards set forth in rule, the network shall be deemed adequate by the commissioner.

(f) Entities providing or administering ERISA self-funded employee welfare plans that elect to be subject to this chapter, shall provide notice on an annual basis, to the commissioner, on a form and in a manner prescribed by the commissioner, attesting to the plan's participation and agreeing to be bound by this section. The health benefit plan must amend the employee benefits plan, coverage policies, contracts, and any other plan documents to reflect that the benefits of this section apply to the health benefit plan's enrollees.

(g) Nothing in this section limits the commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans; to require

additional coverage options for out-of-network services; or to provide for standardization and simplification of coverage.

(h) Beginning January 1, 2019, health insurance carriers operating in this state are required to contribute data on healthcare claims and healthcare provider charges on an annual basis to a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be affiliated with or have ownership interest by an insurance carrier or healthcare provider.

(i) A health insurance carrier that provides false or misleading information to the independent database specified by the commissioner is subject to penalty or sanction pursuant to § 56-2-305.

**56-33-106. Coverage option mandate.**

(a) A carrier that issues a comprehensive health benefit plan must cover facility-based services provided by out-of-network providers at in-network facilities, and must make available to the policyholder or contract holder, coverage at the usual and customary rate for each service provided by an out-of-network provider after imposition of any applicable in-network deductible, co-payment, or co-insurance.

(b) If there is no coverage available pursuant to subsection (a) in a specific region of the state, the commissioner may require a carrier issuing a comprehensive health benefit plan in the region to make available coverage at the usual and customary rate of each service provided by an out-of-network provider after imposition of any permissible in-network deductible, co-payment, or co-insurance. The commissioner may, after considering the public interest, permit a carrier to satisfy the requirements of this section on behalf of another carrier, corporation, or health maintenance organization within the same holding company system.



(c) Nothing in this section limits the commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans and subscriber contracts; to require additional coverage options for services provided by out-of-network providers; or to provide for standardization and simplification of coverage.

**56-33-107. Emergency services provided by out-of-network provider.**

(a) When an enrollee in a health benefit plan receives emergency services from an out-of-network provider or facility, the health benefit plan must ensure that the enrollee must incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider or facility.

(b) Upon the carrier's receipt of a bill from a provider or facility for out-of-network emergency healthcare services, the carrier must make payment to the out-of-network provider or facility at the usual and customary rate or the provider or facility's charge, whichever is less, and issue payment directly to the provider or facility in accordance with the enrollee's assignment of benefit election.

(c) Upon receipt of payment from the carrier issued directly to the provider of emergency services, and paid in accordance with the usual and customary rate determined in this chapter, the provider of emergency services shall be prohibited from balance billing the health benefit plan's enrollee for any amount exceeding the difference between the usual and customary rate and the enrollee's in-network out-of-pocket patient responsibility, deductibles, copayments, or co-insurance. Payment by the carrier must include a notice to the provider of out-of-network emergency services on the applicability of this chapter and whether this chapter applies the enrollee's health benefit plan as the basis for the carrier's payment determination.

**56-33-108. Health benefit plan notice to enrollees.**

(a) Upon request of an enrollee and no later than forty-eight (48) hours after the enrollee has been pre-certified to receive non-emergency services at an out-of-network facility, a health benefit plan must provide by electronic, telephonic, or written correspondence, information on:

(1) Whether the enrollee's scheduling provider is a participating provider in the health benefit plan network;

(2) Whether proposed non-emergency medical care is covered by the health benefit plan;

(3) What the enrollee's personal responsibility will be for payment of applicable copayment or deductible amounts; and

(4) If applicable, coinsurance amounts owed based on the provider's contracted rate for in-network services or the carrier's usual and customary payment rate for out-of-network services.

(b) For health benefit plans subject to this chapter, carriers must include a statement on any remittance advice or explanation of benefits sent to the patient for services provided to the patient at an in-network facility that states the following in the same or similar language:

**Pursuant to Tennessee state law, out-of-network payment was issued to your facility-based provider at the 'usual and customary rate' at the eightieth percentile of the submitted billed charge for the particular health care service performed by a provider in the same or similar specialty, and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. Out-of-network healthcare providers who may have treated you at this facility are prohibited from sending you an additional bill for**

**services rendered. If you receive a bill from a healthcare provider associated with this service, please contact your carrier.**

**56-33-109. Healthcare facility notice to enrollees.**

- (a) This section applies to the provision of non-emergency services only.
- (b) A healthcare facility must post on its website:
  - (1) The networks in which the healthcare facility is a participating provider to the best of its knowledge;
  - (2) A statement that:
    - (A) Physician services provided in the healthcare facility are not included in the facility's charges;
    - (B) Physicians who provide services in the facility may or may not participate with the same health benefit plans as the facility; and
    - (C) The enrollee should check with the provider arranging for the enrollee to receive services in the facility to determine whether that provider participates in the enrollee's health benefit plan's network; and
  - (3) As applicable, the name, mailing address, and telephone number of the facility-based providers and facility-based provider groups that the facility has contracted with to provide services including emergency medicine, anesthesiology, pathology, or radiology.

**56-33-110. Out-of-network billing and payment for non-emergency services.**

- (a) A carrier or health benefit plan, upon receipt of a claim from an out-of-network facility-based provider of non-emergency services delivered to an enrollee at an in-network facility shall:
  - (1) Provide the out-of-network provider with an explanation of benefits as to any payment determination thereof;

(2) Issue payment at the usual and customary rate, or the out-of-network provider's charge, whichever is less, and which must be issued directly to the provider of out-of-network services; and

(3) Count any amount paid by the enrollee that exceeds applicable deductibles, co-insurance, or co-payments towards the enrollee's annual limitation of cost sharing.

(b) Out-of-network facility-based providers shall accept payment received from a carrier pursuant to subsection (a) as payment in full and are prohibited from balance billing the enrollee.

(c) This section does not apply in situations in which a patient has affirmatively chosen to be treated by an out-of-network provider.

**56-33-111. Provider directories.**

(a)

(1) A carrier shall provide a provider directory on both the carrier's website and in print format.

(2) The carrier shall conduct a monthly review of each plan's network directory for accuracy and retain documentation of the audit to be made available to the commissioner upon request.

(3) The directory on the carrier's website and in print format must contain the following information in plain language for each network plan:

(A) A description of the criteria the carrier has used to build its 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 types 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, such as by name, symbols, or grouping, in order for an enrollee or a prospective enrollee to be able to identify the provider type associated with the enrollee's health benefit plan;

(D) If applicable, a statement that authorization or referral may be required to access some providers;

(E) 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; and

(F) A customer service email address and telephone number or electronic link that enrollees or the public may use to notify the carrier of inaccurate provider directory information.

(b) Regarding the directory posted online, the carrier shall:

(1) Update the provider directory at least monthly;

(2) Ensure that the public is able to view all of 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;

(3) Make available in a searchable format the following information for each network plan:

(A) For healthcare providers, name; group name; gender; participating office locations; specialty, if applicable; medical group affiliations, if applicable; facility affiliations if applicable; participating

facility affiliations, if applicable; languages spoken other than English, if applicable; and whether the provider is accepting new patients;

(B) For hospitals, hospital name; hospital type, such as acute, rehabilitation, children's, cancer; participating hospital location; hospital accreditation status; and the network participation status of all facility-based provider groups affiliated with the hospital; and

(C) For facilities, other than hospitals, by type; facility name; facility type; types of services performed; participating facility locations; and the network participation status of all facility-based provider groups affiliated with the facility.

(c) For facilities listed in a network directory, carriers shall include a disclaimer stating that while the facility may be in-network, healthcare providers who provide services at the facility may not be in-network.

(d) A carrier shall:

(1) Contact the facilities and providers listed in the carrier's network directory who have not submitted a claim in the last six (6) months to determine if the facility or provider intends to remain in the carrier's provider network. The contact by the carrier, unless mutually agreed to by the in-network facility or provider and the carrier, shall not alter or modify the terms of the participating agreement between the in-network facility or provider and the carrier; and

(2) Update the information within fifteen (15) business days after receiving notice from the participating facility or provider of a change.

(e) Regarding the provider directory in print format, the carrier shall include a disclosure that the directory is accurate as of the date of printing and that enrollees and prospective enrollees should consult the carrier's electronic provider directory on its

website or call the appropriate customer service phone number to obtain current provider directory information.

(f) If an enrollee relies on the information published by the carrier of health benefit plans and inadvertently, and through no fault of the enrollee, receives care from a provider listed as participating but who in actuality does not participate in the carrier or health benefit plan's network, the carrier shall hold the enrollee harmless from all unexpected out-of-network costs and shall compensate the provider at the lesser of the usual and customary rate or provider's full submitted charge.

(g) Upon request of an enrollee or a prospective enrollee, the carrier shall make available in print format, the following provider directory information for the applicable network plan:

(1) For healthcare professionals, name; contact information; participating office locations; specialty, if applicable; languages spoken other than English, if applicable; and whether the provider is accepting new patients;

(2) For facility based physicians groups, name; contact information; hospital location; specialty; and if applicable languages spoken other than English;

(3) For hospitals, hospital name; hospital type, such as acute, rehabilitation, children's, cancer; and participating hospital location and telephone number; and

(4) For facilities, other than hospitals, by type; facility name; facility type; types of services performed; and participating facility locations and telephone number.

**56-33-112. Rules.**

The commissioner may promulgate rules to carry out this chapter. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

**56-33-113. Penalties.**

The commissioner may take other disciplinary action as permitted pursuant to § 56-2-305 and the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

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. This act shall take effect January 1, 2019, the public welfare requiring it.