

SENATE BILL 510

By Roberts

AN ACT to amend Tennessee Code Annotated, Title 8;
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, Chapter 7, is amended by adding the following as a new part:

56-7-3501. This part shall be known and may be cited as the "Tennessee Right to Shop Act."

56-7-3502. As used in this part:

(1) "Allowed amount" means the contractually agreed upon amount paid by a carrier to a healthcare entity participating in the carrier's network;

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

(3) "Comparable healthcare service" means any covered non-emergency healthcare service or bundle of services;

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

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

(6) "Healthcare entity" means:

(A) Any healthcare facility licensed under title 33 or 68; and

(B) Any healthcare provider licensed under title 63 or 68;

(7) "Incentive program" means the comparable shared savings incentive program established by a carrier pursuant to this part; and

(8) "Insurance carrier" or "carrier" means a health insurance entity as defined in § 56-7-109.

56-7-3503.

(a)

(1) Beginning upon approval of the next health insurance rate filing on or after January 1, 2020, a carrier offering a health plan in this state shall implement an incentive program that provides incentives for enrollees in a health plan who elect to receive a comparable healthcare service from a network provider that is covered by the health plan and that is paid less than the average allowed amount paid by that carrier to network providers for that comparable healthcare service before and after an enrollee's out-of-pocket limit has been met.

(2) Incentives may be calculated as a percentage of the difference between the amount actually paid by the carrier for a given comparable healthcare service and the average allowed amount for that service, or by another reasonable methodology approved by the commissioner. Incentives may be provided as a cash payment to the enrollee, a credit toward the enrollee's annual in-network deductible and out-of-pocket limit, or a credit or reduction of a premium, a copayment, cost sharing, or a deductible. A carrier may let an enrollee choose the method by which the enrollee prefers to receive the incentive.

(3) The incentive program must provide each enrollee with at least fifty percent (50%) of the carrier's saved costs for each comparable healthcare service resulting from shopping by the enrollee. However, the incentive program may exclude incentive payments, credits, or reductions for services where the savings to the carrier is twenty-five dollars (\$25.00) or less.

(4) The average allowed amount must be based on the actual allowed amounts paid to network providers under the enrollee's health plan within a reasonable timeframe, not to exceed one (1) year. The commissioner may approve methodologies that are based on an enrollee's specific health plan,

across all plans offered in the state by an insurance carrier, or that utilize a geographic area to set regional averages.

(5) Annually, at enrollment or renewal, a carrier shall provide notice to enrollees of the right to obtain information described in subdivision (a)(4) and the process for obtaining the information, and a description of how to earn the incentives. A carrier shall provide this notice on the carrier's website and in health plan materials provided to enrollees.

(b) An insurance carrier shall make the incentive program available as a component of all health plans offered by the carrier in this state.

(c) A comparable healthcare service incentive payment made by a carrier in accordance with this section is not an administrative expense of the carrier for rate development or rate filing purposes.

(d) Prior to offering the incentive program to any enrollee, a carrier shall file a description of the incentive program established by the carrier pursuant to this section with the department in the manner determined by the department. The department may review the filing made by the carrier to determine if the carrier's incentive program complies with this section. Denial of a program by the department requires a resubmission by a carrier until the department approves the program.

(e) A carrier shall annually file with the department for the most recent calendar year the total number of comparable healthcare service incentive payments made pursuant to this section, the use of comparable healthcare services by category of service for which comparable healthcare service incentive payments were made, the total incentive payments made to enrollees, the average amount of incentive payments made by service for the transactions, the total savings achieved below the average allowed amount by service for the transactions, and the total number and percentage of

a carrier's enrollees that participated in the transactions. Beginning in 2021 and by April 1 of each year thereafter, the commissioner shall submit an aggregate report for all carriers filing the information required by this subsection (e) to the commerce and labor committee of the senate and the insurance committee of the house of representatives. The commissioner may set reasonable limits on the annual reporting requirements on carriers to focus on the more popular comparable healthcare services.

56-7-3504.

(a) Beginning upon approval of the next health insurance rate filing on or after January 1, 2020, a carrier offering a health plan in this state shall comply with this section.

(b)

(1) A carrier shall make available an interactive mechanism on its publicly accessible website and a toll-free phone number that enables an enrollee to request and obtain from the carrier information on the average payments made by the carrier to network entities or providers for comparable healthcare services, as well as quality data for those providers, to the extent available.

(2) The interactive mechanism and toll-free phone number must allow an enrollee seeking information about the cost of a particular healthcare service to estimate out-of-pocket costs applicable to that enrollee's health plan and compare the average allowed amount paid to a network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed one (1) year.

(3) The out-of-pocket estimate must provide a good faith estimate of the amount the enrollee will be responsible to pay out-of-pocket for a proposed non-

emergency procedure or service that is a medically necessary covered benefit from a carrier's network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the carrier at the time the request is made. A carrier may contract with a third-party vendor to comply with this subsection (b).

(4) A carrier shall provide the information described in this subsection (b) by the carrier's website and toll-free phone number even if the enrollee requesting the information has exceeded the enrollee's deductible or out-of-pocket costs according to the enrollee's health plan. Existing transparency mechanisms or programs that estimate out-of-pocket costs for enrollees still within their deductible qualify under this section as long as those mechanisms or programs continue to disclose the estimated average allowed amount even after an enrollee has exceeded the enrollee's deductible as well as any estimated out-of-pocket cost.

(c) Nothing in this section prohibits a carrier from imposing cost-sharing requirements disclosed in the enrollee's policy, contract, or certificate of coverage for unforeseen healthcare services that arise out of the non-emergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

(d) A carrier shall notify an enrollee that the provided costs are estimated costs, and that the actual amount the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed non-emergency procedure or service.

56-7-3505.

(a) If an enrollee elects to receive a covered healthcare service from an out-of-network provider at a price that is the same or less than the average allowed amount for

that service, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's price and, upon request by the enrollee, shall apply the payments made by the enrollee for that healthcare service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the healthcare services had been provided by a network provider. The carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of submitting proof of payment to an out-of-network provider for purposes of administering this section. A carrier shall not deny or reduce payment for any healthcare service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a provider who is not a member of the carrier's provider network.

(b)

(1) For the purposes of this section, a carrier's average allowed amount is the same as for the purposes of calculating incentive payments under § 56-7-3503(a).

(2) A carrier shall provide notice to enrollees of enrollee rights under this section. A carrier shall provide the notice on the carrier's website and in health plan materials.

(3) A carrier may inform enrollees in the notice provided under subdivision (b)(2) that:

(A) The carrier is unable to certify the quality of care provided by an out-of-network provider;

(B) The benefit of this part is only realized if the final services' costs to the enrollee are below or the same as the in-network average provided by the website and toll-free phone number; and

(C) Any additional financial responsibility over the in-network average provided by the website and toll-free phone number may be treated as the responsibility of the enrollee if complications occur during the procedure. However, any subsequent care received in-network must be treated the same as care that would be provided following a similar complication if the procedure had been provided in-network.

56-7-3506.

The state insurance committee, created by § 8-27-201, shall publish a report no later than January 1, 2020, on examples of shared savings incentive programs that directly incentivize current enrollees and retirees to shop for lower cost care in other states and consider implementation of such a program in this state. The state insurance committee may implement such a program as part of the next open enrollment period if it is believed to be cost effective. The state insurance committee shall share the report in writing to the government operations committees in both the senate and house of representatives.

56-7-3507.

(a) By January 1, 2020, and by January 1 of each subsequent year thereafter, a carrier offering a health plan in this state shall disclose to the commissioner the number of providers removed from its network during the previous five (5) calendar years. This disclosure must include the reasons for removal. For each reason for removal given, the carrier shall include the number of providers removed for the particular reason.

(b) The carrier shall disclose the information required by subsection (a) on the carrier's website and provide the information in writing to any person who requests it. For purposes of this section, electronic disclosure qualifies as a written disclosure.

56-7-3508.

(a) By January 1, 2020, and by January 1 of each subsequent year thereafter, any person providing healthcare services in this state licensed under title 33, 63, or 68, as a nonprofit or charitable entity shall disclose the fiduciary duties the person's directors owe to the individuals benefiting from the charity.

(b) The person shall disclose the information required by subsection (a) on the person's website and provide the information in writing to any person who requests it. For purposes of this section, electronic disclosure qualifies as a written disclosure.

(c) For purposes of this section, "person" includes corporations, partnerships, limited liability companies, and limited partnerships, including both for-profit and nonprofit.

56-7-3509. The commissioner is authorized to promulgate rules as necessary to implement this part. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

56-7-3510. Except for § 56-7-3506, and notwithstanding § 56-7-1005, this part does not apply to any group insurance plan offered under title 8, chapter 27.

SECTION 2. For purposes 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, 2020, the public welfare requiring it, and shall apply to all health plans entered into or renewed on or after that date.