HOUSE BILL 963
By Lundberg

SENATE BILL 937

By Watson

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 7, relative to the predictability of payments by third-party payers.

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 Sections 2 through 9 as a new part 35.

SECTION 2. This part shall be known and may be cited as the "Healthcare Provider Stability Act."

SECTION 3. As used in this part, unless the context otherwise requires:

(1) "Healthcare provider" has the same meaning as defined in § 56-7-3301;

(2) "Material change":

(A) Means a change in fees or payment methodologies that a reasonable person would attach importance to in determining the action to be taken upon the change;

(B) Includes:

(i) A change to fee schedules previously agreed upon by the third-party payer and a healthcare provider, the third-party payer's internal coding guidelines, edits, and payment rules, including, but not limited to, multiple procedure payment reduction rules, claim payment procedures, or any other elements that the third-party payer utilizes to determine payment or reimbursement amounts; or

(ii) Any other means that a third-party payer or healthcare provider may utilize to adjust a rate for payment of items or services previously

agreed upon pursuant to a contract or fee schedule between the third-party payer and a healthcare provider; and

(C) Does not include:

(i) Any revision to the enrollee's benefit package;

(ii) Any process or program the third-party payer utilizes to determine the medical necessity of a healthcare item or service, including, but not limited to, utilization review procedures and prior authorization determinations;

(iii) Any process or program a third-party payer utilizes to investigate and address fraud and abuse with regard to a healthcare provider it has contracted with to provide items or services to its beneficiaries;

(iv) A change in Current Procedural Terminology (CPT) codes pursuant to the release of CPT coding guidelines from the American Medical Association and the Centers for Medicare and Medicaid Services, as applicable;

(v) A change in internal coding guidelines pursuant to a development in evidence-based medicine guidelines issued by a source other than the third-party payer or healthcare provider that does not adjust the rate of payment previously agreed upon by the third-party payer and a healthcare provider in a contract;

(vi) Any change in the average wholesale price for immunizations, vaccines, injectables, and other drugs or solutions; or

(vii) Any change or addition in items or services to be provided by the healthcare provider and paid for by the third-party payer that does not adjust the rate of payment for items or services previously agreed upon by the third-party payer and healthcare provider; and

(3) "Third-party payer" means a health insurer, third-party administrator, or other

person that is obligated pursuant to health insurance coverage or a health benefits plan to pay for covered healthcare services rendered to beneficiaries.

SECTION 4.

(a) If a third-party payer or healthcare provider desires to effect any material changes that adjust a previously agreed upon rate of payment for which a healthcare provider is paid for providing items or services, the third-party payer or healthcare provider shall effect all material changes at one (1) time during a calendar year and is prohibited from effecting a subsequent material change for at least twelve (12) months from a material change.

(b) The third-party payer or healthcare provider is required to send written notice of a material change to the other party sixty (60) days prior to the effective date of the material change.

SECTION 5. A third-party payer or healthcare provider may maintain an individual or class action as the sole remedy to enforce this part. The court may also award attorneys' fees and costs to the prevailing party. Venue for such actions shall be in the county in which the complaining party's principal place of business is located in this state.

SECTION 6. None of the requirements of this part may be waived by contract, and any such purported waiver is void.

SECTION 7. Nothing in this part obviates a third-party payer's obligation to comply with any and all legal requirements to which such payer must comply with respect to participating or nonparticipating healthcare providers.

SECTION 8. Nothing in this part shall apply to any contract between a third-party payer and a health care provider for items or services to be provided for individuals covered by the federal Medicare program, including Medicare Advantage, Medicare Select, Medicare Supplement, Medicare and Medicaid Enrollees (MME), Medicare Dual Special Needs, and

Medicare Private Fee for Service; state, local government, or local education insurance plans established under title 8, chapter 27; the TennCare or Medicaid waiver program established under title 71, chapter 5; any other health plan managed by the health care finance and administration division of the department of finance and administration; or any entity that is subject to delinquency proceedings and for which the commissioner of commerce and insurance has been appointed receiver or any entity placed under administrative supervision by order of the commissioner pursuant to title 56, chapter 9.

SECTION 9. Nothing contained in this part shall prohibit either the third-party payer or the healthcare provider from terminating a contract for the provision and payment of healthcare items or services in accordance with mutually agreed upon terms in that contract.

SECTION 10. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 11. This act shall take effect upon becoming a law, the public welfare requiring it, and shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the state on or after October 1, 2015.