HOUSE BILL 2725
By Campfield

SENATE BILL 3748

By Bunch

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 26, relative to health insurance.

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

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 26, is amended by adding Sections 2 through 13 as a new part thereto.

SECTION 2. As used in this part, unless the context otherwise requires:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a health benefit purchasing cooperative is in compliance with Section 12 of this act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the health benefit purchasing cooperative in establishing premium rates for applicable health benefit plans;

(2) "Base premium rate" means the lowest premium rate charged or that could have been charged under a rating system with similar case characteristics for health benefit plans with the same or similar coverage;

(3) "Basic health care plan" means a health care plan that is lower in cost than a standard health care plan and is required to be offered by all health benefit cooperatives pursuant to Section 11 of this act and approved by the commissioner;

(4) "Board" means the board of directors of a health benefit purchasing cooperative;

(5) "Carrier" means any person that provides one (1) or more health benefit plans in this state, including a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization (HMO);

(6) “Case characteristics” means demographic or other objective characteristics of an individual that are considered by the health benefit purchasing cooperative in the determination of premium rates for the individual, but does not mean claim experience, health status and duration of coverage since issue;

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

(8) “Committee” means the health benefit purchasing cooperative committee, as created by Section 11 of this act;

(9) “Dependent” means the spouse or child of an eligible enrollee, subject to applicable terms of the health care plan covering the enrollee;

(10) “Eligible employee” means an employee who works for a member of a health benefit purchasing cooperative on a full-time basis, with a normal work week of thirty (30) or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a member of a health benefit purchasing cooperative. “Eligible employee” does not include employees who work on a part-time, temporary, or substitute basis;

(11) (A) “Health benefit plan” means:

(i) Any accident and health insurance policy or certificate;

(ii) Nonprofit hospital or medical service corporation contract;

(iii) Health, hospital or medical service corporation plan contract; or

(iv) HMO subscriber contract;

(B) “Health benefit plan” does not mean:

(i) Accident only, specified disease only, fixed indemnity, credit or disability insurance;

(ii) Coverage or medicare services pursuant to contracts with the federal government;

(iii) Medicare supplement or long-term care insurance;

(iv) Dental only or vision only insurance;

(v) Coverage issued as a supplement to liability insurance;

(vi) Insurance arising out of a workers' compensation or similar law;

(vii) Automobile medical payment insurance; or

(viii) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(12) “Health group cooperative” or “cooperative” means a private purchasing cooperative composed of individuals and small businesses formed under this part;

(13) “Impaired insurer” has the same meaning as in § 56-12-203;

(14) “Index rate” means, for each class of business as to a rating period for member of a health benefit purchasing cooperatives with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(15) “Preexisting conditions provision” means a policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinarily prudent person to seek diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage;

(16) “Premium” includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan;

(17) “Rating period” means the calendar period for which premium rates established by a health benefit purchasing cooperative are assumed to be in effect, as determined by the health benefit purchasing cooperative;

(18) “Member of a health benefit purchasing cooperative” means any person who meets the qualifications set out in Section 6 of this act; and

(19) “Standard health care plan” means a health care plan for member of a health benefit purchasing cooperatives required to be offered by all health benefit purchasing cooperatives and approved by the commissioner.

SECTION 3. The purpose of this part is to authorize the creation of health benefit purchasing cooperatives for certain persons through a contract with an insurer authorized to provide health insurance in this state.

SECTION 4. A health benefit purchasing cooperative shall provide that:

(1) All members purchase their health care benefits from the same insurer;

(2) Members become better informed about health care trends and cost increases;

(3) Members are actively engaged in designing health care benefit options that are offered by the insurer and that meet the needs of their community;

(4) The health insurance risk of all of the members is pooled; and

(5) The members actively participate in health improvement decisions for their community.

SECTION 5. A health benefit purchasing cooperative may be incorporated as a nonprofit corporation pursuant to title 48.

SECTION 6.

(a) Except as provided in subsection (b), any person who does business, has a principal office, or resides in the geographic area in which a health benefit purchasing cooperative is organized, that meets the membership criteria established by the health benefit purchasing cooperative in its bylaws, and that pays the membership fee may be a member of the health benefit purchasing cooperative.

(b) A health benefit cooperative may limit membership of individuals through its membership criteria, but such criteria must be applied in the same manner as to all individuals within the same class.

SECTION 7. Each health benefit purchasing cooperative shall file its membership criteria, as well as any amendments to the criteria, with the commissioner.

SECTION 8.

(a) The health care benefits offered by a health benefit purchasing cooperative shall be negotiated between the health benefit purchasing cooperative and the insurer. The insurer must offer coverage to:

(1) An individual who is a member, officer, or eligible employee of a member of the health benefit purchasing cooperative; and

(2) A dependent of an individual under subdivision (a)(1) who receives coverage, including newborn infants.

(b) The contract between the members of a health benefit purchasing cooperative and an insurer shall be for a term of three (3) years. Upon enrollment in the insurer's health benefit plan each member shall pay to the health benefit purchasing cooperative an amount determined by the health benefit purchasing cooperative that is not less than the member's applicable premium for the thirty-sixth month of coverage under the contract. If a member withdraws from the health benefit purchasing cooperative before the end of the contract term the health benefit

purchasing cooperative may retain, as a penalty, an amount specified by the health benefit purchasing cooperative that is not less than the premium that the member paid for the thirty-sixth month of coverage.

SECTION 9. Each health benefit purchasing cooperative shall submit to the speaker of the house of representatives and the speaker of the senate and to the commissioner the following:

(1) An annual report, no later than February 1 of each year, on the progress of the health benefit purchasing arrangement as provided in this part; and

(2) Within one (1) year after the end of the term of the contract as provided in Section 8 (b) of this act a final report describing:

(A) The extent to which the health benefit purchasing arrangement had an impact on the number of uninsured in the geographic area in which it operated;

(B) The effect on health care coverage premiums for groups in the geographic area in which the health benefit purchasing arrangement operated, including groups other than the health benefit purchasing cooperative; and

(C) The degree to which health care consumers were involved in the development and implementation of the health benefit purchasing arrangement.

SECTION 10. The commissioner shall designate by rule and regulation the geographic areas in which health benefit purchasing cooperatives may be organized. There shall be five (5) geographic areas in the state. A geographic area may overlap with one (1) or more other geographic areas.

SECTION 11.

(a)(1) The commissioner shall appoint a health benefit purchasing cooperative committee with fair representation of:

(A) Risk-assuming carriers and reinsuring carriers;

(B) The insurance agent communities; and

(C) Consumers who are to be served by plans covered by this part.

(2) The commissioner shall appoint three (3) representatives from the health care profession who are licensed to practice medicine in this state. Two thirds (2/3) of the committee shall be appointed from among representatives of health benefit purchasing cooperatives.

(b) Subject to the commissioner's approval, the committee shall recommend the form and level of coverages to be made available by health benefit purchasing cooperatives. The committee shall recommend benefit levels, cost-sharing factors, exclusions and limitations for the basic and standard health care plans. One (1) basic health care plan and one (1) standard health care plan shall contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of HMOs, including any restrictions imposed by federal law. The committee shall submit the plans to the commissioner for approval within one hundred eighty (180) days after the committee's appointment according to this section. The plans may include cost containment features such as:

(1) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(2) Case management benefit alternatives;

(3) Selective contracting with hospitals, physicians and other health care providers;

(4) Reasonable benefit differentials applicable to participating and non-participating providers; and

(5) Other managed care provisions.

(c) To assure the broadest availability of health benefit plans, the committee shall recommend for the commissioner's approval market conduct and other requirements for

carriers, agents, brokers and third-party administrators, including requirements developed as a result of a request by the commissioner relating to the following:

(1) The availability of a broadly publicized toll-free telephone number for access by member of a health benefit purchasing cooperative to information concerning this part;

(2) Registration by agents, brokers and third-party administrators of their intention to be agents, brokers and third-party administrators for health benefit plans marketed to members of a health benefit purchasing cooperatives under this part;

(3) Methods concerning periodic demonstration by health benefit purchasing cooperatives, agents, brokers and third-party administrators that they are marketing and issuing health benefit plans to member of a health benefit purchasing cooperatives in fulfillment of the purposes of this part; and

(4) Establishing standards for those conditions under which a carrier would not be required to write business received from a particular agent or broker.

(d) Within two (2) years of policy writing experience under this part, and, at a minimum, every two (2) years thereafter for a period of ten (10) years and from time to time after the ten-year period, the committee shall study the effectiveness of this part, recommend further improvements to achieve greater stability, accessibility and affordability in the member of a health benefit purchasing cooperative marketplace, and submit study summary and recommendations to the commissioner, the speaker of the senate, the speaker of the house of representatives, the commerce, labor and agriculture committees of the senate and the commerce committee of the house of representatives.

SECTION 12.

(a) To improve the availability and affordability of health benefits coverage for member of a health benefit purchasing cooperatives, the health benefit purchasing cooperative

committee shall recommend to the commissioner two (2) plans of coverage, one (1) of which shall be a basic health care plan and the other of which shall be a standard health care plan. Each plan of coverage shall be in two (2) forms, one (1) of which shall be in the form of insurance, and the other of which shall be consistent with the basic method of operation and benefit plans of HMOs, including federally qualified HMOs. The committee shall submit the recommended plans to the commissioner for approval within one hundred eighty (180) days after the initial convening of the committee. The committee shall take into consideration the levels of health benefit plans provided in this state, appropriate medical and economic factors, and shall establish benefit levels, cost-sharing, exclusions and limitations. Notwithstanding subsection (c), in developing and approving the plans, the committee and the commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. The committee shall file with the commissioner its findings and recommendations and reasons for the findings and recommendations. The recommended plans may include cost containment features, including, but not limited to preferred provider provisions, utilization review of medical necessity of hospital and physician services, case management benefit alternatives, or other managed care provisions.

(b) The commissioner shall approve, modify, or disapprove the plans submitted by the committee after a public hearing held pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(c) After the commissioner's approval of the plans submitted by the committee under subsection (a) and in lieu of any contrary procedure established by this part, any health benefit purchasing cooperative may certify to the commissioner, in the form and manner prescribed by the commissioner, that the basic and standard health care plans filed by the carrier are in substantial compliance with the corresponding approved committee plans. Upon receipt by the

commissioner of the certification, the carrier may use the certified plans unless their use is disapproved by the commissioner.

(d) The plans developed under this section are not required to provide coverage that meets the requirements of this part that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider. Any such mandates included in the basic plans shall be limited to those that are essential to the provision of basic primary care.

(e) Within one hundred eighty (180) days after the commissioner's approval under subsection (b), every health benefit purchasing cooperative shall, as a condition of transacting business in this state, offer member of a health benefit purchasing cooperative at least one (1) basic and one (1) standard health care plan. Every member of a health benefit purchasing cooperative that elects to be covered under such a plan and agrees to make the required premium payments and to satisfy other provisions of the plan shall be issued a plan by the health benefit purchasing cooperative; provided that only members of a health benefit purchasing cooperative that have been without health insurance for the preceding six (6) calendar months are eligible to purchase the basic health care plan. After this act has been in effect for one (1) year, the six (6) calendar months eligibility requirement set forth above shall no longer apply. The premium payment requirements used in connection with basic and standard health care plans may address the potential credit risk of a member of a health benefit purchasing cooperative by means of payment security provisions that are reasonably related to the risk and are uniformly applied.

(f) No health benefit purchasing cooperative is required to offer coverage or accept applications:

(1) From an individual already covered under a health benefit plan, except for coverage that is to begin after the individual's anniversary date, but this subdivision (f)(1)

(f) shall not be construed to prohibit a group from seeking coverage or a health benefit purchasing cooperative from issuing coverage to a group before its anniversary date;

(2) If the commissioner determines that acceptance of an application or applications would result in the carrier being declared an impaired insurer; or

(3) If a health benefit purchasing cooperative which does not use preexisting conditions chooses to market to groups of less than five (5), then it shall immediately notify the commissioner and the board, and it shall do so consistently and equally to all such members of health benefit purchasing cooperative groups.

(g) Every health benefit purchasing cooperative shall fairly market the basic and standard health care plan to all members of a health benefit purchasing cooperative in the geographic areas in which the carrier makes coverage available or provides benefits.

SECTION 13.

(a) Health benefit plans covering members of a health benefit purchasing cooperative are subject to the following:

(1) Any preexisting condition provision may not limit or exclude coverage for a period beyond twelve (12) months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, for which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) months immediately before the effective date of coverage, or as to a pregnancy existing on the effective date of coverage;

(2) In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous group health benefit plan if the previous coverage was

continuous to a date not more than thirty (30) days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan;

(3) The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:

(A) For nonpayment of the required premiums by the policyholder or contract holder;

(B) For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees or their representatives;

(C) For noncompliance with plan provisions that have been approved by the commissioner;

(D) When the number of enrollees covered under the plan is fewer than the number of insureds or percentage of enrollees required by participation requirements under the plan; or

(E) When the health benefit purchasing cooperative stops writing new business for members of a health benefit purchasing cooperative market, if the cooperative:

(i) Provides notice to the department and either to the policyholder, contract holder or employer of its decision to stop writing new business for members of a health benefit purchasing cooperative market; and

(ii) Does not cancel health benefit plans subject to this part for one hundred eighty (180) days after the date of the notice required under subdivision (a)(3)(E)(i); and for that business of the carrier that remains in

force, the carrier continues to be governed by this act with respect to business conducted under this part.

(b) A health benefit purchasing cooperative shall not involuntarily transfer a member of a health benefit purchasing cooperative into or out of a class of business. A health benefit purchasing cooperative shall not offer to transfer a member of a health benefit purchasing cooperative into or out of a class of business unless the carrier offers to transfer all members of a health benefit purchasing cooperatives in the class of business without regard to case characteristics, claims experience, health status or duration of coverage since issue.

(c) In connection with the offering for sale of any health benefit plan to a member of a health benefit purchasing cooperative, each health benefit purchasing cooperative shall make a reasonable disclosure as part of its solicitation and sales materials of:

(1) The extent to which premium rates for a specified member of a health benefit purchasing cooperative are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the eligible employees and dependents of the member of a health benefit purchasing cooperative;

(2) Provisions concerning the health benefit purchasing cooperative's right to change premium rates and the factors other than claims experience that affect changes in premium rates;

(3) Provisions relating to renewability of policies and contracts; and

(4) Provisions affecting any preexisting conditions provision.

(d) Each health benefit purchasing cooperative shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and

practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(e) Each health benefit purchasing cooperative shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that it is in compliance with this part and that its rating methods are actuarially sound. The health benefit purchasing cooperative shall retain a copy of the certification at its principal place of business.

(f) A health benefit purchasing cooperative shall make the information and documentation described in subsection (e) available to the commissioner upon request. Except in cases of violations of this part, the information is proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside the department except as agreed to by the health benefit purchasing cooperative or as ordered by a court of competent jurisdiction.

(g) Subdivisions (a)(1)and (3) and subsections (b)-(f) apply to health benefit plans delivered, issued for delivery, renewed or continued in this state or covering persons residing in this state on or after January 1, 2011. Subdivision (a)(2) applies to health benefit plans delivered, issued for delivery, renewed or continued in this state or covering persons residing in this state on or after the date the plan becomes operational, as designated by the commissioner. For purposes of this subsection (g), the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan.

SECTION 13.

(a) Every health benefit purchasing cooperative shall elect either to become a risk-assuming carrier or become a reinsuring carrier. The carrier election shall be binding for a five-year period. The commissioner may, for good cause, permit a carrier to modify its election during the five-year period. All carriers under common ownership or control must make the

same election in this state; provided that the commissioner may, for good cause, permit an affiliated carrier to make a separate election.

(b) A health benefit purchasing cooperative that elects to stop participating as a reinsuring carrier and to become a risk-assuming carrier shall not reinsure or continue to reinsure any member of a health benefit purchasing cooperative health benefit plans as soon as the carrier becomes a risk-assuming carrier; however, a reinsuring carrier electing to become a risk-assuming carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any part of the year that the business was reinsured. A health benefit purchasing cooperative that elects to stop participating as a risk-assuming carrier and to become a reinsuring carrier may reinsure member of a health benefit purchasing cooperative health benefit plans.

(c) Any health benefit purchasing cooperative that stops writing, administering or otherwise providing health benefit plans to employers in this state shall continue to be governed by this part with respect to business conducted under this part that was transacted before the effective date of termination and that remains in force.

SECTION 14. Tennessee Code Annotated, Section 56-26-201, is amended in subdivision (2) by deleting the language "established by an employer, or to an association," and by substituting instead the language "established by an employer, or to an association, including an association of persons and businesses pursuant to the part enacted by this act,".

SECTION 15. If any provision of this act or the application thereof to any person or circumstance is held invalid, such 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 16. This act shall take effect upon becoming a law, the public welfare requiring it.