Amendment No. 1 to SB0510

Watson
Signature of Sponsor

AMEND Senate Bill No. 510 House Bill No. 419*

by deleting all language after the enacting clause and substituting instead the following:

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":

(A) Means any shopable non-emergency outpatient healthcare service or bundle of services; and

(B) Includes, but is not limited to, physical and occupational therapy services; radiology and imaging services; laboratory services; and infusion therapy;

(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;

Amendment No. 1 to SB0510

Watson
Signature of Sponsor

AMEND Senate Bill No. 510 House Bill No. 419*

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

(8) "Shopping and decision support program" means the program established by a carrier pursuant to this part.

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 a shopping and decision support program that provides shopping capabilities and decision support services for enrollees in a health plan. Beginning upon approval of health plans offered on or after January 1, 2021, a carrier shall provide 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, effective January 1, 2021, 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. 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.

(3) The shopping and decision support 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 shopping and decision support program may exclude incentive payments, credits, or reductions for services where the savings to the carrier is fifty dollars ($50.00) 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.

(5) Annually, at enrollment or renewal, a carrier shall provide, at a minimum, 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 shopping and decision support program available as a component of all health plans offered by the carrier in this state.

(c) Prior to offering the shopping and decision support program to any enrollee, a carrier shall file a description of the shopping and decision support program established by the carrier pursuant to this section with the department. The insurance carrier has discretion as to the appropriate format for providing the information required and may customize the format in order to provide the most relevant information necessary to permit the department to determine compliance. The department may review the filing made by the carrier to determine if the carrier's shopping and decision support program complies with this section.

(d)

(1) Beginning January 1, 2022, 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, and the total number and percentage of a carrier's enrollees that participated in the transactions.

(2) Beginning in 2022 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 (d) 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 member portal 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 member portal 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 based on the information provided by the enrollee or the enrollee's provider of the amount the enrollee will be responsible to pay out-of-pocket for a proposed non-emergency procedure or service that is determined by the carrier to be 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, and subject to further medical necessity review by the carrier. A carrier shall 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 member portal 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.

At the request of a patient, a healthcare entity shall provide a copy of an order for a comparable healthcare service within two (2) business days of the request.

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.

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.

56-7-3508.

Except for § 56-7-3506, and notwithstanding § 56-7-1005, this part does not apply to:

(1) Any group insurance plan offered under title 8, chapter 27;

(2) Any managed care organization contracting with the state to provide insurance through the TennCare program or the CoverKids program; or

(3) Any plan described in Section 1251 of the federal Patient Protection and Affordable Care Act (42 U.S.C. § 18011) and Section 2301 of the federal Health Care and Education Reconciliation Act.

56-7-3509.

Notwithstanding this part, the total value of incentives offered to any one (1) enrollee must not exceed six hundred dollars ($600) in any year.

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.