

HOUSE BILL 1106

By Favors

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, Section 56-7-3302, is amended by deleting  
the section and substituting instead the following:

(a)

(1) A health insurance entity shall provide notice to a healthcare provider  
of any material change made in the sole discretion of the insurance carrier to the  
entity's previously released provider manual or a reimbursement rule and policy  
at least sixty (60) days prior to the effective date of the change, and the health  
insurance entity shall ensure that any such material change is clearly identified in  
the following manner:

(A) Disclosing or identifying the change in the provider manual  
through the use of bold print or a font, or both, with the bold print or font  
being the same or larger size as the font generally used throughout the  
policy or manual; and

(B) Disclosing or identifying the change in the reimbursement  
rules and policies and the effective date of the change through the use of  
a separately categorized communication to the provider.

(2) Any disclosures required under this subsection (a) may be distributed  
via:

(A) An internet web-accessible section associated with a web-accessible current version of the provider manual or reimbursement rules and policies; or

(B) Written communication sent to a dedicated email address or as stipulated in the contract between the provider and the health insurance entity. The provider shall submit to the health insurance carrier a dedicated email address to receive the disclosures required by this subsection (a).

(b) Notwithstanding any law to the contrary, nothing in this part shall apply to the TennCare program or any successor Medicaid program provided for in title 71, chapter 5; the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; the Access Tennessee Act of 2006, compiled in title 56, chapter 7, part 29; any other plan managed by the health care finance administration division of the department of finance and administration or any successor division or department; or the group insurance plans offered under title 8, chapter 27; or a contract between a healthcare provider and the state or federal government or their agencies for health services provided through Medicare.

SECTION 2. Tennessee Code Annotated, Section 56-7-1013(a), is amended by designating the existing language as subdivision (1) and adding the following new subdivision (2):

(2) "Fee schedule" means a list of reimbursement amounts assigned to specific codes and used by a health insurance carrier pursuant to a contract between a health insurance carrier and a healthcare provider to calculate payments paid to the provider for therapies, procedures, materials, and other services delivered to enrollees.

SECTION 3. Tennessee Code Annotated, Section 56-7-1013, is amended by deleting subsection (c) and substituting instead the following:

(1) A health insurance carrier shall provide notice of and identify any change to a provider's fee schedule and the effective date of the change at least ninety (90) days prior to the effective date of the change. The notice and identification required by this subdivision (c)(1) shall be sent to a dedicated email address or as otherwise stipulated in the contract between the provider and the health insurance carrier. The provider shall submit to the health insurance carrier a dedicated email address to receive the disclosures required by this part.

(2) A health insurance carrier shall not require any hospital, by contract, reimbursement or otherwise, to notify the health insurance carrier of a hospital inpatient admission within less than one (1) business day of the hospital inpatient admission if the notification or admission occurs on a weekend or federal holiday. Nothing in this subsection (c) shall affect the applicability or administration of other provisions of a contract between a hospital and health insurance carrier, including, without limitation, preauthorization requirements for scheduled inpatient admissions.

(3) This subsection (c) shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

SECTION 4. Tennessee Code Annotated, Section 56-7-1013, is amended by adding the following new subsections:

(f) Within ten (10) business days of receipt of a written request from a provider, a health insurance carrier:

(1) Shall deliver to the provider at the provider's dedicated email address that provider's fee schedule, free of charge, in either a partial or full version as

requested by the provider, in a transferable industry standard spreadsheet, including Microsoft Excel or other comparable format; or

(2) May provide access to the provider's fee schedule on a secure website, so that the provider may access the fee schedule at any time throughout the term of the provider's contract with the health insurance carrier. Nothing in this subdivision (f)(2) requires a health insurance carrier to provide a fee schedule via a website.

(g)

(1) No health insurance carrier shall make a change or changes to a provider's fee schedule except as follows:

(A) Up to one (1) time during a consecutive twelve-month period.

After a health insurance carrier makes a change or changes to the provider's fee schedule, it is prohibited from doing so again for at least twelve (12) months following the effective date of the change or changes;  
or

(B) If a health insurance carrier and a hospital agree to the change or changes in writing.

(2) Subdivisions (c)(1) and (g)(1) do not apply to the following changes to a fee schedule:

(A) Any change in a provider's fee schedule due to a change effected by the federal or state government to its healthcare fee schedule, if the provider and health insurance carrier have previously agreed that the provider's fee schedule is based on a percentage or some other formula of a current government healthcare fee schedule, such as Medicare;

(B) Any change in a provider's reimbursement for drugs, immunizations, injectables, supplies, or devices if the provider and health insurance carrier or pharmacy benefits manager as defined by § 56-7-3102 have previously agreed that any reimbursement for drugs, immunizations, or injectables supplies or devices will be based on a percentage, or some other formula, of a price index not established by the health insurance carrier, such as the average wholesale price or average sales price;

(C) Any changes in the provider's reimbursement for drugs, immunizations, injectables, supplies, or devices if the provider and the health insurance carrier or pharmacy benefits manager as defined in § 56-7-3102 have previously agreed to any reimbursement for drugs, immunizations, injectables, supplies, or devices in accordance with § 56-7-3104 and based upon maximum allowable cost pricing as regulated by §§ 56-7-3101 and 56-7-3106;

(D) Any change to Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, International Statistical Classification of Disease and Related Health Problems (ICD) Codes, and other coding sets recognized or used by Centers for Medicare and Medicaid Services (CMS) that a health insurance carrier utilized in creating a provider's fee schedule;

(E) Any change to revenue codes as established by the National Uniform Billing Committee (NUBC);

(F) Any changes in a provider's fee schedule due to one (1) or more of the following if previously agreed to in a provider's agreement with a health insurance carrier:

(i) Payments made to the healthcare provider by the health insurance carrier or payments made to the health insurance carrier by the provider that are based on values or quality measures explicitly described in the written agreement between the provider and the health insurance carrier intended to improve care provided to the health insurance carrier's members;

(ii) Escalator or de-escalator clauses;

(iii) Provisions that require adjustments to payment due to population health management performance or results; or

(iv) Any arrangements, initiatives, or value-based payments relating to or resulting from the implementation or operation of the Tennessee Health Care Innovation Initiative or any successor state program applicable to provider agreements covered by this section.

(h) Nothing in this section shall apply to an enrollee's benefit package, or coverage terms and conditions, unrelated to application of fee schedules and reimbursements, including, but not limited to, provisions regarding eligibility for coverage, deductibles and copayments, coordination of benefits, and coverage limitations and exclusions.

(i) Nothing in this section shall apply to 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 the Insurers Rehabilitation and Liquidation Act, compiled in chapter 9 of this title.

(j) Notwithstanding anything in this section to the contrary, this section shall not apply to any contract amendment that is made due to a change in federal or state law.

(k) Nothing in this section shall apply to any contract between a health insurance carrier and a healthcare provider for items or services to be provided for individuals covered by any Medicare Advantage, Medicare Select, Medicare Supplement, Medicare and Medicaid Enrollees (MME), Medicare Dual Special Needs, and Medicare Private Fee for Service; or the state, local government, and local education insurance plans established under title 8, chapter 27.

(l) Notwithstanding any law to the contrary, nothing in this section shall apply to the TennCare program or any successor Medicaid program provided for in title 71, chapter 5; the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; the Access Tennessee Act of 2006, compiled in title 56, chapter 7, part 29; any other plan managed by the health care finance administration division of the department of finance and administration or any successor division or department; or the group insurance plans offered under title 8, chapter 27.

SECTION 5. This act shall take effect January 1, 2019, the public welfare requiring it, and shall apply to all contracts existing on that date and to all contracts entered into or renewed after that date.