SENATE BILL 2232
By Hensley

HOUSE BILL 2005

By Kumar

AN ACT to amend Tennessee Code Annotated, Title 56, relative to seeking payment from a patient for out-of-network care.

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

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section to be appropriately designated:

(a) As used in this section, unless the context requires otherwise:

(1) "Copayment or deductible" means the portion of a charge for services covered by a managed health insurance plan that is the obligation of the enrollee to pay under the terms of the plan;

(2) "Enrollee" means a person who has contracted for or who participates in a managed health insurance plan;

(3) "Healthcare provider" or "provider" means a person licensed under title 63 to provide healthcare services or a facility licensed under title 33 or title 68 to provide healthcare services;

(4) "Managed health insurance issuer" has the same meaning as defined in § 56-32-128; and

(5) "Managed health insurance plan" or "plan" means health insurance coverage, as defined in § 56-7-109, that offers health insurance coverage or benefits under a contract that restricts reimbursement for covered services to a defined network of providers.

(b) It shall be an unfair trade practice in violation of chapter 8 of this title for any out-of-network healthcare provider to request payment of a balance due from an

enrollee, other than a copayment or deductible at the in-network rate, for medical services covered under a managed health insurance plan provided by a managed health insurance issuer, unless the provider has complied with subsection (c).

(c) In order for an out-of-network healthcare provider to request payment of a balance due from an enrollee, other than a copayment or deductible, for medical services covered under a managed health insurance plan utilizing a network of providers, the provider shall inform the enrollee in a written notice at the time of providing service that the provider is an out-of-network provider for the enrollee's managed health insurance plan and that the enrollee may have financial liability for services rendered by the provider. If the enrollee is unable to understand or agree to this notice, then only in-network charges shall apply to the enrollee. The notice shall inform the enrollee of any alternative options to receive the medical service sought of which the provider is aware. The notice shall be brief, clear, and concise.

(d) The commissioner is authorized to promulgate rules to effectuate the purposes of this section. All such rules shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. For rulemaking purposes 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, 2017, the public welfare requiring it, and shall apply to contracts or policies issued, amended, or renewed on or after January 1, 2017.