HOUSE BILL 2322

By Hazlewood

AN ACT to amend Tennessee Code Annotated, Title 8 and Title 56, relative to health insurance.

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

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following as a new section:

(a) As used in this section:

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

(2) "Health benefit plan":

(A) Means a hospital or medical expense policy, health, hospital, or medical service corporation contract, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer, including group plans administered pursuant to title 8, chapter 27, or a plan subject to part 22 of this chapter, or a certificate issued under the policies, contracts, or plans; and

(B) Does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement as defined in § 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1)), specified disease, vision care, other limited benefit health insurance, coverage issued as a supplement to liability insurance, workers' compensation insurance, automobile medical payment insurance, or 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.

(b) A health benefit plan must include coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, psychophysiological testing and treatment, neurofeedback therapy, remediation, post-acute transition services, community reintegration services, including outpatient day treatment services, and other post-acute care treatment services required for and related to treatment of an acquired brain injury.

(c) A health benefit plan must not:

(1) Include, in any annual or lifetime limitation on the number of days of acute care treatment covered under the plan, any post-acute care treatment covered under the plan; or

(2) Limit the number of days of:

(A) Covered post-acute care, including a therapy, treatment, rehabilitation, testing, remediation, or other service described in subsection (b); or

(B) Covered inpatient care, to the extent that the treatment or care is determined to be medically necessary as a result of and related to an acquired brain injury; for purposes of this subdivision (c)(2)(B), the insured's or enrollee's treating physician determines whether treatment or care is medically necessary in consultation with the treatment or care provider, the insured or enrollee, and, if appropriate, members of the insured's or enrollee's family; the determination may be subject to review under subsection (f).

(d) Except as provided in subdivision (c)(1) or (c)(2), a health benefit plan must include the same amount limitations, deductibles, copayments, and coinsurance factors for coverage required under this section as applicable to other medical conditions for which coverage is provided under the health benefit plan.

(e)

(1) In addition to the required coverage described under subsection (b), a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the care of an insured or enrollee who:

(A) Has incurred an acquired brain injury;

(B) Has become unresponsive to treatment; and

(C) Becomes responsive to treatment at a later date.

(2) For purposes of determining whether an expense incurred pursuant to subdivision (e)(1) is reasonable, factors to be considered include:

(A) The cost;

(B) The time that has expired since the insured's or enrollee's previous evaluation;

(C) Any difference in the expertise of the physician or practitioner performing the evaluation;

(D) Changes in technology; and

(E) Advances in medicine.

(f) Notwithstanding another law to the contrary, an issuer of a health benefit plan shall respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three (3) business days after the date on which the person makes the request or submits the appeal. The person must make the request or submit the appeal in the manner prescribed by the

terms of the health benefit plan's insurance policy or agreement, contract, evidence of coverage, or similar coverage document.

(g) The issuer of a health benefit plan that contracts with or approves admission to a service provider may not, solely because a facility is licensed by this state as an inpatient rehabilitation facility, refuse to contract with or approve admission to the facility to provide services that are:

(1) Required by this section;

(2) Within the scope of the license of the inpatient rehabilitation facility; and

(3) Within the scope of the services provided under a rehabilitation program for brain injury that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or another nationally recognized accredited rehabilitation program.

(h) The issuer of a health benefit plan that requires or encourages an insured or enrollee to use healthcare providers that are designated by the plan must ensure that the services required by this section that are within the scope of the license of an inpatient rehabilitation facility and that may be provided under a program described in subdivision (g)(3) are made available and accessible to the insured or enrollee at an adequate number of inpatient rehabilitation facilities.

(i) A health benefit plan must not treat care provided in accordance with this section as custodial care solely because it is provided by an inpatient rehabilitation facility if the facility holds a CARF accreditation or another nationally recognized accreditation for a rehabilitation program for brain injury.

(j) To ensure the health and safety of individuals insured by or enrolled in a health benefit plan, the commissioner may require that a licensed inpatient rehabilitation

facility that provides covered post-acute care other than custodial care under this section to an insured or enrollee with an acquired brain injury hold a CARF accreditation or another nationally recognized accreditation for a rehabilitation program for brain injury.

SECTION 2. This act takes effect July 1, 2024, the public welfare requiring it, and applies to plans entered into, amended, issued, or renewed on or after that date.