SENATE BILL 692

By Southerland

AN ACT to amend Tennessee Code Annotated, Title 56, relative to rental network contract arrangements.

WHEREAS, transparent contracting for preferred provider organization services and contractual discounts is a vital component of lowering the administrative costs of providing health care because transparency alleviates confusion and increases detection of inappropriate access; and

WHEREAS, preferred provider organization services and contractual discounts should only be accessed pursuant to contract and in accordance with terms agreed to by the contracting provider; and

WHEREAS, to increase transparency in contracting and prevent inappropriate access to a provider's services and contractual discounts:

(1) A provider should have accurate information concerning where to submit claims and inquiries;

(2) A provider should be able to identify the health care contract applicable to the relationship between a provider and a patient at the time of service;

(3) A provider should have ready access, through a web site and by telephone, to information identifying third parties permitted access to the provider's services and contractual discounts;

(4) Any Explanation of Payments (EOPs), Remittance Advices (RAs), or other similar documentation submitted to a provider, or the provider's billing office, should clearly identify the contractual relationship through which a third party has gained access to such provider's services and contractual discounts;

(5) The terms of an underlying contract between a provider and a contracting entity should control access to the provider's services and contractual discounts by third parties;

(6) A provider should receive consideration for access to the provider's services and contractual discounts in the form of patients steered to the provider's services or in some other agreed upon manner; and

(7) Access to a provider's services and contractual discounts that is established by a contract should cease when that contract is terminated; now, therefore,

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

SECTION 1. Tennessee Code Annotated, Title 56, is amended by adding Sections 2 through 10 as a new, appropriately designated chapter.

SECTION 2. This chapter shall be known and may be cited as the “Preferred Provider Organization Transparency Act”.

SECTION 3. As used in this chapter:

(1) "Affiliate" means an individual or entity that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control, with a contracting entity;

(2) “Contracting entity” means any individual or entity that is engaged in the act of contracting with providers and that has entered into a provider network contract with a provider for the delivery of health care services;

(3) "Control" or "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an individual or entity, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official

position with or corporate office held by the individual or entity. “Control” is presumed to exist if any individual or entity, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other individual or entity;

(4) “Covered individual” means an individual who is covered under a health insurance plan;

(5) "Department" means the department of commerce and insurance;

(6) "Discount medical plan organization" means an entity that, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount;

(7) “Entity” means a corporation, business trust, trust, partnership, limited liability company, association, joint venture, public corporation, or any other legal or commercial entity;

(8) “Health care services” means services for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease;

(9)

(A) “Health insurance plan” means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise;

(B) “Health insurance plan” does not include one (1) or more, or any combination of, the following: coverage only for accident, or disability income insurance; coverage issued as a supplement to liability insurance; liability

insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage similar to the foregoing as specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; dental or vision benefits; benefits for long-term care, nursing home care, home health care, or community-based care; specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or such other similar, limited benefits as are specified in regulations; Medicare supplemental health insurance as defined under § 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or other similar limited benefit supplemental coverages;

(10) "Physician" means any individual licensed or permitted to practice medical care under title 63, chapters 6 and 9;

(11) "Physician hospital organization" means an organization that includes, but is not limited to, hospitals and physicians and that contracts with and provides administrative services to hospitals and physicians that have entered into or intend to enter into managed care arrangements;

(12) "Physician organization" means an organization that contracts with and provides administrative services to physicians that have entered into managed care arrangements;

(13) "Provider" means a physician, a physician organization, or a physician hospital organization. "Provider" does not include a physician organization or physician

hospital organization that leases or rents the physician organization’s or physician hospital organization’s network to a third party;

(14) “Provider network contract" or "provider agreement" means a direct contract between a contracting entity and a provider for the delivery of health care services specifying the rights and responsibilities of the contracting entity and the provider in relation to access and payment for health care services to covered individuals; and

(15) “Third party” means an organization that enters into a contract with a contracting entity or with another third party to gain access to a provider network contract. "Third party" also includes a contracting entity's subsidiaries and affiliates, except as provided in Section 4(a).

SECTION 4.

(a) This chapter does not apply in circumstances where access to the provider network contract is granted to an affiliate or a subsidiary of a contracting entity, or other entity if operating under the same brand licensee program as the contracting entity.

(b) This chapter does not apply to a contract between a contracting entity and a discount medical plan organization.

(c) This chapter does not apply to provider network contracts for services provided:

(1) To Medicare beneficiaries;

(2) As part of medical assistance provided pursuant to title 71, chapter 5, parts 1 or 14;

(3) To beneficiaries for services under title 71, chapter 3, part 11, or other state children's health insurance program (SCHIP) beneficiaries; or

(4) The state group health insurance program.

SECTION 5.

(a) Any individual or entity that commences business as a contracting entity shall register with the department within thirty (30) days of commencing business in this state unless such individual or entity is licensed by the department as an insurer. Any contracting entity not licensed by the department as an insurer shall register with the department within ninety (90) days of the effective date of this chapter. If a contracting entity fails to register with the department in compliance with this section, then the commissioner may assess penalties as set forth in § 56-2-305 (a)(1) or (a)(2).

(b)

(1) Registration shall consist of the submission of the following information:

(A) The official name of the contracting entity, including any d/b/a designations used in this state;

(B) The mailing address and official telephone number for the contracting entity's principal headquarters;

(C) The name and telephone number of the contracting entity's representative who shall serve as the primary contact with the department; and

(D) Any other information as requested by the department.

(2) The information required by this subsection (b) shall be submitted in written or electronic format, as prescribed by the department.

(c) The department may impose a registration fee to defray the cost of administering this section.

SECTION 6.

(a) A contracting entity shall only grant access to a provider’s health care services and contractual discounts pursuant to the contracting entity's provider network contract if:

(1) The provider network contract clearly and plainly authorizes the contracting entity to enter into an agreement with a third party allowing the third party to exercise the contracting entity’s rights and responsibilities under the provider network contract as if the third party were the contracting entity; and

(2) The third party accessing a provider's services and contractual discounts pursuant to the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract.

(b) A contracting entity that grants a third party access to a provider’s health care services and contractual discounts pursuant to a provider network contract shall:

(1) Identify and supply to a provider, upon request at the time a provider network contract is entered into with the provider, a written or electronic list of all third parties known at the time of contracting, to which the contracting entity has or will grant access to the provider’s health care services and contractual discounts pursuant to the provider network contract;

(2) Maintain an Internet web site and a toll-free telephone number through which a provider may obtain a listing, updated at least quarterly, of the third parties to which the contracting entity or another third party has executed contracts to grant access to such provider’s health care services and contractual discounts pursuant to the provider network contract;

(3) Provide each third party who contracts with the contracting entity to gain access to the provider network contract a summary of the contracting entity's current standard provider contract terms;

(4) Require that each third party who contracts with the contracting entity to gain access to the provider network contract:

(A) Designate an individual or department responsible for responding to provider inquiries concerning the third party's access to the provider network contract; and

(B) Include the following information on each remittance advice (RA), explanation of payment (EOP), or other similar documentation furnished to a provider when a contractual discount is exercised pursuant to the contracting entity's provider network contract:

(i) The source of the contractual discount taken by the third party; and

(ii) A direct toll-free telephone number answerable Monday through Friday during normal business hours for the individual or department designated to be responsible for responding to provider inquiries pursuant to subdivision (b)(4)(A);

(5)

(A) Notify any third party who contracts with the contracting entity to gain access to a provider's services and contractual discounts pursuant to the provider network contract of the termination of the provider network contract within twenty-one (21) calendar days of the contracting entity's receipt of notification of such termination.

(B) The notice required by this subdivision (b)(5) shall be provided through written notice, electronic communication, or an update to an electronic database of provider listings.

(c) Subject to any applicable continuity of care requirements, provisions of the provider network contract, or contrary provisions of law:

(1) A third party's right to access a provider's health care services and contractual discounts pursuant to a provider network contract shall terminate on the date the provider network contract is terminated;

(2) Claims for health care services performed after the termination date of the provider network contract are not eligible for processing and payment in accordance with the provider network contract; and

(3) Claims for health care services performed before the termination date of the provider network contract, but processed after the termination date, are eligible for processing and payment in accordance with the provider network contract.

(d)

(1) All information made available to a provider in accordance with the requirements of this chapter shall be confidential and shall not be disclosed to any individual or entity not involved in the provider's practice or the administration of such practice without the prior written consent of the contracting entity.

(2) A contracting entity may reference or include within the contract or a related document the language contained in subdivision (d)(1), or language that is substantially similar in scope and purpose, in order to affirm each party's knowledge of and agreement to comply with the confidentiality provision.

(3) This subsection (d) shall not preclude the information being disclosed for purposes of dispute resolution, enforcement of this chapter or assistance in enforcing this chapter.

SECTION 7.

(a) A third party, having itself been granted access to a provider's health care services and contractual discounts pursuant to a provider network contract, that subsequently grants access to another third party is obligated to comply with the rights and responsibilities imposed on contracting entities under Sections 5 and 6.

(b) A third party that enters into a contract with another third party to access a provider's health care services and contractual discounts pursuant to a provider network contract is obligated to comply with the rights and responsibilities imposed on third parties under this section and Section 6.

(c) A third party that subsequently grants access to another third party will provide to the contracting entity the location of a web site that the contracting entity will make available to providers as provided in Section 6(b)(2) that will identify to providers any individual or entity to whom the third party has granted access to the provider's health care services and contractual discounts pursuant to the provider network contract. The third party shall update its web site on a routine basis as additional individuals or entities are granted access and shall review the web site no less frequently than quarterly to ensure the completeness and accuracy of the information available on the web site.

SECTION 8.

(a) No contracting entity shall grant a third party access to the contracting entity's provider network contract by lease, rent, or by any other means unless the third party accessing the provider network contract is:

(1) A payer of claims or a third party administrator or other entity that administers or processes claims on behalf of the payer;

(2) A preferred provider organization or preferred provider network including a physician organization or physician-hospital organization; or

(3) An entity engaged in the electronic claims transport between the contracting entity and the payer if such entity does not provide access to the provider's services and contractual discounts to any other third party.

(b)

(1) Contracting entities and third parties shall maintain and make available information required by Sections 6(b)(2) and 7(c) and shall include the information required by Section 6(b)(4) on any remittance advice (RA), explanation of payment (EOP), or other similar documentation submitted to a provider.

(2) A provider may refuse to accept a contractual discount on an RA, EOP, or other similar documentation if the contractual discount is not exercised pursuant to a network provider contract as provided in this chapter or if the provider cannot ascertain if the contractual discount is exercised pursuant to a network provider contract because the contracting entity or third party has failed to comply with subdivision (b)(1). The provider shall notify the contracting entity or third party of the provider's refusal to accept the contractual discount.

(3) The provider may require payment of the charge with no discount applied unless the contracting entity or third party within thirty (30) calendar days of receipt of notice of the apparent violation of the requirements of this section:

(A) Notifies the provider that the apparent violation resulted from an administrative oversight or other unintentional error and advises the provider of steps taken to remedy and avoid recurrence of the error; and

(B) Submits to the provider a corrected RA or EOP with documentation demonstrating eligibility for any discount applied.

SECTION 9.

(a) The department shall enforce this chapter. The department is authorized to promulgate rules to effectuate this chapter in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5. The initial rules promulgated by the department may be designated as public necessity rules if the department finds that it cannot implement such rules by the effective date of this chapter exercising the rulemaking procedures for the promulgation of permanent rules and if the department complies with § 4-5-209.

(b) The department is authorized, if necessary, to establish reasonable fees to offset the costs of administering this chapter.

SECTION 10.

(a) It is an unfair insurance practice for the purposes of the Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009, compiled in title 56, chapter 8, part 1, to knowingly access a provider’s services or exercise a provider's contractual discounts pursuant to a provider network contract if such access or exercise is not pursuant to a contractual relationship with the provider or with a contracting entity or third party who has a contractual relationship with the provider as specified in this chapter.

(b)

(1) To effectuate the purposes of this section, the department shall develop a complaint form for providers or others to submit alleging violations of this chapter.

(2) Information provided in good faith to the department shall not make the provider or other individual or entity providing the information liable for civil damages as a result of providing such information.

SECTION 11. This act shall take effect October 1, 2009, the public welfare requiring it, and shall apply to provider network contracts entered into, renewed or materially amended on or after that date.