SENATE BILL 694

By Southerland

AN ACT to amend Tennessee Code Annotated, Title 56, to enact the "Rental Network Contract Arrangements Act".

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

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 8, is amended by adding Sections 2 through 10 of this act as a new part.

SECTION 2. This part shall be known and may be cited as the “Rental Network Contract Arrangements Act”.

SECTION 3. As used in this part, unless the context otherwise requires:

(1) “Contracting entity” means any person or entity that enters into direct contracts with providers for the delivery of health care services in the ordinary course of business;

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

(3) “Department” means the department of commerce and insurance;

(4) “Direct notification” is a written or electronic communication from a contracting entity to a provider documenting third party access to a provider network;

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

(6)

(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 section 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;

(7) "Physician" means an individual licensed or permitted to practice medicine and surgery under title 63, chapter 6 or 9;

(8)

(A) “Provider” means a physician, or a physician organization or physician hospital organization that is acting exclusively as an administrator on behalf of a physician to facilitate the physician’s participation in health care contracts;

(B) “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;

(9) “Provider network contract" means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and provider relative to the delivery of and payment for health care services to covered individuals; and

(10) “Third party” means an organization that gains access to a provider network contract by entering into a contract with a contracting entity or with another third party who has gained access to the provider network contract.

SECTION 4.

(a) This part does not apply to provider network contracts for services provided:

(1) To Medicare;

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

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

(b) This part does not apply in circumstances where access to the provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity.

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

SECTION 5.

Any person that commences business as a contracting entity shall register with the department within thirty (30) days of commencing business in this state unless such

person is licensed by the department as an insurer. On and after the effective date of this part, each 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 part.

(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 main telephone number for the contracting entity's main headquarters; and

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

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

(3) The department may collect a reasonable fee for the purpose of administering the registration process.

SECTION 6.

(a) A contracting entity may not grant access to a provider's health care services and contractual discounts pursuant to a provider network contract unless:

(1) The provider network contract specifically states that the contracting entity may enter into an agreement with a third party allowing the third party to obtain 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 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 access to a provider's health care services and contractual discounts pursuant to a provider network contract shall:

(1) Identify and provide to the provider, upon request at the time a provider network contract is entered into with a 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 a provider network contract;

(2) Maintain an Internet web site or other readily available mechanism, such as a toll-free telephone number, through which a provider may obtain a listing, updated at least every ninety (90) days, 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 a provider network contract;

(3) Provide the third party who contracts with the contracting entity to gain access to the provider network contract with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract;

(4) Require that the third party who contracts with the contracting entity to gain access to the provider network contract identify the source of the contractual discount taken by the third party on each remittance advice (RA) or explanation of payment (EOP) form furnished to a provider when such discount is pursuant to the contracting entity's provider network contract; and

(5)

(A)

(i) Notify the third party who contracts with the contracting entity to gain access to the provider network contract of the termination of the provider network contract no later than the date established by rule by the department, which date shall be prior to the effective date of the final termination of the provider network contract; and

(ii) Require any third party that is eligible to access a provider's discounted rate pursuant to the contract to be terminated to cease claiming entitlement to the discounted rate or other contracted rights or obligations for services rendered pursuant to such contract after termination of the provider network contract.

(B) The notice required under this subsection (b) may be provided through any reasonable means, including but not limited to: written notice, electronic communication, or an update to electronic database or other provider listing.

(c) Subject to any applicable continuity of care requirements, agreements, or contractual provisions:

(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 this part shall be confidential and shall not be disclosed to any person or entity not involved in the provider's practice or the administration thereof without the prior written consent of the contracting entity; provided, however, that such information may be disclosed to an agency of the state or law enforcement officer pursuant to an investigation or enforcement action or for the purposes of dispute resolution.

(2) Nothing contained in this part shall be construed to prohibit a contracting entity from requiring the provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the provider's direct practice management or billing activities.

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 of this act.

(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.

(c)

(1) A third party shall inform the contracting entity and providers under the contracting entity's provider network contract of the location of a web site, toll-free number, or other readily available mechanism, to identify the name of the person or entity to which the third party subsequently grants access to the provider's health care services and contractual discounts pursuant to the provider network contract.

(2) The web site shall be updated on a routine basis as additional persons or entities are granted access. The web site shall be updated to reflect all current persons and entities with access every ninety (90) days. Upon request, a contracting entity shall make access information available to a provider via telephone or through direct notification.

SECTION 8.

(a) It is an unfair insurance practice for the purposes of § 56-2-305 and title 56, chapter 8, part 1, to knowingly access or utilize a provider's contractual discount pursuant to a provider network contract without a contractual relationship with the provider, contracting entity, or third party, as specified in this part.

(b) Contracting entities and third parties are obligated to comply with Sections 6(b)(2) and (4) or 7(c)(1) and (2) concerning the services referenced on a remittance advice (RA) or explanation of payment (EOP). A provider may refuse the discount taken on the RA or EOP if the discount is taken without a contractual basis or in violation of

these sections. However, if a contracting entity or third party's failure to comply is due to an error in the RA or EOP and such error is corrected by the contracting entity or third party within thirty (30) days following notice by the provider, then the provider shall allow the discount.

(c) A contracting entity may not lease, rent, or otherwise grant to a third party, access to a provider network contract unless the third party accessing the health care contract is:

(1) A payer or third party administrator or another 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 that does not provide access to the provider's services and discount to any other third party.

SECTION 9. Unless otherwise provided in this part, a violation of this part shall be considered a violation under § 56-2-305. Enforcement of this part shall follow that prescribed by § 56-2-305 and title 56, chapter 8, part 1.

SECTION 10. The commissioner of commerce and insurance is authorized to promulgate necessary rules and regulations in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, to implement the provisions of this act.

SECTION 11. For the purpose of promulgating rules, this act shall take effect upon becoming law, the public welfare requiring it. For all other purposes, this act shall take effect on October 1, 2009, the public welfare requiring it, and shall apply to contracts entered into or renewed on or after that date.