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SENATE BILL 2463

By Roberts

AN ACT to amend Tennessee Code Annotated, Title 33; Title 56; Title 63 and Title 68, relative to health care.

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

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

**56-7-3501.** This part shall be known and may be cited as the "Tennessee Right to Shop Act."

**56-7-3502.** As used in this part:

(1) "Allowed amount" means the contractually agreed upon amount paid by a carrier to a healthcare entity participating in the carrier's network;

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

(3) "Comparable healthcare service": means any covered non-emergency healthcare service or bundle of services;

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

(5) "Health plan" has the same meaning as the term "health insurance coverage" as defined in § 56-7-109;

(6) "Healthcare entity" means:

(A) Any healthcare facility licensed under title 33 or 68; and

(B) Any healthcare provider licensed under title 63 or 68;

(7) "Insurance carrier" or "carrier" means a health insurance entity as defined in § 56-7-109; and

(8) "Program" means the comparable shared savings incentive program established by a carrier pursuant to this part.

**56-7-3503.**

(a)

(1) Beginning January 1, 2019, a carrier offering a health plan in this state shall develop and implement a program that provides incentives for enrollees in a health plan who elect to receive a comparable healthcare service that is covered by the plan from providers that charge less than the average allowed amount paid by that carrier to network providers for that comparable healthcare service.

(2) Incentives may be calculated as a percentage of the difference between the amount actually paid by the carrier for a given service and the average allowed amount for that service, or by another reasonable methodology approved by the commissioner. Incentives may be provided as a cash payment to the enrollee, or as credit toward the enrollee's annual in-network deductible and out-of-pocket limit. Carriers may let enrollees decide which method they prefer to receive the incentive.

(3) The incentive program shall provide enrollees with at least fifty percent (50%) of the carrier's saved costs for each comparable healthcare service resulting from shopping by enrollees. However, the program may exclude incentive payments for services where shopping results in savings to the carrier of twenty-five dollars ($25.00) or less.

(4) The commissioner shall promulgate rules to determine how to calculate the average allowed amount for a comparable healthcare service. The average allowed amount shall be based on the actual allowed amounts paid to network providers under the enrollee's health plan within a reasonable timeframe not to exceed one (1) year.

(5) A carrier shall provide notice to enrollees of their right to obtain information about the average allowed amount for a procedure or service and of the process for obtaining such information. A carrier shall provide this notice on the carrier's website and in benefit plan material.

(6) Carriers may require that an enrollee provide evidence that the enrollee shopped prior to selecting a provider as a condition of eligibility for an incentive payment. Evidence of shopping may include a quote from the provider, or evidence that the enrollee utilized the carrier's cost transparency website or toll-free number, required to be established under this part, to determine the price of the service prior to treatment.

(b) An insurance carrier shall make the incentive program available as a component of all health plans offered by the carrier in this state. Annually, at enrollment or renewal, a carrier shall provide notice about the availability of the program, a description of the incentives available to an enrollee, and how to earn such incentives to any enrollee who is enrolled in a health plan eligible for the program.

(c) A comparable healthcare service incentive payment made by a carrier in accordance with this section is not an administrative expense of the carrier for rate development or rate filing purposes.

(d) Prior to offering the program to any enrollee, a carrier shall file a description of the program established by the carrier pursuant to this section with the department in the manner determined by department. The department may review the filing made by the carrier to determine if the carrier's program complies with this section. Filings and any supporting documentation, made pursuant to this subsection (d) are confidential until the filing has been approved or denied by the department.

(e) Annually a carrier shall file with the department for the most recent calendar year the total number of comparable healthcare service incentive payments made pursuant to this section, the use of comparable healthcare services by category of service for which comparable healthcare service incentives are made, the total payments made to enrollees, the average amount of incentive payments made by service for such transactions, the total savings achieved below the average allowed amount by service for such transactions, and the total number and percentage of a carrier's enrollees that participated in such transactions. Beginning no later than eighteen (18) months after implementation of comparable healthcare service incentive programs under this section and annually by April 1 of each year thereafter, the commissioner shall submit an aggregate report for all carriers filing the information required by this subsection (e) to the senate commerce and labor committee and the insurance and banking committee of the house of representatives. The commissioner may set reasonable limits on the annual reporting requirements on carriers to focus on the more popular comparable healthcare services.

**56-7-3504.**

(a) Beginning upon approval of the next health insurance rate filing on or after January 1, 2019, a carrier offering a health plan in this state shall comply with this section.

(b) A carrier shall establish an interactive mechanism on its publicly accessible website that enables an enrollee to request and obtain from the carrier information on the payments made by the carrier to network entities or providers for comparable healthcare services, as well as quality data for those providers, to the extent available. The interactive mechanism must allow an enrollee seeking information about the cost of a particular healthcare service to compare allowed amounts among network providers,

estimate out-of-pocket costs applicable to that enrollee's health plan, and the average paid to a network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed one (1) year. The out-of-pocket estimate must provide a good faith estimate of the amount the enrollee will be responsible to pay out-of-pocket for a proposed non-emergency procedure or service that is a medically necessary covered benefit from a carrier's network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the carrier at the time the request is made. A carrier may contract with a third-party vendor to satisfy the requirements of this subsection (b).

(c) Nothing in this section prohibits a carrier from imposing cost-sharing requirements disclosed in the enrollee's policy, contract, or certificate of coverage for unforeseen healthcare services that arise out of the non-emergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

(d) A carrier shall notify an enrollee that the provided costs are estimated costs, and that the actual amount the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed non-emergency procedure or service.

**56-7-3505.**

(a) If an enrollee elects to receive a covered healthcare service from an out-of-network provider at a price that is the same or less than the average allowed amount for that service, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's price and, upon request by the enrollee, shall apply the payments made by the enrollee for that healthcare service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the healthcare services had been provided by a network provider. The carrier shall provide

a downloadable or interactive online form to the enrollee for the purpose of submitting proof of payment to an out-of-network provider for purposes of administering this section.

(b) For the purposes of this section, a carrier's average allowed amount is the same as for the purposes of calculating incentive payments under § 56-7-3503. A carrier shall provide notice to enrollees of their rights under this section. A carrier shall provide this notice on the carrier's website and in benefit plan material.

**56-7-3506.**

(a) If a patient or prospective patient is covered by insurance, a healthcare entity that participates in a carrier's network shall, upon request of a patient or prospective patient, provide within two (2) working days, based on the information available to the healthcare entity at the time of the request, sufficient information regarding the proposed non-emergency admission, procedure, or service for the patient or prospective patient to receive a cost estimate from the patient's insurance carrier to identify out-of-pocket costs, which could be through an applicable toll-free telephone number or website. A healthcare entity may assist a patient or prospective patient in using a carrier's toll-free number and website.

(b) If a healthcare entity is unable to quote a specific amount under subsection (a) in advance due to the healthcare entity's inability to predict the specific treatment or diagnostic code, the healthcare entity shall disclose what is known for the estimated amount for a proposed non-emergency admission, procedure, or service, including the amount for any facility fees required. A healthcare entity must disclose the incomplete nature of the estimate and inform the patient or prospective patient of their ability to obtain an updated estimate once additional information is determined.

(c) Prior to a non-emergency admission, procedure, or service and upon request by a patient or prospective patient, a healthcare entity outside the patient's or prospective patient's insurer network shall, within two (2) working days, disclose the price that will be charged for the non-emergency admission, procedure, or service, including the amount for any facility fees required.

(d) Healthcare entities shall post in a visible area notification of the patient's ability, for those with individual or small group health insurance, to obtain a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow an insurance carrier to assist the patient in comparing out-of-pocket and contracted amounts paid for the patient's care to different providers for similar services. This notification shall inform patients of their right to obtain services from different providers regardless of a referral or recommendation from the provider at the healthcare entity, and that seeing a high-value provider, either their currently referred provider or a different provider, may result in an incentive to the patients if they follow the steps set by their insurance carrier. The notification should give an outline of the parameters of potential incentives approved in this part. The notification should also inform patients that their carrier is required to provide enrollees an estimate of out-of-pocket costs and contracted amounts paid for their care to different providers for similar services via a toll-free telephone number and health care price transparency tool. A healthcare entity may provide additional information in any form to patients that inform them of carrier specific price transparency tools or toll-free phone numbers.

**56-7-3507.**

(a) The state insurance committee, created by § 8-27-201, shall conduct an analysis no later than January 1, 2020, of the cost effectiveness of implementing an

incentive-based program for current enrollees and retirees under programs the committee operates.  Any program found to be cost effective shall be implemented as part of the next open enrollment.  The state insurance committee shall communicate the rationale for its decision to the state government committee of the house of representatives and the senate state and local government committee in writing.

**56-7-3508.**

(a)  Beginning January 1, 2019, and on January 1 of each subsequent year, a carrier offering a health plan in this state shall disclose to the commissioner the number of the carrier's employees who received compensation with a value of more than five hundred thousand dollars ($500,000) per year for the prior calendar year.

(b)  Beginning January 1, 2019, and on January 1 of each subsequent year, a carrier offering a health plan in this state shall disclose the number of the carrier's employees who received compensation with a value of more than one million dollars ($1,000,000) per year for the prior calendar year.

(c)  Beginning January 1, 2019, and on January 1 of each subsequent year, a carrier offering a health plan in this state shall disclose the number of the carrier's employees who received compensation with a value of more than three million dollars ($3,000,000) per year for the prior calendar year.

(d)  For purposes of this section, "compensation" includes, but is not limited to, salary, bonuses, and benefits, including housing, insurance, retirement, stock options, and transportation.

(e)  The carrier shall disclose the information required by this section on the carrier's website and provide the information in writing to any person who requests it. Electronic disclosure qualifies as a written disclosure.

**56-7-3509.**

(a) Beginning on January 1, 2019, and on January 1 of each subsequent year, any healthcare provider licensed under title 33, 63, or 68 providing healthcare services in this state shall disclose to the commissioner the number of its employees who received compensation with a value of more than five hundred thousand dollars ($500,000) per year for the prior calendar year.

(b) Beginning January 1, 2019, and on January 1 of each subsequent year, any healthcare provider licensed under title 33, 63, or 68, providing healthcare services in this state shall disclose to the commissioner the number of its employees who received compensation with a value of more than one million dollars ($1,000,000) per year for the prior calendar year.

(c) Beginning January 1, 2019, and on January 1 of each subsequent year, any healthcare provider licensed under title 33, 63, or 68 offering healthcare services in this state shall disclose to the commissioner the number of its employees who received compensation with a value of more than three million dollars ($3,000,000) per year for the prior calendar year.

(d) For purposes of this section, "compensation" includes, but is not limited to, salary, bonuses, and benefits, including housing, insurance, retirement, stock options, and transportation.

(e) An entity providing information under this section shall disclose the information on its website and provide the information in writing to any person who requests it. Electronic disclosure qualifies as a written disclosure.

(f) For purposes of this section, "person" includes corporations, partnerships, limited liability companies, and limited partnerships, including both for-profit and non-profit.

(g) The department of health, the department of mental health and substance abuse services, and any licensing board operating under those departments shall assist the commissioner in administering this section.

**56-7-3510.**

(a) Beginning on January 1, 2019, and on January 1 of each subsequent year, any non-profit healthcare provider licensed under title 33, 63, or 68 in this state shall disclose to the commissioner what the provider would have paid in taxes for the prior year if the provider were a for-profit entity. This disclosure must include income taxes, property taxes, including business equipment taxes, and any other taxes the provider does not have to pay as a result of being a non-profit entity.

(b) The non-profit provider shall disclose the information required by subsection (a) on the provider's website and provide the information in writing to any person who requests it. Electronic disclosure qualifies as a written disclosure.

**56-7-3511.**

(a) Beginning on January 1, 2019, and on January 1 of each subsequent year, a carrier offering a health plan in this state shall disclose to the commissioner the number of providers removed from its network during the previous five (5) calendar years. This disclosure must include the reasons for removal. For each reason for removal given, the carrier shall include the number of providers removed for that reason.

(b) The carrier shall disclose the information required by subsection (a) on the carrier's website and provide the information in writing to any person who requests it. Electronic disclosure qualifies as a written disclosure.

**56-7-3512.**

(a) Beginning on January 1, 2019, and on January 1 of each subsequent year, any person providing healthcare services in this state licensed under title 33, 63, or 68,

shall disclose to the commissioner the percentage of its revenue derived from medicaid or the TennCare program for the previous fiscal year.

(b) Beginning on January 1, 2019, and on January 1 of each subsequent year, any person providing healthcare services in this state licensed under title 33, 63, or 68, shall disclose to the commissioner the percentage of its revenue derived from medicare for the previous fiscal year.

(c) Beginning on January 1, 2019, and on January 1 of each subsequent year, any person providing healthcare services in this state shall disclose to the commissioner the percentage of its revenue derived from private health plans for the previous fiscal year.

(d) Beginning on January 1, 2019, and on January 1 of each subsequent year, any person providing healthcare services in this state licensed under title 33, 63, or 68, shall disclose to the commissioner the percentage of its revenue derived from private payers for the previous fiscal year. For purposes of this section, a "private payer" is any person making payment other than a licensed insurance carrier, a self-insured employer sponsored plan, medicaid, medicare, or a veteran's benefit.

(e) Beginning on January 1, 2019, and on January 1 of each subsequent year, any person providing healthcare services in this state licensed under title 33, 63, or 68, shall disclose to the commissioner the percentage of its revenue derived from veteran's benefits for the previous year.

(f) The person shall disclose the information required by this section on the person's website and provide the information in writing to any person who requests it. Electronic disclosure qualifies as a written disclosure.

(g) For purposes of this section:

(1) "Person" includes corporations, partnerships, limited liability companies, and limited partnerships, including both for-profit and non-profit; and

(2) "Fiscal year" refers to the healthcare provider's fiscal year.

**56-7-3513.**

(a) Beginning on January 1, 2019, and on January 1 of each subsequent year, a carrier offering health insurance in this state shall disclose in writing to the commissioner and to any prospective purchaser of a health plan the average rate increase for the carrier for the prior five (5) years. The commissioner shall by rule determine the methodology for calculating the average rate increase and who qualifies as a prospective purchaser.

**56-7-3514.**

(a) Beginning on January 1, 2019, and on January 1 of each subsequent year, any person providing healthcare services in this state licensed under title 33, 63, or 68, shall disclose to the commissioner the average increase in revenues for the prior five (5) years.

(b) The person shall disclose to the commissioner the information required by subsection (a) on the person's website and provide the information in writing to any person who requests it. Electronic disclosure qualifies as a written disclosure.

(c) For purposes of this section, "person" includes corporations, partnerships, limited liability companies, and limited partnerships, including both for-profit and non-profit.

**56-7-3515.**

(a) Beginning on January 1, 2019, and on January 1 of each subsequent year, any person providing healthcare services in this state licensed under title 33, 63, or 68,

as a non-profit or charitable entity shall disclose the fiduciary duties the person's directors owe to the individuals benefiting from the charity.

(b) The person shall disclose the information required by subsection (a) on the person's website and provide the information in writing to any person who requests it. Electronic disclosure qualifies as a written disclosure.

(c) For purposes of this section, "person" includes corporations, partnerships, limited liability companies, and limited partnerships, including both for-profit and non-profit.

**56-7-3516.** The commissioner is authorized to promulgate rules as necessary to implement this part. The rules shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. For purposes of promulgating rules, 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, 2019, the public welfare requiring it, and shall apply to all health plans entered into or renewed on or after that date.