



HOUSE BILL 2503

By Sexton

AN ACT to amend Tennessee Code Annotated, Title 3; Title 4; Title 5; Title 6; Title 7; Title 8; Title 10; Title 12; Title 29; Title 35; Title 36; Title 37; Title 39; Title 40; Title 41; Title 42; Title 45; Title 47; Title 49; Title 50; Title 52; Title 53; Title 56; Title 58; Title 63; Title 67; Title 68 and Title 71, relative to health insurance.

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

SECTION 1. Tennessee Code Annotated, Section 56-7-1013(f)(1), is amended by deleting "ten (10) business days" and substituting "nine (9) business days".

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it.

Amendment No. 1 to HB2503

Kumar
Signature of Sponsor

AMEND Senate Bill No. 2557*

House Bill No. 2503

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as new sections:

(a) As used in this section:

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

(2) "Health insurance entity" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including an insurance company, a health maintenance organization, or a nonprofit hospital and medical service corporation;

(3) "Marketplace" means the federally facilitated marketplace for health insurance policies sold in accordance with the federal Patient Protection and Affordable Care Act (42 U.S.C. § 18011 et seq.) for this state; and

(4) "Per term" means the applicable duration or period of time for a specific policy provision in a health insurance plan offered in accordance with this section, including the timeframe during which a deductible or maximum allotted benefit accumulates and is calculated.

(b) A health insurance entity may offer a short-term limited-duration plan on the marketplace if the plan:

(1) Provides no less than the following minimum coverage and benefits:

(A) A per person deductible of no more than ten thousand dollars (\$10,000) per term;

(B) A per family deductible for all covered family members of no more than ten thousand dollars (\$10,000) per term;

(C) A coinsurance of no more than twenty percent (20%) per term;

(D) A maximum out-of-pocket coinsurance of no more than five thousand dollars (\$5,000) per term;

(E) A maximum benefit, per person, per term, of one million dollars (\$1,000,000);

(F) Coverage with a copay of no more than fifty dollars (\$50.00) per person, per term, for a visit with a physician for the enrollee's history and exam only;

(G) Coverage with a copay of no more than fifty dollars (\$50.00) per person, per term, for an urgent care visit;

(H) A copay of no more than twenty percent (20%) of the reasonable and customary charges for:

(i) A preventative care visit;

(ii) An emergency room visit for accident or illness;

(iii) An inpatient hospital service;

(iv) An outpatient surgery;

(v) A lab; and

(vi) An x-ray; and

(I) Four (4) tiers of pharmacy benefits for outpatient prescription drugs as follows:

(i) For the first tier, coverage of preferred generic drugs with a copay of no more than twenty-five dollars (\$25.00) and no deductible;

(ii) For the second tier, coverage of generic drugs;

(iii) For the third tier, coverage of preferred brand drugs;

and

(iv) For the fourth tier, coverage of non-preferred generic and non-preferred brand name drugs; and

(2) Complies with the duration limitations or requirements imposed by federal law for a short-term limited-duration plan to be offered on the marketplace.

(c) Except as provided under subsection (d):

(1) A health insurance entity offering a plan pursuant to this section may require an individual to meet eligibility requirements to enroll in the plan;

(2) A plan offered pursuant to this section must comply with § 56-7-2356; and

(3) A health insurance entity may offer benefits or coverage under a short-term limited-duration plan on the marketplace that exceed the minimum requirements of subsection (b).

(d) If this section conflicts with federal law, then the federal law controls to the extent of the conflict.

(e) The department shall promulgate rules to effectuate this section. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

(a) As used in this section:

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

(2) "Health insurance entity" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including an insurance company, a health maintenance organization, or a nonprofit hospital and medical service corporation;

(3) "Hospital indemnity coverage" means coverage that provides benefits on an independent, noncoordinated basis and that pays a fixed amount for specified events without regard to other insurance;

(4) "Marketplace" means the federally facilitated marketplace for health insurance policies sold in accordance with the federal Patient Protection and Affordable Care Act (42 U.S.C. § 18011 et seq.) for this state; and

(5) "Per term" means the applicable duration or period of time for a specific policy provision in a health insurance plan offered in accordance with this section, including the timeframe during which a deductible or maximum allotted benefit accumulates and is calculated.

(b) A health insurance entity may offer hospital indemnity coverage on the marketplace if the coverage allows an individual to choose from five (5) tiers that provide at least the following coverage:

(1) For the first tier, a deductible of no more than two thousand five hundred dollars (\$2,500);

(2) For the second tier, a deductible of no more than five thousand dollars (\$5,000);

(3) For the third tier, a deductible of no more than seven thousand five hundred dollars (\$7,500);

(4) For the fourth tier, a deductible of no more than ten thousand dollars (\$10,000); and

(5) For the fifth tier, a deductible of no more than fifteen thousand dollars (\$15,000).

(c) Except as provided under subsection (d):

(1) A health insurance entity offering coverage pursuant to this section may require an individual to meet eligibility requirements to enroll in the coverage;

(2) Coverage offered pursuant to this section must comply with § 56-7-2356; and

(3) A health insurance entity may offer benefits or coverage under a hospital indemnity policy on the marketplace that exceed the minimum requirements of subsection (b).

(d) If this section conflicts with federal law, then the federal law controls to the extent of the conflict.

(e) The department shall promulgate rules to effectuate this section. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 3. The commissioner of commerce and insurance shall notify the revisor of statutes in the general assembly's office of legal services within thirty (30) days of the date a federal law or regulation goes into effect allowing the sale of short-term limited-duration plans or hospital indemnity coverage on the marketplace.

SECTION 4.

(a) Notwithstanding another law to the contrary, Section 1 of this act takes effect on the thirtieth day following the passage or issuance of a federal law or regulation allowing the sale of short-term limited-duration plans on the marketplace, the public welfare requiring it.

(b) Notwithstanding another law to the contrary, Section 2 of this act takes effect on the thirtieth day following the passage or issuance of a federal law or regulation

allowing the sale of hospital indemnity coverage on the marketplace, the public welfare requiring it.

(c) Section 3 of this act takes effect upon becoming a law, the public welfare requiring it.

Amendment No. 2 to HB2503

Jones J
Signature of Sponsor

AMEND Senate Bill No. 2557*

House Bill No. 2503

by deleting subdivision (c)(1) in Section 1 and substituting:

(1) A health insurance entity offering a plan pursuant to this section may require an individual to meet eligibility requirements to enroll in the plan; provided, that the health insurance entity shall not conduct medical underwriting for, or discriminate on the basis of a preexisting condition of, an individual for such plan;

AND FURTHER AMEND by deleting subdivision (c)(1) in Section 2 and substituting:

(1) A health insurance entity offering coverage pursuant to this section may require an individual to meet eligibility requirements to enroll in the coverage; provided, that the health insurance entity shall not conduct medical underwriting for, or discriminate on the basis of a preexisting condition of, an individual for such coverage;