STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
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DOUGLAS M. SIZEMORE
COMMISSIONER

BULLETIN

To: All Insurance Companies and Health Maintenance Organizations Doing Business in Tennessee

From: Douglas M. Sizemore, Commissioner
Tennessee Department of Commerce and Insurance

Re: **Public Chapter 1033**

Date: December 18, 1998

The purpose of this bulletin is to set forth guidelines to be followed by managed health insurance issuers subject to the requirements of Public Chapter 1033, "The Consumer Health Care Advocacy Act." This new law requires managed health insurance issuers, including HMOs, to offer or contract with another carrier to offer, either a POS option or a preferred provider organization plan. The legislation also provides standards for network adequacy; prohibitions against discrimination against classes of providers who provide covered services under the plan; direct access to an obsetrician/gynecologist for at least one (1) annual preventative care visit without a referral from a primary care provider; direct access to an optometrist or ophthalmologist for at least one (1) annual visit for covered vision care services as well as services and necessary follow-up care related to the treatment without a referral from a primary care provider; standards for continuity of care with respect to providers who terminate their agreements with the managed health insurance issuer or who are terminated without cause by the managed health insurance issuer; standards regarding pharmacy and pharmacy access, including standards of notification and grievance procedures relative to drug formularies; and communication protections for providers.

The provisions of the legislation requiring managed health insurance issuers, including HMOs, to offer either a point of service plan or a preferred provider organization plan, were codified at T.C.A. § 56-32-228. Subsection (b)(2) requires HMOs to fully disclose to the enrollees the terms and conditions, co-payments or other cost-sharing features, and the associated costs for each option offered by the HMO in clear, understandable terms. HMOs are required to submit the proposed disclosure to the department for approval and the department will review those filings on a case by case basis. The

department will not approve any disclosure form which does not clearly identify and compare the cost to the enrollees of the plans and the differences between the in-network and out-of-network benefits.

With respect to premium rates, T.C.A. § 56-32-228(c) provides that the amount of additional premium charged by an HMO for providing these options must be fair and reasonable in relation to the benefits provided, taking into account any co-payments or other cost-sharing features. Pursuant to T.C.A. § 56-32-207(b), all charges for health care services are required to be filed and approved by the commissioner . The department will review all filings for additional charges for health care services under the new law on a case by case basis. All filings must be actuarially sound and must be accompanied by adequate supporting information.

If an HMO determines that the requirements of T.C.A. § 56-32-228 have been satisfied pursuant to subsection (f) because the employer or other person sponsoring the health insurance or health benefits plan includes for all principal enrollees a preferred provider organization plan, a plan which offers unrestricted access to providers, or a point of service benefit, then the HMO must notify the Department at least sixty (60) days prior to the termination of any plan which it relies upon to satisfy the requirements of this statute. It is the responsibility of the HMO to ensure that its enrollees are afforded the benefits mandated by this statute.

Douglas M. Sizemore
Commissioner of Commerce and Insurance