SENATE BILL 989

By Gardenhire

AN ACT to amend Tennessee Code Annotated, Title 8, Chapter 27, relative to local government entities that self-fund a plan of insurance.

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

SECTION 1. Tennessee Code Annotated, Section 8-27-507, is amended by deleting the section.

SECTION 2. Tennessee Code Annotated, Section 8-27-608, is amended by deleting the section.

SECTION 3. Tennessee Code Annotated, Title 8, Chapter 27, is amended by adding the following as a new part:

8-27-901. Definitions.

As used in this part:

(1) "Administrator" means:

(A) An individual, either employed by, or contracted with, the sponsor or the plan to provide administrative services on behalf of the plan; or

(B) An entity with whom the sponsor contracts to provide administrative services on behalf of the plan;

(2) "Days" means calendar days, unless otherwise noted;

(3) "Insured" means any individual, other than the primary insured, who receives benefits under the plan;

(4) "Plain language" means writing designed to ensure the reader understands the meaning of the passage as quickly, easily, and completely as possible, avoiding verbose, convoluted language, and jargon;

(5) "Plan" means a self-funded plan of insurance established and funded by a sponsor pursuant to this part for the purpose of providing group life, hospitalization, disability, on-the-job injury or work-related injury program, or medical insurance, where funding for the plan is primarily derived from local tax revenues, which are used to fund, in excess of fifty-one percent (51%), the total costs of the plan, and where the benefits are paid directly through the sponsor's general assets or through a trust fund established for that purpose. A "plan" includes those to which the primary insured pays to the plan a nominal fee, not to exceed a total of ten percent (10%) of the total cost of coverage for the primary insured and any insureds whose relationship to the primary insured allows them to receive benefits under the plan. Whether or not the plan contracts with an administrator is not a factor in determining whether the plan meets this definition;

(6) "Plan document" means a document by which a plan is established and operated;

(7) "Plan participant" means either a primary insured or insured;

(8) "Primary insured" means the individual employed by, or contracted with, the sponsor and to whom, based on the individual's status as an employee or contractor, the plan provides benefits;

(9) "Request for subrogation or reimbursement interest" or "RSRI" means a form drafted by the plan in plain language and included in the SPD that the plan participant, their attorney, or other party in interest, may use to request that the plan provides notice of its subrogation or reimbursement interest;

(10) "Reimbursement interest" means the plan's right of recovery of benefit amounts paid by the plan on behalf of the plan participant from the participant's recovery from a third-party tortfeasor arising from the injury or illness of the plan participant caused by such tortfeasor. "Reimbursement interest" does not include pre- or post-judgment interest;

(11) "Settlement" means an agreement reached between a plan participant and the plan, or between the plan participant and a third-party tortfeasor or the third-party insurer, or both;

(12) "Sponsor" means a county, municipality, municipal corporation, or special school district in this state that establishes and funds a plan;

(13) "Subrogation interest" means the right to recovery that the plan has in any litigation or settlement arising from the injury or illness of a plan participant caused by a third-party tortfeasor. "Subrogation interest" does not include pre- or post-judgment interest;

(14) "Summary plan description" or "SPD" means a summary of the plan document, which may or may not be part of the plan document;

(15) "Summary of material modification" or "SMM" means a summary of any material amendment to the plan adopted by the sponsor, including, but not limited to, changes in deductibles, co-pays, and eligibility requirements; covered services or benefits; formulas; methodologies; schedules; networks; prior authorization requirements; and drug tiers;

(16) Third-party administrator" or "TPA" means an organization with which the plan contracts to process claims or manage certain other aspects of the plan, including, but not limited to, customer service, plan design, benefits

notification, subrogation services, general plan administration, and appeals review;

(17) "Third-party for medical services" or "third party" includes, but is not limited to, a health and liability insurer, an administrator of an ERISA plan, an employee welfare benefit plan, a workers' compensation plan, CHAMPUS, Medicare, and other parties that are by statute, contract, or agreement legally responsible for payment of a claim for a healthcare item or service;

(18) "Third-party insurer" means an insurer that provides insurance coverage to a third-party tortfeasor, regardless of whether the coverage is personal or commercial, including, but not limited to, automobile, income replacement, premises liability, home owners, umbrella, group life, health, workers compensation, hospitalization, and disability; and

(19) "Third-party tortfeasor" means an individual or entity who commits a tort against a plan participant that causes a plan participant to require medical treatment for which the plan makes payments to a provider of medical services for the benefit, or on behalf, of the plan participant.

8-27-902. Plan document contents; SPD contents.

(a) The plan document must include:

(1) The name of the plan administrator and the designation of any named fiduciaries other than the plan administrator under the claims procedure for deciding benefit appeals;

(2) A description of the benefits provided;

(3) The standard of review for benefit decisions;

(4) Who is eligible to participate, which includes designating classes of employees, establishing an employment waiting period prior to eligibility for plan

participation, designating the hours per week an employee must work in order to be eligible for plan participation, and establishing tiers of coverage;

(5) How much the primary insured must pay towards the cost of each tier of coverage;

(6) The plan sponsor's amendment and termination rights and procedures and how plan assets will be distributed if the plan is terminated;

(7) Rules restricting and regulating the use of personal health information (PHI), if the plan sponsor uses PHI;

(8) Subrogation, reimbursement, coordination of benefits, and offset provisions;

(9) Procedures for allocating and designating administrative duties to a TPA or committee;

(10) To the extent the plan has assets, the manner in which it is funded;

(11) Information regarding COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. § 300bb-1 et seq)), HIPAA (Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et seq.)), and other federal mandates;

(12) Preexisting condition exclusions;

(13) Special enrollment rules;

(14) Mental health parity;

(15) Coverage for adopted children and domestic partners;

(16) Qualified medical support orders; and

(17) Minimum hospital stays following childbirth.

(b) The summary plan description must include, at a minimum:

(1) A summary description of all benefits and costs to insureds under the plan, including co-pays, deductibles, and premiums for different tiers of coverage, if applicable;

(2) A list of eligible plan participants;

(3) Contact information for the administrator;

(4) Contact information for the sponsor;

(5) A mailing address for each type of notice required by this part; and

(6) A copy of any forms required by the plan or by this part;

8-27-903. Subrogation; reimbursement.

(a) A plan shall not recover a medical payment paid to, or on behalf of, a plan participant under a plan unless:

(1) The medical payment has been incorrectly paid; or

(2) The plan participant recovers, or is entitled to recover, from a third-party tortfeasor or third-party insurer reimbursement for all or part of the costs of care or treatment for the injury or illness for which the medical payment is paid.

(b) The plan is subrogated to all rights of recovery against any person or entity for the cost of care or treatment for any injury or illness caused by a third-party tortfeasor for which medical payment is provided, contractual or otherwise, by the plan for the benefit of, or on behalf of, a plan participant. The subrogation right attaches automatically as a lien against any proceeds received by the plan participant from a third-party tortfeasor for the cost of care or treatment for any injury or illness caused by the third-party tortfeasor for which medical payment is provided.

(c) The plan has a right of reimbursement from any plan participant for the cost of care or treatment for any injury or illness caused by a third-party tortfeasor for which medical payment is provided, contractual or otherwise, by the plan for the benefit of, or

on behalf of, a plan participant. The reimbursement right attaches automatically as a lien against any proceeds received by the plan participant from a third-party tortfeasor for the cost of care or treatment for any injury or illness caused by the third-party tortfeasor for which medical payment is provided. The right of reimbursement is contingent upon:

(1) The plan stipulating that the reimbursement proceeds be held for the exclusive purpose of providing benefits to plan participants and their beneficiaries; and

(2) The plan stipulating that the plan waives its right of reimbursement when the plan participant is adjudged permanently disabled and thereby receives corresponding benefits from the social security administration or suffers a catastrophic loss, including, but not limited to, death; long-term or permanent disability; loss of a limb, extremity, or eye; permanent loss of fifty percent (50%) or more of sight or hearing; a prolonged vegetative state; permanent mental impairment; protracted and complex recovery requiring multiple or successive surgeries; or any other similar, life-altering loss.

(d) A plan is not required to choose between the plan's right of subrogation or right of reimbursement. However, once the plan has received the total amount of medical payments made on behalf of a plan participant, whether under a right of subrogation or a right of reimbursement, the plan's subrogation and reimbursement interests are extinguished.

(e) The plan may elect, on a case by case basis, whether to waive its subrogation or reimbursement interests. If the plan elects to waive one (1) interest, the waiver does not extinguish the other. If the plan elects to waive either its subrogation or

reimbursement interests, the plan shall promptly notify the insured or the insured's attorney, in writing sent by certified mail with either return signature or electronic receipt.

(f) The plan shall not withdraw or reduce payments to a provider of medical services in order to recover funds obtained by a plan participant from a third-party tortfeasor or third-party insurer for medical services rendered by the medical-services provider if the plan has reason to know that the funds were obtained without the knowledge or direct assistance of the provider.

(g) If the plan asserts its right to subrogation or reimbursement, the plan shall clearly state the assertion in plain language in the SPD, informing the primary insured of the plan's rights of recovery against third parties and plan participants, and that the primary insured should seek the advice of an attorney regarding those rights of recovery to which the plan may be entitled.

(h) If a plan has a third-party administrator, recovery for any benefits incorrectly paid must be exclusively from such third-party administrator.

8-27-904. Plan participant rights and duties.

(a) By accepting payment of benefits pursuant to a plan authorized by this part, a plan participant has assigned to the plan the right of third-party insurance benefits or other recovery rights to which the plan participant may be entitled, which must be noted in plain language in the SPD.

(b) By accepting payment of benefits pursuant to a plan authorized by this part, a plan participant acknowledges the plan's right to reimbursement, which must be noted in plain language in the SPD.

(c) A plan under this part may deem a plan participant ineligible for continued or future coverage under the plan, if the plan participant:

(1) Receives payment from a third-party tortfeasor, third-party insurer, third party for medical payments, or other individual or entity originally paid by the plan for the benefit of, or on behalf of, the plan participant; and

(2) Fails or refuses to promptly reimburse the plan for the amounts paid by the plan.

(d) A plan shall not remove a plan participant under a plan pursuant to subsection (c) unless the plan or administrator provides the primary insured with written notice of intent to remove the plan participant. The plan or administrator shall send the notice at least ninety (90) days prior to the date the plan participant will lose benefits under the plan by certified mail with signed or electronic receipt. To be effective the notice must at a minimum include:

(1) The name of the plan participant to be removed from the plan;

(2) The date the plan participant will cease to be covered under the plan;

(3) The reason for removal from the plan;

(4) The name, title, phone number, mailing address, and email address of an individual with the authority to cancel or change the plan participant's removal, if the removal violates the terms of the plan, or as the sponsor permits.

(e) The plan shall not prevent a provider from receiving payment for services already rendered to a provider even if the plan participant is removed from participation in a plan pursuant to subsection (c). However, this subsection (e) does not require the plan to pay benefits to medical services providers if the benefits have already been paid to a plan participant.

8-27-905. Third parties.

(a) A third-party insurer or other third party, upon receiving a request from a plan, shall provide information identifying persons covered by third parties for medical

services. As a condition of doing business in this state or providing coverage to residents of this state, and subject to subsection (c), a third party for medical services shall, upon request from a plan or an administrator, electronically provide full eligibility files that contain information to determine the period a plan participant may be or may have been covered by the third party. The eligibility files must include the nature of the coverage that is or was provided by the third party; the name, address, date of birth, social security number, group number, and identifying number of the plan under which the plan participant may receive benefits; and the effective and termination dates for the coverage.

(b) A third party is not liable to a policyholder for proper release to a plan or an administrator of the information contained in the eligibility files provided pursuant to subsection (a).

(c) The third party shall provide the eligibility files pursuant to subsection (a) upon receipt of written request from a plan or an administrator with the third party establishing confidentiality requirements for the information. The plan or administrator may serve the request on the third party electronically or by mail.

(d) Third parties shall respond to all written inquiries by a plan regarding a claim for payment for any healthcare item or service that are submitted not later than three (3) years after the date of the provision of the healthcare item or service, or within three (3) years of conclusion of litigation. Third parties shall respond to a plan's or administrator's request for payment by providing payment on the claim, a written request for additional information with which to process the claim, or a written reason for denial of the claim within ninety (90) days of receipt of written proof of loss or claim for payment for healthcare services provided to, for the benefit of, or on behalf of, a plan participant. Such response from a third-party notice may be sent to the plan electronically if the plan

administrator has provided an email address or other electronic means of communication, or by certified mail with either a return signature or electronic receipt. Notwithstanding title 56, a failure to pay or deny a claim within one hundred eighty (180) days after receipt of the claim constitutes a waiver of any objection to the claim and an obligation to pay the claim.

8-27-906. Information to be provided; Notifications; RSRI

(a) A plan shall list the address or addresses to which all notices required by this section must be sent in the plan document, in the SPD, and in all materials the plan provides to the primary insured regarding benefits under the plan, including information published on the internet or on a sponsor's intranet or electronic portal. The address must be an address that accepts certified mail.

(b) At each enrollment renewal period, the plan shall mail to each primary insured, at the primary insured's last address of record provided to the plan, an SPD that provides an RSRI form and details about the current plan benefits. To the extent that the sponsor maintains an intranet or other electronic portal for the benefit of its employees, such information must be readily available on this platform at all times and to all primary insureds and employees who may be eligible to participate in the plan. If the sponsor maintains a platform that satisfies the foregoing, the platform may be used in lieu of the plan mailing each primary insured an SPD; provided, that for each new enrollment period all primary insureds and employees who may be eligible to participate in the plan are required to electronically acknowledge receipt of, and access to, the SPD via the platform

(c) SMMs must be drafted in plain language and be provided to each primary insured under the plan within sixty (60) days after the date of adoption of any material reduction in benefits or material increase in cost to plan participants. An SMM may be

provided either by certified mail or via the sponsor's intranet or electronic portal; provided, that the primary insured is required to electronically acknowledge receipt of such SMM via the platform. At a new enrollment period the plan may use an SMM to disclose only the changes to the plan rather than drafting a new SPD; provided, that the plan also provides a copy of the original SPD to which the changes apply, and provided that primary insureds and employees who may be eligible to participate in the plan are required to electronically acknowledge receipt of, and access to, the SMM via the platform.

(d) Before the entry of the judgment or settlement in a personal injury case, the plan participant or the plan participant's attorney, or other individual or the individual's attorney, who has an interest in recovery under this part, shall notify the plan by completing the plan's RSRI form or in writing, either of which must be sent by certified mail, with return receipt signature or electronic verification, at the address provided in the SPD or plan document, requesting that the plan determine the amount, if any, of the plan's subrogation or reimbursement interest. Written notice must, at a minimum, provide the plan participant's full name; date of birth; social security number, if known; and the date the plan participant's claim arose. If the plan participant's attorney or representative fails to provide notice to the plan as required by this section, upon motion by the plan, the plan participant's attorney's interest in any recovery must be reduced by up to fifty percent (50%) with the forfeited amount paid to the plan. If the plan participant is unrepresented and fails to provide notice as required by this section, upon motion by the plan the court shall award to the plan from the plan participant's recovery an amount that, in the court's discretion, reimburses the plan for amounts the plan lost due to the plan participant's failure or refusal to provide the plan with the notice required under this section. Such amount may be up to the full amount of the plan's subrogation or

reimbursement interest to the extent that such interest may be satisfied from the recovery proceeds, without reduction and irrespective of the plan participant's claims.

(e) Within ninety (90) days of receipt of the notice required by subsection (d), a plan having a subrogation or reimbursement interest shall respond to the individual who provided the notice in writing sent by certified mail, with either return receipt signature or electronic verification, providing the amount of the subrogation or reimbursement interest, or both, a request for additional information or documentation, or notice that additional time is necessary to determine the amount of the plan's subrogation or reimbursement interest, or both. If additional time is necessary, a plan shall provide a response containing the amount of the subrogation or reimbursement interest, or both, within one hundred eighty (180) days of receipt of the notice required by subsection (d), unless treatment of the plan participant, or billing of the plan by medical services providers, is ongoing. If a plan or plan administrator notifies the plan participant or the plan participant's attorney that the plan is unable to provide the amount of its subrogation or reimbursement interest, or both, because treatment or billing is ongoing, the notification is a valid response, and the plan's subrogation or reimbursement interest, or both, is not extinguished. The plan participant or the plan participant's attorney bear the burden of additional requests to the plan to ascertain the amount of the plan's subrogation or reimbursement interest, or both. The plan participant or the plan participant's attorney shall then inform the court regarding the results of the notice, if any, to the plan. If the plan fails to respond within the period specified in this subsection (e), then the plan's subrogation or reimbursement interest, or both, is extinguished and disbursements may be made without recourse upon the plan participant or the plan participant's attorney, or other individual who may have an interest in such disbursements.

(f)

(1) This section does not preclude the plan from declining to provide its subrogation or reimbursement interest, or both, until the plan receives one (1) or more of the following:

(A) The plan participant's affidavit attesting that treatment beyond routine follow-up for injuries sustained in the incident at issue has ceased beyond routine follow-up;

(B) The plan participant's attorney's affidavit attesting to the amount of available recovery, including the sources of all such recovery, the amount of interest the attorney is claiming in any recovery, and whether to the best of the attorney's knowledge and belief, the plan participant's medical care for injuries sustained in the incident at issue has ceased beyond routine follow-up; and

(C) The plan participant's treating physician's statement indicating the plan participant's date of maximum medical improvement, return to work date, permanent impairment or disability, and anticipated additional treatment beyond routine follow-up.

(2) A plan's request for the information listed in subdivision (f)(1) does not extinguish the plan's subrogation or reimbursement interest and is not considered for purposes of calculating the plan's one hundred eighty (180) day response period.

(g) If the plan participant or the plan participant's attorney received a timely response from the plan, but the amount of the subrogation or reimbursement interest, or both, remains in dispute, upon motion by the plan, the trial judge shall hold a hearing in accordance with subsection (h). After trial and at the time of the entry of the judgment or

settlement in a case in which the plan has a subrogation or reimbursement interest, or both, under this section, it is the responsibility of the trial judge to calculate the amount of the subrogation or reimbursement interest, or both, and incorporate the court's findings concerning such interest in the final judgment or settlement.

(h) The trial judge shall base the gross amount of the subrogation or reimbursement interest upon the findings of the verdict at trial concerning medical expenses and evidence introduced after the trial about the total sum of moneys paid by the plan for medical expenses for injuries arising from the incident that is the basis of the action. The trial judge shall reduce the gross amount of the subrogation or reimbursement interest by one (1) or more of the following factors, as applicable:

(1) To the extent that the plan participant plaintiff is partially at fault in the incident giving rise to the litigation, the subrogation or reimbursement interest is reduced by the percentage of fault assessed against the plan participant plaintiff;

(2) To the extent that the finder of fact allocated fault to a person who was immune from suit, the subrogation or reimbursement interest is reduced by the percentage of fault assessed against the immune person;

(3) To the extent that the finder of fact allocates fault to a governmental entity that has its liability limited under state law, and the fault of the entity, when multiplied by the total dollar value of the damages found by the finder of fact, exceeds the amount of judgment that can be awarded against the entity, the subrogation or reimbursement interest is reduced proportionately by a percentage derived by dividing the uncollectable portion of the judgment against the plan by the total damages awarded; or

(4) To the extent that the finder of fact allocated fault to a person that the plan participant plaintiff did not sue, the plan's subrogation or reimbursement interest is reduced by the percentage of fault assessed against the nonparty.

(i) After the calculations described in subsection (h) are performed, the trial judge shall reduce the subrogation or reimbursement interest pro rata by the amount of reasonable attorneys' fees and litigation costs incurred by the plan participant plaintiff in obtaining the recovery.

(j) The amount determined from the calculations required under subsections (h) and (g) is the net subrogation or reimbursement interest. If a plan participant plaintiff or the plan participant's attorney collects the judgment, each has the obligation to promptly remit the net subrogation or reimbursement interest and attorneys' fees and costs to the counsel or other individual specified in the plan document or SPD, as required by the final judgment. If the plan participant plaintiff and the plan participant's attorney collect only a portion of the final judgment, each has the obligation to promptly remit a pro rata share of the net subrogation interest and attorneys' fees and costs to the counsel or other individual specified in the plan document or SPD, as required by the final judgment. If the plan participant plaintiff and the plan participant's attorney later collect additional moneys against the judgment, there is a continuing obligation on both to remit a pro rata share of the moneys collected as required by the final judgment.

(k) If a plan participant plaintiff or the plan participant's attorney, or both, fails to timely remit to the counsel or other individual specified in the plan document or SPD the plan's pro rata portion of judgment moneys received, upon motion by the plan, the court shall award to the plan attorney's fees for the cost of the motion, interest on moneys withheld, as well as the amounts withheld, and may, in its discretion, order those who

failed to timely release funds to forfeit to the plan all sums received in payment of the judgment.

(I) If the case between the plan participant plaintiff and the defendant is settled before trial and the parties and the plan are unable to reach an agreement on the amount of the subrogation or reimbursement interest, then the trial judge shall hold a hearing to determine the gross and net subrogation or reimbursement interests, taking into account the criteria listed in subsection (h) and the likelihood of collecting any judgment against parties determined to be at fault. Expert foundation is not required to prove any claimed damages. An aggrieved party may appeal the court's decision.

8-27-907. Limitations.

If a plan participant initiates suit against a plan or administrator for any action taken on behalf of the plan with respect to benefits under the plan, recovery is limited to accrued benefits due under the terms of the plan, a declaratory judgment on entitled-to benefits, or an injunction against a plan's or administrator's improper refusal to pay benefits. Relief under this section does not include damages, but it may include reasonable attorney's fees.

8-27-908. Intent of general assembly.

It is the intention of the general assembly that §§ 8-27-905 – 8-27-907 be used in lieu of application of the "made whole" doctrine for any recovery authorized under this part. Sections 8-27-905 – 8-27-907 apply to cases that have been settled when no lawsuit has been filed.

8-27-909. Request by plan participant for plan document.

The plan document must be made available to all plan participants for review, either electronically or in printed format, upon a plan participant's request.

SECTION 4. The headings to sections, parts, and chapters in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 5. This act takes effect July 1, 2021, the public welfare requiring it, and applies to plans entered into or renewed on or after that date.