Notice
of Rulemaking Hearing
Department of Commerce and Insurance
Division of Insurance

There will be a hearing before the Commissioner of Commerce and Insurance to consider the promulgation of rules pursuant to T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204 and will take place in Fifth Floor, Conference Room A of the Davy Crockett Tower located at 500 James Robertson Parkway in Nashville, Tennessee at 10:00 a.m. CST on the 15th day of August, 2007.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Commerce and Insurance to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings), to allow time for the Department to determine how it may reasonably provide such aid or service. Initial contact may be made with Don Coleman, the Department's ADA Coordinator, at 500 James Robertson Parkway, Fifth Floor, Nashville, Tennessee 37243, telephone (615) 741-0481.

For a copy of this notice of rulemaking hearing, contact: Tracey Gentry Harney, Chief Counsel for Insurance, Department of Commerce and Insurance, Davy Crockett Tower, Twelfth Floor, 500 James Robertson Parkway, Nashville, Tennessee 37243, telephone (615) 741-2199.

Substance of Proposed Rules

Chapter 0780-01-92
Prevention of Illegal Multiple Employer Welfare Arrangements and Other Illegal Health Insurers

New Rules
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0780-01-92-.01 Purpose.

The purpose of this Chapter is to prevent the operation of illegal health insurers, including illegal multiple employer welfare arrangements, in this state. This Chapter states the law on this topic and establishes specific standards for persons and licensees who become aware of, or are asked to assist such an operation. This Chapter is designed to require those persons and licensees to establish and follow responsible procedures to identify and report illegal health insurers. The Department expects that compliance with this Chapter will protect the public from entities offering fraudulent or otherwise illegal and unsound health care coverage.

Authority: T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

0780-01-92-.02 Scope.

This Chapter shall apply to the conduct of insurance companies, insurance producers and third party administrators doing business in this state.

Authority: T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

0780-01-92-.03 Authority.

This Chapter is issued under the authority of T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

Authority: T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

0780-01-92-.04 Definitions.

(1) "Admitted insurer" means an insurer, health maintenance organization, or hospital medical service corporation licensed to do business in this state, including an entity licensed to operate under T.C.A. § 56-26-204;

(2) "Arrangement" means a fund, trust, plan, program or other mechanism by which a person provides, or attempts to provide, health care benefits;

(3) "Commissioner" means the Commissioner of the Tennessee Department of Commerce and Insurance;

(4) "Department" means the Tennessee Department of Commerce and Insurance;

(5) "Department MEWA contact" means the individual or position designated by the Department to be the MEWA contact as identified on the Department web site;

(6) "Employee leasing arrangement" means a labor leasing, staff leasing, employee leasing, professional employer organization, contract labor, extended employee staffing or supply, or other arrangement, under contract or otherwise, whereby one business or entity represents that it leases or provides its workers to another business or entity;

(7) "Employee welfare benefit plan" or "health benefit plan" means a plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employer organization, or by both, to the extent that the plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment;

(8) "Fully insured" means that for the health care benefits or coverage provided or offered by or through a health benefit plan or arrangement:

(a) An admitted insurer is directly obligated by contract to each participant to provide all of the coverage under the plan or arrangement; and

(b) The liability and responsibility of the admitted insurer to provide covered services or for payment of benefits is not contingent, and is owed directly to the individual employee, member or dependent;

(9) "Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities;

(10) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance;

(11) "Licensee" means a person that is, or that is required to be, licensed or registered under the laws of this state as an insurance producer, third party administrator, insurer, employee leasing arrangement or preferred provider organization;

(12) "MEWA" means a multiple employer welfare association as defined by the Employee Retirement Income Security Act;

(13) "Non-admitted insurer" means an insurer not licensed to engage in the business of insurance in this state as an insurance company;

(14) "Person" means any natural or artificial person including, but not limited to, an individual, partnership, association, trust or corporation;

(15) "Preferred provider organization" means an entity that engages in the business of offering a network of health care providers, whether or not on a risk basis, to employers, insurers or any other person who provides a health benefit plan;

(16) "Professional employer organization" means an arrangement, under contract or otherwise, whereby one business or entity represents that it co-employs or leases workers to another business or entity for an ongoing and extended, rather than a temporary or project-specific, relationship;

(17) "Third party administrator" or "administrator" has the meaning provided under T.C.A. § 56-6-401;

(18) "Transacting of insurance" has the meaning set forth in T.C.A. § 56-2-107 and includes:

(a) Issuing a stop loss policy covering an employer located in this state. Stop loss coverage of an employer for claims incurred under the employer's self-funded health benefit plan is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance;

(b) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, with an employer located in this state that is directly or indirectly the beneficiary of the trust;

(c) Agreeing to loan or advance funds to pay claims incurred under an employer's self-funded health benefit plan if the availability of funds to advance is significantly dependent on payment of contributions and the claims experience of two or more employers who have entered into a similar loan or advance agreement; or

(d) Engaging in a risk distribution arrangement providing for compensation of loss through the provision of services, including an arrangement established through marketing or representations to consumers, without specification in a contract;

(19) "Unauthorized health insurance" means:

(a) Health insurance offered by a non-admitted insurer except to the extent the laws of this state allow the coverage to be offered by a non-admitted insurer licensed in another state through an employer or group located out of state; and

(b) Includes health care benefits or coverage offered by a professional employer organization or an employee leasing arrangement that is not:

1. Fully insured by an admitted insurer; or

2. Authorized to offer health benefits to its client's employees pursuant to the plan adopted pursuant to T.C.A. § 62-43-113(d)(3);

(c) "Unauthorized health insurance" does not include:

1. Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers (including one or more self-employed individuals), that is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

2. Health care benefits or coverage under an employee welfare benefit plan established or maintained by a rural electric cooperative or a rural telephone cooperative as defined under 29 U.S.C. § 1002(40)(B);

3. Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers but only if the employers are within the same control group so the plan is deemed to be a single employer plan under 29 U.S.C. § 1002(40)(B); and

4. Health care benefits or coverage under a church plan as defined under 29 U.S.C. § 1002(33).

Authority: T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

0780-01-92-.05 Licensee Reporting Requirements.

(1) A licensee shall file a written report with the Department MEWA contact when a licensee knows a product is, or is about to be, offered to the public in this state, and the licensee, based on the information known to the licensee, reasonably should know that the product is unauthorized health insurance. Knowledge of an insurance producer regarding an unauthorized health insurance arrangement is not imputed to licensed insurers represented by that insurance producer unless the insurer had actual knowledge that the insurance producer is, or is about to be, offering to the public products that are unauthorized health insurance in this state.

(2) Circumstances where a licensee knows that a product is, or is about to be, offered to the public in this state, include when the licensee knows that any person is:

(a) Recruiting producers to solicit or offer, or is soliciting or offering, a health benefit plan generally to the public in this state; or

(b) Seeking an administrator for, or is administering a health benefit plan that is intended to be offered generally to the public of this state.

(3) Circumstances where a licensee reasonably should know that a product is unauthorized health insurance include, but are not limited to, the following:

(a) The licensee knows that the product is represented to be a self-funded plan and that it is offered widely to multiple employers or generally to individuals;

(b) The licensee knows that the product is a professional employer organization self-funded plan and that it is offered widely to multiple client employers; and

(c) The licensee knows that the plan is represented to be a self-funded plan established or maintained pursuant to a collective bargaining agreement and that the plan is offered widely to multiple employers, or generally to individuals, or both, through producers who are compensated on a commission or similar basis.

(4) (a) A report filed under this Rule is confidential and privileged from disclosure in response to a subpoena or otherwise under T.C.A. §§ 56-8-118 and 56-53-109 and shall not be subject to discovery or admissible in evidence in any private action. Noting in this Chapter shall limit the commissioner's authority to use a report filed pursuant to this Chapter in the furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, determines to be necessary to further the purposes of this Chapter.

(b) Nothing in this Chapter shall prevent or be construed as preventing the commissioner from disclosing the contents of a report filed under this Rule to the insurance department of any other state or agency of the federal government at any time, or any other regulatory or law enforcement agency provided the agency or office receiving the report or matters relating thereto agrees to hold it confidential and in a manner consistent with this Chapter. For reports filed under this Rule, T.C.A. § 56-53-109 applies.

(5) A report filed under this Rule is confidential and privileged from disclosure in response to a subpoena or otherwise under T.C.A. §§ 56-8-118 and 56-53-109 except to the extent the commissioner determines disclosure is appropriate to accomplish a regulatory purpose.

(6) There is immunity from civil liability under T.C.A. § 56-53-110.

(7) A licensee complies with this Rule if the licensee files the required report within thirty (30) days or a period reasonable under the circumstances, whichever is later.

Authority: T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

0780-01-92-.06 Responsibility to Exercise Due Diligence.

(1) Soliciting Producer. A producer, prior to engaging in or assisting any person to engage in offering a health benefit plan to an employer or person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

(a) For any insurance coverage that is represented as issued relating to the health benefit plan:

1. The insurer issued the policy;

2. The coverage is as represented;

3. The insurer is an admitted insurer in this state; and

4. The policy has been filed with, and approved by, the Department or is exempt from filing requirements;

(b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

(c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured or self-insured under T.C.A. § 63-43-113(d)(3); or

(d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

(2) Stop loss policy producer. A producer, prior to submitting an application for a stop loss policy to an insurer for a health benefit plan offered to employees, employee dependents, or a person located within this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including measures reasonably appropriate to establish:

(a) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

(b) The health benefit plan that is not offered by an employee leasing arrangement or professional employer organization to client employers that is not authorized to self-insure under T.C.A. § 63-43-113(d)(3); or

(c) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

(3) Third Party Administrator. A third party administrator, prior to entering into an administrative contract with a health benefit plan, and prior to assisting any person with administration of a health benefit plan, covering employees of an employer or a person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including measures reasonably appropriate to establish:

(a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:

1. The insurer issued the policy;

2. The coverage is as represented;

3. The insurer is an admitted insurer in this state; and

4. The policy has been filed with, and approved by, the Department or is exempt from filing requirements;

(b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

(c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured or self-insured under T.C.A. § 63-43-113(d)(3); or

(d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

(4) Insurer.

(a) An insurer, prior to issuing a stop loss policy for a health benefit plan covering employees, employee dependents, or individuals located within this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

1. For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

2. The health benefit plan that is not offered by an employee leasing arrangement or professional employer organization to client employers; or

3. For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

(b) An insurer shall not engage in the transacting of insurance by issuing a stop loss policy unless the insurer is an admitted insurer in this state and the stop loss policy form has been filed and approved by the Department, or the form is exempt from filing. The transacting of insurance includes, but is not limited to:

1. Issuing a stop loss policy covering an employer located in this state. Coverage of an employer for claims incurred under the employer's self-funded health benefit plan with a stop loss policy is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance; and

2. Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, when an employer located in this state is directly or indirectly the beneficiary of the trust.

(c) An insurer shall not engage in the transacting of insurance in this state by issuing a stop loss policy unless, prior to issuing a contract for the stop loss policy, the insurer discloses clearly and conspicuously to the employer, in writing:

1. The employer is not covered for claims below the stop loss attachment point:

2. A description of the attachment point, including the specific and aggregate attachment points; and

3. The insurer provides no other coverage of the employer's retention.

(5) Preferred provider organization. A preferred provider organization, prior to entering into any contract with a person offering or providing a health benefit plan in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including measures reasonably appropriate to establish:

(a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:

1. The insurer issued the policy;

2. The coverage is as represented;

3. The insurer is an admitted insurer in this state; and

4. The policy has been filed with, and approved by, the Department or is exempt from filing requirements;

(b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

(c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured or self-insured under T.C.A. § 63-43-113(d)(3); or

(d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

(6) (a) A licensee or other person who acts according to the written advice of the MEWA contact has a defense to any violation of this Rule if:

1. The information provided by the licensee or other person to the MEWA contact, to the extent material to the MEWA contact's advice, is accurate and complete; and

2. The information is provided by the licensee or other person to the MEWA contact in writing.

(a) For the purpose of this Chapter, the Department's published list of admitted insurers on its web site is deemed to be accurate. A licensee or other person has a defense to any allegation that a listed insurer is not an admitted insurer. Nothing in this Paragraph relieves a licensee or other person from conducting due diligence to determine whether an entity is in fact the same entity as a listed admitted insurer.

(b) A violation of the Rule is mitigated, and the Department shall reduce or eliminate any sanction otherwise applicable, if a licensee or other person demonstrates all of the following:

1. It maintained supervisory procedures and controls that complied with 0780-01-92-.07;

2. The violation occurred despite the maintenance of those procedures and controls;

3. It promptly reported the health benefit plan to the MEWA contact once the licensee or other person had actual knowledge that it was unauthorized health insurance; and

4. It took prompt corrective action.

(7) Nothing in this Rule requires an insurance producer, third party administrator, insurer or preferred provider organization to conduct due diligence with respect to a health benefit plan that it is not assisting and with respect to which it does not engage in the transacting of insurance.

Authority: T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

0780-01-92-.07 Supervisory Procedures and Controls.

(1) An insurance producer, third party administrator, insurer or preferred provider organization or an agent of same shall establish and maintain documented supervision procedures and controls that are reasonably designed to achieve compliance with this Chapter.

(2) The supervisory procedures shall include:

(a) Training;

(b) Internal controls;

(c) Periodic audits;

(d) Supervisory review; and

(e) Monitoring and enforcement of contractual provisions established under 0780-01-92-.06(3) and (5).

(3) The extent of the supervisory procedures and controls a producer is required to maintain under this Rule may appropriately reflect the size and complexity of the insurance

producer's operations and the scope and nature of the insurance producer's insurance activities.

Authority: T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

0780-01-92-.08 Licensing Education Requirements.

(1) An insurance producer shall not be licensed in this state to sell health insurance unless the insurance producer, prior to licensing, receives not less than one (1) hour of education in:

(a) Identification of unauthorized health insurance; and

(b) The producer's responsibilities under this Chapter.

(2) An insurer providing health insurance in this state shall require its appointed insurance producers to obtain not less than one (1) hour of continuing education every four (4) years covering:

(a) Identification of unauthorized health insurance; and

(b) The producer's responsibilities under this Chapter.

(3) A third party administrator, preferred provider organization or insurer shall include in its application for a license a brief summary of its procedures and controls required under 0780-01-92-.07. Failure of the applicant to demonstrate that the applicant maintains the required procedures and controls shall constitute grounds for the commissioner to deny the application for licensure.

Authority: T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

0780-01-92-.09 Penalties and Liabilities.

(1) Any violation of this Chapter subjects an insurer to the sanctions set forth in T.C.A. §§ 56-1-416 and 56-8-109.

(2) Any violation of this Chapter subjects an insurance producer to the sanctions set forth in T.C.A. §§ 56-6-112 and 56-8-109.

(3) Any violation of this Chapter subjects a third party administrator to the sanctions set forth in T.C.A. §§ 56-6-410 and 56-8-109.

(4) The penalties set forth in this Rule shall be in addition to any other penalties set forth by statute or rule for such conduct.

Authority: T.C.A. §§ 56-2-301, 56-6-124, 56-6-410, 56-8-113 and 56-53-101, et seq.

The notice of rulemaking set out herein was properly filed in the Department of State on the 29th day of June, 2007. (FS 06-44-07; DBID 682)