SENATE BILL 744
By Johnson

HOUSE BILL 1150

By Casada

AN ACT to amend Tennessee Code Annotated, Title 4; Title 29; Title 33; Title 56; Title 63; Title 67 and Title 68, relative to the Insurance Costs Reduction Act.

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

SECTION 1. Tennessee Code Annotated, Section 29-26-101(a)(2)(A), is amended by deleting the subdivision and substituting instead the following:

(A)

(i) Except as provided in subdivision (a)(2)(A)(ii), a health care practitioner licensed, authorized, certified, registered, or regulated under any chapter of title 63 or title 68, including, but not limited to, medical resident physicians, interns, and fellows participating in a training program of one (1) of the accredited medical schools or of one (1) of such medical school's affiliated teaching hospitals in this state;

(ii) Notwithstanding subdivision (a)(2)(A)(i), a "health care provider" does not include a health care practitioner licensed under title 63, chapter 6 or 9, except as otherwise provided in § 29-26-311(b)(1);

SECTION 2. Tennessee Code Annotated, Title 29, Chapter 26, Part 1, is amended by adding the following new section:

This part shall not apply to a health care practitioner licensed under title 63, chapter 6 or 9. Part 3 of this chapter shall apply to any person seeking recovery for a medical injury, as defined by § 29-26-302, where a health care practitioner licensed under title 63, chapter 6 or 9, performed medical treatment on a person; provided, however, if the proximate cause of the medical injury is in dispute, then all proceedings

under the Insurance Costs Reduction Act, compiled in part 3 of this chapter, must be exhausted prior to any health care liability action being brought against a health care practitioner not licensed under title 63, chapter 6 or 9.

SECTION 3. Tennessee Code Annotated, Title 29, Chapter 26, is amended by adding the following new part:

29-26-301.

This part shall be known and may be cited as the "Insurance Costs Reduction Act."

29-26-302.

As used in this part:

(1) "Applicant" means a person who files an application under this part requesting the investigation of an alleged occurrence of a medical injury;

(2) "Application" means a request for investigation by the patient compensation system of an alleged occurrence of a medical injury and does not constitute a demand for payment under any applicable state or federal law;

(3) "Board" means the patient compensation board created in § 29-26-303;

(4) "Collateral source" means any payments made to the applicant, or made on the applicant's behalf, by or pursuant to:

(A) The federal Social Security Act (42 U.S.C. §§ 301 et seq.); any federal, state, or local income disability act; or any other public programs providing medical expenses, disability payments, or other similar benefits, except as prohibited by federal law;

(B) Any health, sickness, or income disability insurance; automobile accident insurance that provides health benefits or income disability coverage; or any other similar insurance benefits, except life insurance benefits available to the applicant, whether purchased by the applicant or provided by others;

(C) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other healthcare services; or

(D) Any contractual or voluntary wage continuation plan provided by employers or by any other system intended to provide wages during a period of disability;

(5) "Compensation schedule" means a schedule of damages for medical injuries;

(6) "Department" means the department of health;

(7) "Healthcare practitioner" or "practitioner" means a physician licensed under title 63, chapter 6 or 9;

(8) "Independent medical review panel" or "panel" means a panel of qualified physicians convened to review each application;

(9) "Medical injury":

(A) Means a personal injury or wrongful death due to medical treatment, including a missed diagnosis, where all of the following exist:

(i) The healthcare practitioner performed a medical treatment on the applicant;

(ii) The applicant suffered a medical injury with damages;

(iii) The medical treatment was the proximate cause of the damages; and

(iv) Based on the facts at the time of medical treatment, one (1) or more of the following:

(*a*) An accepted method of medical services was not used for treatment; or

(*b*) An accepted method of medical services was used for treatment, but executed in a substandard fashion; and

(B) Does not mean an injury or wrongful death caused by a product defect in a drug or a device used during the medical treatment; and

(10) "Patient compensation system" or "PCS" means the system created pursuant to § 29-26-303.

29-26-303.

(a) The patient compensation system is created. The PCS is administered by the department. However, the department may contract with designated agents to provide for the administration of this part.

(b)

(1) The patient compensation board is established to govern the patient compensation system.

(2) The board is composed of eleven (11) members who shall represent the medical, legal, patient, and business communities from diverse geographic areas throughout this state. Members of the board shall be appointed as follows:

(A) Five (5) of the members must be appointed by, and serve at the pleasure of, the governor, one (1) of whom must be a physician licensed under title 63, chapter 6 or 9, who actively practices in this state, one (1) of whom must be an executive in the business community, one (1) of whom must be a hospital administrator, one (1) of whom must be a certified public accountant, who actively practices in this state, and one (1) of whom must be an attorney;

(B) Three (3) of the members must be appointed by, and serve at the pleasure of, the speaker of the senate, one (1) of whom must be a physician licensed under title 63, chapter 6 or 9, who actively practices in this state, and one (1) of whom must be a patient advocate; and

(C) Three (3) of the members must be appointed by, and serve at the pleasure of, the speaker of the house of representatives, one (1) of whom must be a physician licensed under title 63, chapter 6 or 9, who actively practices in this state, and one (1) of whom must be a patient advocate.

(3)

(A) Each member must be appointed for a four-year term. For the purpose of providing staggered terms of the initial appointments, the five (5) members appointed by the governor must be appointed to two-year terms and the remaining six (6) members must be appointed to three-year terms. Initial appointments must be made no later than April 1, 2017.

(B) If a vacancy occurs on the board before the expiration of a term, the original appointing authority must appoint a successor to serve the unexpired portion of the term.

(4) The board must annually elect from its membership one (1) member to serve as chair of the board and one (1) member to serve as vice chair.

(5) The first meeting of the board must be held no later than August 1, 2017. Thereafter, the board must meet at least quarterly upon the call of the chair. A majority of the board members constitutes a quorum. Meetings may be held by teleconference, web conference, or other electronic means.

(6) Members of the board must serve without compensation but, when engaged in the conduct of their official duties as members of the board, must be reimbursed in accordance with the comprehensive travel rules as promulgated by the department of finance and administration and approved by the attorney general and reporter.

(7) The board has the following powers and duties:

(A) Ensuring the operation of the patient compensation system in accordance with applicable federal and state laws, rules, and regulations;

(B) Entering into contracts as necessary to administer this part;

(C) Employing an executive director and other staff as are necessary to perform the functions of the patient compensation system, except that the governor shall appoint the initial executive director;

(D) Reviewing application data to conduct root cause analyses in order to develop and disseminate best practices based on the reviews. In addition, the board shall document safety-related data obtained during an investigation conducted by the office of medical review, including the cause of the medical injury, the contributing factors, and any interventions that may have prevented the injury;

(E) Approving a schedule of compensation for medical injuries, as recommended by the compensation committee;

(F) Approving medical review panelists, as recommended by the medical review committee;

(G) Approving an annual budget; and

(H) Annually approving healthcare practitioner contribution amounts.

(8)

(A) The executive director shall oversee the operation of the patient compensation system in accordance with this part. The staff listed in subdivisions (b)(8)(B)-(F) reports directly to, and serves at the pleasure of, the executive director.

(B) The advocacy director shall:

(i) Ensure that each applicant is provided high-quality individual assistance throughout the process, from initial filing to disposition of the application;

(ii) Assist each applicant in determining whether to retain an attorney, which assistance shall include an explanation of possible fee arrangements and the benefits and disadvantages of retaining an attorney;

(iii) If the applicant seeks to file an application without an attorney, assist the applicant in filing the application; and

(iv) Regularly provide status reports to the applicant or applicant's attorney regarding the applicant's application.

(C) The chief compensation officer shall recommend to the administrative law judges a compensation schedule for each type of injury. The compensation schedule may include provisions for the consideration of specific economic damages associated with the medical injury. The chief compensation officer shall not be a licensed physician or an attorney.

(D) The chief financial officer shall be responsible for overseeing the financial operations of the patient compensation system, including the annual development of a budget.

(E) The chief legal officer shall represent the patient compensation system in all hearings, oversee the operation of the patient compensation system to ensure compliance with established procedures, and ensure adherence to all applicable federal and state laws, rules, and regulations.

(F) A suitable number, as determined by the board, of administrative law judges shall:

(i) Evaluate and, as necessary, investigate all applications in accordance with this part, including, but not limited to, determining whether an application presents a medical injury;

(ii) Have the power to administer oaths, take depositions, issue subpoenas, compel the attendance of witnesses and the production of papers, documents, and other evidence, and obtain patient records pursuant to the applicant's release of protected health information; and

(iii) Allocate compensation for each application in accordance with the compensation schedule.

(9) Board members must be indemnified by the state for any liability they might incur while acting in the capacity of a board member.

(c) The advocacy director shall convene an independent medical review panel to investigate whether an application constitutes a medical injury pursuant to § 29-26-305(c). Each panel is composed of an odd number of at least three (3) panelists chosen

from a list of panelists representing a like or similar specialty or practice as any practitioner named in the application, and are convened upon the call of the chief medical officer. Each panelist must be paid a stipend as determined by the board for the panelist's service on the panel. In order to expedite the review of applications, the advocacy director may, whenever practicable, group related applications together for consideration by a single panel.

(d) A board member, panelist, or employee of the patient compensation system shall not engage in any conduct that constitutes a conflict of interest. A board member, panelist, or employee shall immediately disclose in writing the presence of a conflict of interest when the board member, panelist, or employee knows or should have known that the factual circumstances surrounding a particular application constitutes or constituted a conflict of interest. A board member, panelist, or employee who violates this subsection (d) is subject to disciplinary action as determined by the board. For purposes of this subsection (d), a "conflict of interest" means a situation in which the private interest of a board member, panelist, or employee could influence the board member, panelist, or employee's judgment in the performance of the board member, panelist, or employee's duties under this part. A conflict of interest includes, but is not limited to:

(1) Any conduct that would lead a reasonable person having knowledge of all of the circumstances to conclude that a board member, panelist, or employee is biased against or in favor of an applicant; and

(2) Participation in any application in which the board member, panelist, or employee, or the parent, spouse, or child of the board member, panelist, or employee, has a financial interest.

(e)

(1) The board must promulgate rules to administer this part, which shall include rules addressing:

(A) The application process, including forms necessary to collect relevant information from applicants;

(B) Disciplinary procedures for a board member, panelist, or employee who violates the conflict of interest provisions set out in subsection (d);

(C) Stipends paid to panelists for their service on an independent medical review panel; such stipends may be scaled in accordance with the relative scarcity of the practitioner's specialty, if applicable; and

(D) Payment of compensation awards through periodic payments and the apportionment of compensation among multiple practitioners, as recommended by the chief compensation officer.

(2) All rules promulgated pursuant to this subsection (e) must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

29-26-304.

(a) On or after January 1, 2018, in order to obtain compensation for a medical injury, a person, or the person's legal representative, must submit an application with the patient compensation system. The application must include the following:

(1) The full name and address of the applicant, or the applicant's legal representative, and the basis of the representation;

(2) The full name and address of any practitioner who provided medical treatment allegedly resulting in the medical injury;

(3) A brief statement of the facts and circumstances surrounding the medical injury that gave rise to the application;

(4) An authorization for release to the office of medical review of all protected health information that is potentially relevant to the application;

(5) Any other information that the applicant believes will be beneficial to the investigatory process, including the names of potential witnesses; and

(6) Documentation of any applicable private or governmental source of services or reimbursement relative to the medical injury.

(b) All applications submitted to the patient compensation system pursuant to this section must be submitted orally through a 1-800 number selected by the board.

(c) If an application is not complete, the PCS must, within thirty (30) days after receipt of the initial application, notify the applicant in writing of any errors or omissions. An applicant has thirty (30) days after receipt of the notification in which to correct the errors or omissions in the initial application.

(d) An application must be filed within two (2) years after the date on which a medical injury occurred. In no event may an application be filed more than five (5) years after the date on which the medical treatment occurred.

(e) After the filing of an application, the applicant may supplement the initial application with additional information that the applicant believes may be beneficial in the resolution of the application.

(f) Applications for compensation filed with the patient compensation system are made for the purposes of instituting an investigation into a medical injury and do not constitute a written demand for payment.

(g) Nothing in this part prohibits an applicant or practitioner from retaining an attorney for the purpose of representing the applicant or practitioner in the review and resolution of an application.

29-26-305.

(a)

(1) Within ten (10) days of the receipt of a completed application, the advocacy director must set a hearing date, which must be within thirty (30) days of receiving the completed application, to determine whether there is prima facie evidence in the application that establishes a medical injury. The applicant, as well as the practitioner must be notified of the time, place, and date of the hearing by registered mail, return receipt requested, at least ten (10) days prior to such hearing. The hearing must be held before an administrative law judge from the patient compensation system. None of the parties at the hearing are required to be present or have an attorney present.

(2) If the administrative law judge determines that there is prima facie evidence in the application that establishes a medical injury, the advocacy director must notify, by registered mail, return receipt requested, each practitioner named in the application within five (5) days from such determination. The notification must inform the practitioner that the practitioner may support the application to expedite the processing of the application. A practitioner has fifteen (15) days from receipt of notification of an application to support the application. If the practitioner supports the application, the administrative law judge must review the application in accordance with subsection (b). A finding that there is prima facie evidence in the application that establishes a medical injury is not considered a final determination for purposes of § 29-26-306.

(3) If the administrative law judge determines that the application does not provide prima facie evidence to establish a medical injury, the advocacy director must send a rejection letter to the applicant by registered mail, return receipt requested, which informs the applicant of the applicant's right to appeal. A finding that there is no prima facie evidence in the application that establishes a medical injury is considered a final determination for purposes of § 29-26-306.

(b)

(1) An application that is supported by a practitioner in accordance with subsection (a) shall be reviewed by the administrative law judge within thirty (30) days of the notification of the practitioner's support of the application to validate the application.

(2) If the administrative law judge finds that the application is valid, the judge must determine an award of compensation in accordance with the compensation schedule provided by the chief compensation officer. A finding that the application is valid and a subsequent award of compensation is considered a final determination for purposes of § 29-26-306.

(3) If the administrative law judge finds that the application is not valid, the judge must notify the applicant of the rejection of the application within five (5) business days from such finding, and, in the case of fraud, the administrative law judge shall also notify relevant law enforcement authorities. A finding that the application is not valid is considered a final determination for purposes of § 29-26-306.

(c)

(1) If the administrative law judge determines that the application provides prima facie evidence establishing a medical injury, and the practitioner

does not elect to support the application, the judge must order that an independent medical review panel be convened to complete a thorough investigation of the application within sixty (60) days after the determination by the judge.

(2) The investigation shall be conducted by the independent medical review panel and shall include a thorough investigation of all available documentation, witnesses, and other information, including national practice standards for the care and treatment of patients, as determined to exist and be relevant by the chief medical officer.

(3) Within fifteen (15) days after the completion of the investigation, the medical review panel must provide the applicant, the practitioner, and the administrative law judge access to records, statements, and other information obtained in the course of the investigation in accordance with relevant state and federal laws.

(4) Within thirty (30) days after the completion of the investigation, the judge must determine whether the application constitutes a medical injury.

(5) The administrative law judge and the independent medical review panel shall have access to all redacted information obtained by the office in the course of its investigation of the application, including national practice standards for the care and treatment of patients, as determined to exist and be relevant by the chief medical officer or the panel. If the judge determines that the medical treatment conformed to national practice standards for the care and treatment of patients, then the application is dismissed and the practitioner is not held responsible for the applicant's injury. The judge must make a written determination within ten (10) days after being provided the records pursuant to

subdivision (c)(3) and shall notify the applicant and the practitioner within five (5) business days from such determination.

(6)

(A) If the administrative law judge determines that none of the factors described in subdivision (c)(6)(B)(iv) apply, then the application is dismissed, and the practitioner is not held responsible for the applicant's medical injury.

(B) If the administrative law judge determines, by a preponderance of the evidence, that the factors described in subdivisions (c)(6)(B)(i)-(iv) exist, then the judge must report to the patient compensation system that the application constitutes a medical injury:

(i) The practitioner performed a medical treatment on the applicant;

(ii) The applicant suffered a medical injury with damages;

(iii) The medical treatment was the proximate cause of the damages; and

(iv) Based on the facts at the time of medical treatment, one (1) or more of the following:

(*a*) An accepted method of medical services was not used for treatment; or

(*b*) An accepted method of medical services was used for treatment but executed in a substandard fashion.

(C) A determination pursuant to subdivision (c)(6)(A) or (c)(6)(B) shall be considered a final determination for purposes of § 29-26-306.

(d) Upon any final determination made pursuant to this section, the chief medical officer must notify the parties by registered or certified mail of the right to appeal the determination within five (5) days from the final determination. A party has fifteen (15) days from the receipt of the letter in which to appeal the determination pursuant to § 29-26-306.

(e) If an administrative law judge finds that an application constitutes a medical injury pursuant to subsection (c), and all appeals of that finding have been exhausted pursuant to § 29-26-306, the judge must, within thirty (30) days after either the finding of the panel or the exhaustion of all appeals of that finding, whichever occurs later, make a written determination of an award of compensation in accordance with the compensation schedule provided by the chief compensation officer and the findings of the panel. The determination of an award of compensation is considered a final determination for purposes of § 29-26-306. The judge must notify the applicant and the practitioner by registered or certified mail of the amount of compensation, and must additionally explain the process to appeal the determination of the judge. Either party has fifteen (15) days from receipt of the letter to appeal the determination of the office pursuant to § 29-26-306.

(f) Compensation for each application is offset by any past and future collateral source payments. In addition, compensation may be paid by periodic payments as determined by the chief compensation officer in accordance with the rules promulgated by the board.

(g) Within fifteen (15) days after either the acceptance of compensation by the applicant or the conclusion of all appeals pursuant to § 29-26-306, whichever occurs later, the board must provide compensation to the applicant in accordance with the final compensation award.

(h) The filing of an application involving a healthcare practitioner is not reportable to any applicable licensing entity, unless there is a separate determination by the board or the independent medical review panel that the practitioner represents an imminent risk of harm to the public.

(i) If a practitioner represents an imminent risk of harm to the public as determined by the independent medical review panel, the patient compensation system must provide the department and the appropriate state licensing entity of the practitioner, against whom a medical injury was determined to exist, with electronic access to applications. The department and the appropriate state licensing entity shall review the applications to determine whether any of the incidents that resulted in the applications potentially involved conduct by the licensee that is subject to disciplinary action. Neither the board nor the PCS is required to report to the National Practitioner Data Bank.

(j) Any compensation paid to an applicant pursuant to this part is not a finding of fault of a healthcare practitioner and is not a payment made for medical malpractice or other professional liability.

29-26-306.

An applicant, an applicant's legal representative, or a practitioner may appeal any final determination made in the patient compensation system pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5; provided, that the applicant or practitioner provide written notice, on a form prescribed by the board, to the commissioner within thirty (30) days of the final determination. If the applicant or practitioner fails to send such written notice, then the appeal is waived.

29-26-307.

(a) The board shall annually determine and assess a contribution amount pursuant to subsection (b) that is paid by each healthcare practitioner performing

medical services in this state for the payment of damages for medical injuries and for the administration of this part. The contribution amount shall be determined by January 1 of each year.

(b)

(1) Except as otherwise provided in subdivision (b)(2), each healthcare practitioner shall pay contribution amounts based on the compensation rating model set out in subsection (c).

(2) Variations from the standard contribution amount described in subdivision (b)(1) are as follows:

(A) A practitioner who can show, to the satisfaction of the board, that the practitioner does not engage in a full-time medical practice may have a percentage reduction of the contribution amount;

(B) A practitioner who has had a higher than average rate of compensation for medical injuries pursuant to this part must have a contribution amount increased pursuant to guidelines established by the board;

(C) There shall be an across the board reduced rate of contribution amounts for all practitioners in any year in which the prior year resulted in a collection of contributions that was greater than the subsequent year; provided, that the rate reduction does not result in reduction in the reserve maintained pursuant to subdivision (b)(3). The reduced rate shall be calculated at a percentage that is allocated among practitioners equally. The board shall determine the rate reduction amount; and

(D) There shall be an across the board rate increase of contribution amounts for all practitioners in any year in which the prior year resulted in an under-collection of contributions that was less than the subsequent year or in any year there is otherwise a reduction in the reserve maintained pursuant to subdivision (b)(3). The increased rate shall be calculated at a percentage that is allocated among practitioners equally. The board shall determine the rate increase amount.

(3) The board shall determine an amount that shall be maintained in reserve in order to assure the payment of all benefits for medical injuries pursuant to this part.

(c) The base contribution amount for each practitioner is as follows:

Compensation Rating Model	
Addictionology	$2,600.00
Administrative Medicine	$2,600.00
Aerospace Medicine	$2,600.00
Allergy & Immunology	$2,800.00
Anesthesiology	$6,000.00
Cardiac Surgery	$20,100.00
Cardiovascular Disease - Invasive	$4,700.00
Colon & Rectal Surgery	$7,100.00
Cosmetic - Major Surgery	$11,600.00
Critical Care Medicine - Non-Interventional	$3,800.00
Dermatology - Minor Surgery	$5,100.00
Emergency Medicine	$14,800.00

Endocrinology, Diabetes and Metabolism	$3,500.00
Family Medicine - No Surgery	$3,800.00
Gastroenterology - Interventional	$5,700.00
General Practice - No Surgery	$3,800.00
General Surgery - No Cosmetics	$16,500.00
Geriatric Medicine	$3,500.00
Gynecology - Major Surgery	$10,800.00
Gynecology - Minor Surgery	$7,100.00
Hand Surgery	$10,100.00
Head & Neck Surgery	$10,100.00
Hematology - No Surgery	$3,500.00
Hospice/Palliative Medicine	$3,500.00
Hospitalist	$3,800.00
Infectious Disease	$3,800.00
Internal Medicine - Interventional Cardiology	$7,600.00
Internal Medicine - Minor Invasive	$5,700.00
Maternal & Fetal Medicine	$23,700.00
Neonatology - Interventional	$5,700.00
Nephrology - Interventional	$6,300.00
Neurological Surgery	$22,300.00
Neurology - Interventional	$7,100.00
Nuclear Medicine - Interventional	$7,600.00
Obstetrics & Gynecology	$23,700.00
Occupational Medicine	$2,600.00

Oncology - Surgery	$16,500.00
Ophthalmology - Major Surgery	$5,000.00
Oral/Maxillofacial Surgery - Cosmetic	$11,600.00
Orthopedics Major Surgery - Not Including Spine	$12,300.00
Orthopedics Major Surgery - Spine With Instrumentation	$12,300.00
Otorhinolaryngology - Minor Surgery	$6,300.00
Pain Medicine - Minor Interventional	$6,300.00
Pathology	$3,500.00
Pediatric Interventional Cardiology	$7,100.00
Pediatrics - Minor Surgery	$8,600.00
Pediatrics - No Surgery	$3,500.00
Pharmacology	$2,600.00
Physical Medicine, Rehabilitation - Non-Interventional	$2,800.00
Plastic Surgery	$11,600.00
Preventive Medicine	$2,600.00
Psychiatry	$2,800.00
Pulmonary Medicine - Major Interventional	$5,000.00
Radiology - Major Interventional	$7,600.00
Radiology - Minor Invasive	$4,700.00
Rheumatology	$3,500.00
Sleep Medicine	$2,800.00

Surgical Critical Care	$23,700.00
Thoracic Surgery	$16,100.00
Urology - Major Surgery	$6,500.00
Vascular Surgery	$17,000.00

(d) The contribution assessed pursuant to this section is payable by each healthcare practitioner on July 1 of each year beginning on July 1, 2018. Each healthcare practitioner must pay the contribution amount within thirty (30) days from the date that notice is delivered to the healthcare practitioner. If any healthcare practitioner fails to pay the contribution determined under this section within the thirty-day period, the board must notify the practitioner by certified or registered mail that the practitioner's license is subject to revocation if the contribution is not paid within sixty (60) days from the date of the receipt of the original notice.

(e) A healthcare practitioner who fails to pay the contribution amount assessed pursuant to this section within sixty (60) days from the date of the receipt of the original notice is subject to suspension or revocation of the practitioner's license by the appropriate licensing entity and any other fines prescribed by § 29-26-312.

(f) There is created the patient compensation fund as an account in the general fund. All amounts collected under this section shall be paid to the patient compensation fund and may be expended for purposes authorized by this part. Any amounts deposited in this fund shall remain in the fund until expended for purposes authorized by this part, and shall not revert to the general fund.

29-26-308.

No later than January 1, 2019, and annually thereafter, the board must submit a report that describes the filing and disposition of applications from the prior fiscal year.

The report must include, in the aggregate, the number of applications, the disposition of such applications, and the compensation awarded. The report must also provide recommendations, if any, regarding legislative changes that would improve the efficiency of the functions of the patient compensation system. The report must be provided to the governor, the speaker of the senate, and the speaker of the house of representatives.

29-26-309.

(a) This part applies exclusively to applications submitted under this part. An applicant whose injury is excluded from coverage under this part may file a claim for recovery of damages in accordance with other provisions of law.

(b) An individual who accepts a settlement offer related to a medical injury may not file an application under this part for the same medical injury. In addition, if an application has been filed prior to settlement of the claim for the medical injury in the application, and the applicant subsequently settles the claim with the healthcare practitioner, the applicant's application is dismissed.

29-26-310.

(a) When the injury or death for which compensation is payable under this part was caused under circumstances creating a legal liability against some person other than the healthcare practitioner to pay damages, the applicant has the right to receive compensation under this part, and the applicant may pursue the applicant's remedy by proper action in a court of competent jurisdiction against the other person.

(b)

(1) In the event of a recovery against the third person by the applicant by judgment, settlement, or otherwise, and the applicant has received compensation pursuant to this part, the patient compensation system shall have a subrogation lien against the recovery, and the system may intervene in any action to protect

and enforce the lien, up to the proportionate percentage of fault of the third person minus any fault allocated by the court to the healthcare practitioner.

(2) In the event the net recovery by the applicant exceeds the amount paid pursuant to this part, and all benefits have not been paid under this part, the patient compensation system shall be entitled to a credit towards the amount owed for the medical injury pursuant to this part, as it accrues, to the extent the net recovery collected exceeds the amount paid through the patient compensation system and is in proportion to the percentage of fault of the healthcare practitioner and the third person that is allocated by the court.

29-26-311.

(a) If a person from another state temporarily comes to this state to seek medical treatment from a healthcare practitioner who is subject to this part and the person subsequently alleges that a medical injury has occurred as a result of the practitioner's services, this part does control and the person's only remedy against the healthcare practitioner is through this part. The benefits under this part are the exclusive remedy against the healthcare practitioner for any medical injury suffered by a person while the healthcare practitioner was providing medical services in this state.

(b)

(1) If a healthcare practitioner from another state comes to this state to perform medical treatment on a person and the person subsequently alleges that a medical injury has occurred as a result of the practitioner's services, this part does not control and the person shall be unable to seek a remedy pursuant to this part; instead, the person must seek redress pursuant to title 29, chapter 26, part 1.

(2) If a healthcare practitioner in this state who is subject to this part temporarily leaves this state to perform medical treatment on a person and the person subsequently alleges that a medical injury has occurred as a result of the practitioner's services, this part does not control and the person shall be unable to seek a remedy pursuant to this part; instead, the person must seek redress pursuant to the laws of the other state.

29-26-312.

(a) The board shall, by rules promulgated pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, establish and collect penalties for the following:

(1) Failure of a healthcare practitioner to timely pay the contribution amount assessed pursuant to § 29-26-307;

(2) Bad faith failure by a healthcare practitioner to support an application;

(3) Failure of any party to cooperate in good faith with any proceeding or investigation conducted pursuant to this part; and

(4) Bad faith filing of an application by any person.

(b) All penalties collected pursuant to this section shall be paid into and become a part of the patient compensation fund to be used, at the discretion of the board, to offset the cost of administering this part.

(c) The board may assess the penalties authorized by this section, upon providing notice and an opportunity for a hearing to any person against whom the penalties will be assessed. If a hearing is requested, an administrative law judge has the authority to hear the matter as a contested case, relating to the assessment of the penalties authorized by this section. When a hearing or review is requested, the requesting party has the burden of proving, by a preponderance of the evidence, that the

penalized party was either not subject to this part, or that the penalties assessed pursuant to this section should not have been assessed. Any party assessed a penalty pursuant to this section has the right to appeal the penalty assessed pursuant to the Uniform Administrative Procedures Act.

29-26-313.

Medical records provided to the patient compensation system in the course of its activities and the review of applications pursuant to this part are not public records and are exempt from title 10, chapter 7, part 5, and are proprietary and not subject to public examination, and are not discoverable or admissible in civil litigation.

29-26-314.

(a) Any provision of law granting immunity for the rendering of medical services to a patient by a healthcare practitioner remains in effect. Nothing in this part abrogates such immunity or provides relief under this part.

(b) Any applicant seeking compensation for a medical injury that falls within the jurisdiction of the Tennessee claims commission, as such jurisdiction is described in title 9, chapter 8, part 3, remains with the commission and is not provided relief under this part.

29-26-315.

(a) This part abrogates and supersedes any common law or statutory cause of action claiming liability for a medical injury resulting from medical treatment provided on or after January 1, 2018, against a healthcare practitioner. It is the intent of the general assembly that this part is legally sufficient to satisfy any requirements of the Constitution of Tennessee, Article I, § 6.

(b) Healthcare liability actions claiming liability for a medical injury against a healthcare practitioner resulting from medical treatment provided prior to January 1,

2018, are governed by part 1 of this chapter, and the common law, as both existed prior to January 1, 2018.

(c) This part applies to medical injuries resulting from medical treatment provided on or after January 1, 2018.

SECTION 4. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 5. For purposes of holding meetings of the boards and committees, assessing the contribution amounts, and conducting administrative actions necessary to create the patient compensation system, 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, 2018, the public welfare requiring it.