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Opinion No. 09-157

Recovery of Payments to Health Care Providers

QUESTIONS

Tennessee Code Annotated § 56-7-110 addresses the recovery of payments made in error to health care providers by health insurance entities. While this statute allows for the recovery of such payments, certain protections are afforded to health care providers because the statute prescribes how and when such payments may be recovered. In an effort to further protect health care providers, the General Assembly recently amended Tenn. Code Ann. § 56-7-110 by its enactment of Chapter 462 of the Public Acts of 2009. Section 7 of this Act restricts those that may seek recovery of payments from health care providers; it provides that “only a health insurance entity, or such health insurance entity’s agent, that contracts with health care providers or is responsible for paying contracted or non-contracted health care providers may seek to recover any payments made to those health care providers. No other entity may pursue recoupments governed by this section.”

1. Does Section 7 of Chapter 462 unconstitutionally deprive self-insured employee benefit health plan administrators (governmental entities or private employers) of the right to choose what type of vendor will audit and/or recover overpayments of benefit plan assets over which they are required to exercise a fiduciary responsibility?

2. Does Section 7 of Chapter 462 establish a legal monopoly among a small group of qualifying vendors without the governmental protections usually required of a legal monopoly and, therefore, violate Article I, Section 22, of the Tennessee Constitution?

3. Does Section 7 of Chapter 462 violate any other provision of the Tennessee Constitution or Code?

OPINIONS

1. Section 7 of Chapter 462 does not unconstitutionally deprive self-insured employee benefit health plan administrators of the liberty to contract.

2. No.

3. Section 7 of Chapter 462 does not violate any provision of the Tennessee Constitution. With respect to the Tennessee Code, however, we think a conflict exists, if the three self-insured governmental plans administered by committees pursuant to Tenn. Code Ann. §§ 8-27-101, *et seq.*, are not “health insurance entities” under Tenn. Code Ann. § 56-7-110. If these plans are not “health insurance entities,” we think that the specific statutes addressing the contractual authority of these three plans would control over the more general statute addressing the recovery of payments to health care providers by health insurance entities.

ANALYSIS

Tennessee Code Annotated § 56-7-110 addresses the recovery of payments made in error to health care providers by health insurance entities. While this statute allows for the recovery of such payments, certain protections are afforded to health care providers. For instance, claims to recover payments made in error must be asserted within certain time frames. Generally, a health insurance entity must seek recovery of a payment made in error to a health care provider within eighteen months from the time that the health insurance entity paid the claim submitted by the health care provider. *See* Tenn. Code Ann. § 56-7-110(c). The time to seek recovery is even shorter when the health insurance entity has verified that an individual is a covered person and the health care provider renders services in reliance on the verification. In such event, recovery of a payment made in error must be sought within six months from the time that the health insurance entity paid the claim submitted by the health care provider. *See* Tenn. Code Ann. § 56-7-110(f).

In an effort to further protect health care providers, the General Assembly recently amended Tenn. Code Ann. § 56-7-110 by its enactment of Chapter 462 of the Public Acts of 2009. Section 7 of this Act restricts those that may seek recovery of payments; it provides:

In order to ensure that the original intent of this section is followed and to prevent any entity from circumventing the time frames established by this section, only a health insurance entity, or such health insurance entity’s agent, that contracts with health care providers or is responsible for paying contracted or non-contracted health care providers may seek to recover any payments made to those health care providers. No other entity may pursue recoupments governed by this section.¹

Your first question is whether Section 7 unconstitutionally deprives self-insured employee benefit health plan administrators (governmental entities or private employers) of the right to choose what type of vendor will audit and/or recover overpayments of benefit plan assets over which they are required to exercise a fiduciary responsibility. This question appears to assume that Section 7 precludes *all* self-insured employee benefit health plan administrators from choosing what type of vendor will audit and/or recover overpayments of benefit plan assets. Thus, before addressing your specific question, we address this underlying assumption.

¹ Chapter 462 is effective on October 1, 2009, except for Section 7, which took effect when Chapter 462 became law on June 23, 2009. 2009 Tenn. Pub. Acts, Ch. 462, § 8.

As set forth above, Section 7 allows “only a health insurance entity, or such health insurance entity’s agent, that contracts with health care providers or is responsible for paying contracted or non-contracted health care providers [to] seek to recover any payments made to those health care providers.” “Health insurance entity” is a defined term in Tenn. Code Ann. § 56-7-110. Subsection (a)(4) of the statute provides that “[h]ealth insurance entity” has the same meaning as in Tenn. Code Ann. § 56-7-109. Subsection (a)(4) of Tenn. Code Ann. § 56-7-109 states:

“Health insurance entity” means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation[.]

The first part of this definition requires the entity to be one subject to the insurance laws of this state or to the jurisdiction of the Commissioner of Commerce and Insurance. Assuming the existence of such an entity, the second part of the definition requires the entity to be one that contracts or offers to contract to provide health insurance coverage.

We initially consider whether self-insured health plans meet the first prong of the definition of a “health insurance entity.” With respect to self-insured governmental health plans, the court in *Gray v. City of Memphis*, 2005 WL 652786 (Tenn. Ct. App. 2005), found that the provisions of Title 56 apply to the State and its political subdivisions except in those instances where the General Assembly has stated that a certain provision of Title 56 does not apply to these entities. *Id.* at *6 (citing Tenn. Code Ann. § 56-4-207 as example). In examining Tenn. Code Ann. §§ 56-7-101, *et. seq.*, we find no provision indicating that Tenn. Code Ann. § 56-7-110 is not to apply to self-insured governmental health plans. Moreover, we note that the General Assembly has specifically excepted the TennCare bureau from Tenn. Code Ann. § 56-7-110’s application in subsection (k). Thus, it appears that Tenn. Code Ann § 56-7-110 applies to state and local self-insured health plans; otherwise, the General Assembly would have excepted them as well. *See Gray*, 2005 WL 652786 at *6. Accordingly, self-insured governmental health plans appear to meet the first part of the definition of “health insurance entity” because such plans are subject to the insurance laws of this state.

With respect to private self-insured employee health plans, it is first necessary to distinguish between those health plans subject to the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C §§ 1001, *et seq.*, and those that are not. A self-insured “employee welfare benefit plan”² subject to ERISA is generally sheltered from state insurance regulation. *See*

² The term “employee welfare benefit plan” under ERISA means “any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such 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, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation

UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 367 n. 2, 119 S.Ct. 1380, 1386 n. 2, 143 L.Ed.2d 462 (1999); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746-47, 105 S.Ct. 2380, 2392-93, 85 L.Ed.2d 728 (1985). While there are instances when self-insured ERISA plans are affected by insurance laws of this state, such plans are usually not subject to such laws. *See id.* Thus, in considering whether a self-insured ERISA plan is an “entity subject to the insurance laws of this state or the jurisdiction of the commissioner,” we are mindful of the well-settled principle of statutory construction that “[i]n interpreting [a statute] the legislative intent must be determined from the plain language it contains, read in the context of the entire statute, without any forced or subtle construction which would extend or limit its meaning.” *National Gas Distributors, Inc. v. State*, 804 S.W.2d 66, 67 (Tenn. 1991). In our opinion, the most natural and nonconstrained reading of the statute’s language suggests that the General Assembly did not intend to define “health insurance entity” so as to include self-insured ERISA plans. Non-ERISA self-insured plans, however, are subject to state insurance regulation. *See Cassidy v. Akso Nobel Salt, Inc.*, 308 F.3d 613, 615 (6th Cir. 2002).

Having determined that self-insured governmental health plans and non-ERISA health plans meet the first part of the definition of a “health insurance entity,” we next consider whether these types of plans meet the second part of that term’s definition, which requires the entity to be one “that contracts or offers to contract to provide health insurance coverage.” The term “health insurance coverage” is defined by statute to mean:

benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any policy, certificate or agreement offered by a health insurance entity; provided, that health insurance coverage does not include policies or certificates covering only accident, credit, disability income, long-term care, hospital indemnity, medicare supplement as defined in § 1882(g)(1) of the Social Security Act, codified in 42 U.S.C. § 1395ss(g)(1), specified disease, other limited benefit health insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability insurance policy or equivalent self-insurance[.]

Tenn. Code Ann. § 56-7-109(a)(3).³

In determining whether self-insured governmental health plans in this state “contract[] or offer[] to contract to provide health insurance coverage,” we begin by examining the three self-funded health plans administered by committees under Tenn. Code Ann. §§ 8-27-101, *et seq.*

benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).” 29 U.S.C. § 1002(1).

³ Tenn. Code Ann. § 56-7-110(a)(3) provides that “[h]ealth insurance coverage” has the same meaning as in Tenn. Code Ann. § 56-7-109.

These are the state plan offered to state employees; the plan offered to local government employees and quasi-governmental organizations, administered by the Local Government Insurance Committee; and the plan offered to local education employees, administered by the Local Education Insurance Committee. All three committees are specifically given statutory authority to contract to provide insurance benefits. Tenn. Code Ann. § 8-27-102(a) (state employee plan); Tenn. Code Ann. § 8-27-207(d) (local government plan); Tenn. Code Ann. § 8-27-301(b) (local education plan). Further, each committee has statutory authority to enter into self-insured contracts with health maintenance organizations. Tenn. Code Ann. § 8-27-201(a)(6) (state employee plan); Tenn. Code Ann. § 8-27-207(j) (local government employee plan); Tenn. Code Ann. § 8-27-301(c) (local education plan). In light of these provisions, we believe that the three self-funded plans administered by committees under Tenn. Code Ann. §§ 8-27-101, *et seq.*, meet the second part of the definition of a “health insurance entity” when they contract or offer to contract for the provision of medical care benefits.

With respect to other self-insured governmental health plans and non-ERISA self-insured health plans, the terms of such plans would have to be examined. If they permit the plans to contract or offer to contract to provide “health insurance coverage,” we likewise think such plans would meet the second part of the definition of a “health insurance entity.”

In making the determination that self-insured governmental health plans and non-ERISA self-insured health plans may be “health insurance entities,” we are not unmindful of the last phrase of the definition of a “health insurance entity” in Tenn. Code Ann. § 56-7-109(a)(4), which states that such an entity “includ[es], but [is] not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation[.]” While governmental self-insured health plans and non-ERISA self-insured health plans are not contained in this list, statutory construction principles do not preclude these plans from being “health insurance entities.” To explain, Tenn. Code Ann. § 56-7-109(a)(4) provides a general definition for “health insurance entity” followed by language stating that the definition “includ[es] but [is] not limited to” specific entities. When the term “includes” is used in conjunction with a general definition, it is a term of enlargement, not limitation. *Kendrick v. Kendrick*, 902 S.W.2d 918, 924 (Tenn. Ct. App. 1994) (citations omitted); *see Cohen v. Cohen*, 937 S.W.2d 823, 828 n. 4 (Tenn. 1996). Accordingly, the use of the term “includes” in conjunction with a general definition indicates that the enumerated items that follow are illustrative, not exclusive. *Kendrick*, 902 S.W.2d at 924 (citation omitted); *see Cohen*, 937 S.W.2d at 828, n. 4. The rule of ejusdem generis does not apply.⁴ *Kendrick*, 902 S.W.2d at 923; *Cf. State v. Spicewood Creek Watershed Dist.*, 848 S.W.2d 60, 63 (Tenn. 1993) (Court cited prior cases applying rule of ejusdem generis in finding that term defined *only* by the use of the language of “including but not limited to” was confined to those entities of the same type or class as the examples listed). Thus, governmental self-insured health plans and non-ERISA self-

⁴ The rule of ejusdem generis provides that when general words follow specific words which limit a statute’s scope, the general words will ordinarily be construed to apply to things of the same class or kind as those indicated by the specific words. *Kendrick*, 902 S.W.2d at 923, n. 6 (citing *Nance v. Westside Hosp.*, 750 S.W.2d 740, 743 (Tenn. 1988)).

insured health plans may be “health insurance entities” (assuming they meet the general definition of a “health insurance entity”), even though they are not specifically listed in Tenn. Code Ann. § 56-7-109(a)(4); the listed entities are illustrative, not exclusive. *See Kendrick*, 902 S.W.2d at 924; *Cohen*, 937 S.W.2d at 828, n. 4.

Moreover, a construction of “health insurance entity” that includes self-insured governmental health plans and non-ERISA self-insured health plans is proper when Title 56 is considered in its entirety. *See Busby v. Massey*, 686 S.W.2d 60, 62 (Tenn. 1984) (courts are to construe statutes as a whole). The General Assembly has used the definition of “health insurance entity” in the “Tennessee Health Insurance Portability, Availability and Renewability Act,” which is codified at Tenn. Code Ann. §§ 56-7-2801, *et seq.* In that Act, the General Assembly defines a “health insurance issuer” in the same manner as it defines a “health insurance entity” in Tenn. Code Ann. § 56-7-109(a)(4); however, the definition contains an additional sentence wherein the General Assembly specifically excludes group health plans.

“Health insurance issuer” means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage,^[5] including, but not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation. “Health insurance issuer” does not include a group health plan[.]

Tenn. Code Ann. § 56-7-2802(16).

The last sentence of Tenn. Code Ann. § 56-7-2802(16) is significant. The inclusion of this sentence reflects the General Assembly’s recognition that a group health plan can be “an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage.” Otherwise, there would have been no need for the General Assembly to add this final sentence. Thus, we believe that self-insured governmental plans and non-ERISA health plans are included in the definition of a “health insurance entity” in Tenn. Code Ann. § 56-7-109(a)(4) since the definition contained in that provision is identical to that of a “health insurance issuer” in Tenn. Code Ann. § 56-7-2802(16). If the General Assembly had wanted to exclude such plans from the definition of a “health insurance entity” in Tenn. Code Ann. § 56-7-109(a)(4), it could have done so as it did in Tenn. Code Ann. § 56-7-2802(16). *See State v. Hawk*, 170 S.W.3d 547, 551 (Tenn. 2005) (where legislature includes particular language in one section of a statute but omits it in another section, it is presumed that the legislature acted purposefully in including or excluding that particular subject).

⁵ Like Tenn. Code Ann. § 56-7-109(a)(3), Tenn. Code Ann. § 56-7-2802(15) defines “health insurance coverage” as “benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any policy, certificate, or agreement offered by a health insurance issuer.”

For all of these reasons, we believe that self-insured governmental health plans and non-ERISA self-insured health plans meet the definition of a “health insurance entity” in Tenn. Code Ann. § 56-7-109(a)(4) when they contract or offer to contract for the provision of medical care benefits. Consequently, we think that Section 7 does not deprive administrators of these types of self-insured plans of the right to choose what type of vendor will audit and/or recover overpayments because Section 7 permits a “health insurance entity, or such health insurance entity’s agent” to seek the recovery of payments made in error to health care providers. An agent is simply “[o]ne who undertakes to transact some business, or to manage some affair, for another, by the authority and on account of the latter, and to render an account of it.” *Miller v. Insurance Co. of North America*, 366 S.W.2d 909, 911 (Tenn. 1963); see *Black’s Law Dictionary*, p. 68 (8th ed. 2004) (defining “agent” as “one who is authorized to act for or in the place of another.”). An agent may be an employee or a contractor. *Dempster Bros., Inc. v. U. S. Fidelity & Guaranty Co.*, 388 S.W.2d 153, 156 (Tenn. Ct. App. 1965). Thus, Section 7 does not deprive administrators of self-insured governmental health plans and non-ERISA self-insured health plans from choosing what type of vendor will audit and/or recover overpayments because Section 7 allows an “agent” of the health insurance entity to seek recovery of those payments.

In sum, we think Section 7 does not deprive administrators of self-insured governmental health plans and non-ERISA self-insured health plans of the right to choose what type of vendor will audit and/or recover overpayments because such plans are “health insurance entities” when they contract or offer to contract to provide health insurance coverage. Section 7, however, might deprive administrators of ERISA self-insured health plans of the right to choose what type of vendor will audit and/or recover overpayments because such a plan does not meet the definition of a “health insurance entity.”⁶ With that said, we realize a court of competent jurisdiction may find that no self-insured health plan meets the definition of a “health insurance entity,” so we now return to your first question wherein that assumption is made.

You first ask whether Section 7 unconstitutionally deprives self-insured health plan administrators of the right to choose what type of vendor will audit and/or recover overpayments of benefit plan assets. The liberty to contract is one of the rights guaranteed by the Fourteenth Amendment of the United States Constitution. *State ex rel. Hamby v. Cummings*, 166 Tenn. 460, 463, 63 S.W.2d 515, 516 (1933); *Moyers v. City of Memphis*, 135 Tenn. 263, 186 S.W. 105, 112 (1916). The right to contract, however, is not absolute; the right is subject to curtailment, limitation, and destruction by the General Assembly when done pursuant to “the law of the land.”⁷ *Daugherty v. State*, 393 S.W.2d 739 (Tenn. 1965), *cert. denied*, 384 U.S. 435, 86 S.Ct. 1601, 16 L.Ed.2d 671 (1966); *Harbison v. Knoxville Iron Co.*, 103 Tenn. 421, 53 S.W. 955, 960 (Tenn. 1899), *aff’d*, *Knoxville Iron Co v. Harbison*, 183 U.S. 13, 22 S.Ct. 1, 46 L.Ed. 55 (1901).

⁶ We state that Section 7 *might* deprive administrators of ERISA self-insured health plans of the right to choose what type of vendor will audit and/or recover overpayments because ERISA may pre-empt Section 7 depending on the terms of the plan and the facts and circumstances surrounding the overpayment.

⁷ The “law of the land” provision of Article I, Section 8, of the Tennessee Constitution is synonymous with the due process of law provisions of the United States Constitution, Amendments 5 and 14. *Daugherty*, 393 S.W.2d at 743.

Under the police power, the State has the right to enact and enforce all such laws not in plain conflict with some provision of the Tennessee Constitution or the United States Constitution as may rightly be deemed necessary or expedient for the safety, health, morals, comfort, and welfare of its people. *Harbison*, 53 S.W. at 960.

It is well settled that the right to contract is subject to reasonable limitation under the State's reserved police power. *Harbison*, 53 S.W. at 960. Moreover, it is within the power of the government to restrain some individuals from all contracts, as well as all individuals from some contracts. *Moyers*, 186 S.W. at 112. While the law of the land section of the Constitution forbids that any individual be singled out for legislative action, it does not deny the right to the legislature to make proper classification for purposes of legislation. *Motlow v. State*, 125 Tenn. 547, 145 S.W. 177, 188-89 (1911). Such classification, however, must rest upon some natural or reasonable basis, having some substantial relation to the public welfare, and the same provisions must approximately apply in the same way to all of the members of the class. *Id.*⁸

Section 7 of Chapter 462 provides that “only a health insurance entity, or such health insurance entity's agent, that contracts with health care providers or is responsible for paying contracted or non-contracted health care providers may seek to recover any payments made to those health care providers. No other entity may pursue recoupments governed by [Tenn. Code Ann. § 56-7-110.]” We think Section 7 is a valid exercise of the State's police power since it pertains to health care providers and, ultimately, to the delivery of health care to Tennessee citizens. We also believe that there is a rational basis for allowing only health insurance entities or their agents to seek recovery of payments made to health care providers. As stated at the outset of this opinion, Tenn. Code Ann. § 56-7-110 requires that claims to recover payments made in error be asserted within certain time frames. The time period is especially short when the health insurance entity has verified that an individual is a covered person and the health care provider renders services in reliance on the verification. The stated purpose of Section 7 is “to ensure that the original intent of Tenn. Code Ann. § 56-7-110 is followed and to prevent any entity from circumventing the time frames established by this section.” We think Section 7 furthers its stated purpose. Section 7 protects health care providers by providing them with a known entity that may recover payments from them. Moreover, by allowing only health insurance entities or their agents to seek recovery of payments, we think that it is reasonable to believe that the time frames established by Tenn. Code Ann. § 56-7-110 will more likely be observed. Thus, we think Section 7 satisfies the rational basis test. Accordingly, it is our opinion that Section 7 does not deprive self-insured employee benefit health plan administrators of their liberty to contract with vendors of their choice to audit and/or recover overpayments.⁹

⁸ Where legislation is a form of economic regulation, not affecting a fundamental right or suspect class, it may be sustained constitutionally as to the classes it creates if there is a rational basis for such legislative action. *New Orleans v. Duke*, 427 U.S. 297,303, 96 S.Ct. 2513, 2516-17, 49 L.Ed.2d 511 (1976).

⁹ As stated in footnote 6, though, there may be instances when ERISA pre-empts Section 7 where an ERISA plan is concerned.

Your second question is whether Section 7 of Chapter 462 establishes a legal monopoly among a small group of qualifying vendors without the governmental protections usually required of a legal monopoly and, therefore, violates Article I, Section 22, of the Tennessee Constitution. This constitutional provision states “[t]hat perpetuities and monopolies are contrary to the genius of a free State, and shall not be allowed.” In considering this section, the Tennessee Supreme Court has held a monopoly to be “an exclusive right granted to a few, which was previously a common right. If there is no common right in existence prior to the granting of the privilege . . . the grant is not a monopoly.” *Watauga v. Johnson City*, 589 S.W.2d 901, 904 (Tenn. 1979).

We do not believe Section 7 establishes a monopoly. Even if we were to characterize the right at issue under Tenn. Code Ann. § 56-7-110 as one to collect a debt and assume that a “common right” exists, we do not believe that Section 7 creates an exclusive grant within the meaning of Article I, Section 22. As emphasized earlier, Section 7 permits a “health insurance entity, or such health insurance entity’s agent” to seek the recovery of payments made to health care providers. Thus, Section 7 does not limit the recovery of payments under Tenn. Code Ann. § 56-7-110 to only certain vendors; it simply requires that the health insurance entity hire the vendor as its agent. Moreover, even if Section 7 did create a monopoly, courts construing Article I, Section 22, have allowed monopolies pursuant to the State’s police power, where the public health, safety, or well being is served. *See Checker Cab. Co. v. Johnson City*, 216 S.W.2d 335, 337 (Tenn. 1948). Section 7 is a valid exercise of the General Assembly’s police power for the reasons previously stated. Accordingly, we do not believe Section 7 violates Article I, Section 22, of the Tennessee Constitution.

Your final question is whether Section 7 of Chapter 462, as written, violates any other provision of the Tennessee Constitution or Code. For the same reasons that Section 7 does not unconstitutionally interfere with the liberty to contract, or violate Article I, Section 22, it also does not violate the equal protection clause of the Tennessee Constitution. Equal protection does not require that all persons be dealt with identically, but it does require that a distinction made have some relevance to the purpose for which the classification is made. *Baxstrom v. Herold*, 383 U.S. 107, 111, 86 S.Ct. 760, 763, 15 L.Ed.2d 620 (1966). In the absence of a suspect classification or an intrusion upon a fundamental constitutional right, review is limited to whether the classification is rationally related to a legitimate governmental interest. *State v. Tester*, 879 S.W.2d 823, 828 (Tenn. 1994); *State v. Ray*, 880 S.W.2d 700, 706 (Tenn. Crim. App. 1993). As explained above, we believe the classification made by Section 7 is supported by a rational basis.

Additionally, we do not believe that Section 7 violates Article I, Section 20, of the Tennessee Constitution, which prohibits the passage of a law impairing the obligation of contracts. Since Section 7 was effective upon becoming a law, some existing contractual relationships might be affected. Nevertheless, Tennessee courts have recognized that contracts may be subject to interference, or otherwise be affected by, subsequent statutes and ordinances enacted in the bona fide exercise of an appropriate and valid police power. *Profill Dev., Inc. v. Dills*, 960 S.W.2d 17, 33 (Tenn. Ct. App. 1997); *Sherwin-Williams Co. v. Morris*, 156 S.W.2d

350, 352 (Tenn. 1941). Having previously concluded that Section 7 is a proper exercise of the State's police power, it is our opinion that Section 7 does not violate Article I, Section 20, of the Tennessee Constitution.

In sum, we do not think Section 7 of Chapter 462 violates any provision of the Tennessee Constitution. With respect to the Tennessee Code, however, we think a conflict exists, if the three self-insured governmental plans administered by committees established by Tenn. Code Ann. §§ 8-27-101, *et seq.*, are not "health insurance entities" under Tenn. Code Ann. § 56-7-110. Under Tenn. Code Ann. §§ 8-27-101, *et seq.*, all three plans are specifically authorized to "contract with insurance companies, claims administrators and other organizations for some or all of the insurance benefits or services, including actuarial and consulting advice." Tenn. Code Ann. § 8-27-102(a) (state employee plan); Tenn. Code Ann. § 8-27-207(d) (local government plan); Tenn. Code Ann. § 8-27-301(b) (local education plan). Pursuant to this express authority, these three plans are permitted to contract with other entities to seek recovery of payments from healthcare providers. If these three plans are not "health insurance entities," Section 7 would prevent these plans from entering into such contracts since it provides that no other entity may pursue recoupment governed by Tenn. Code Ann. § 56-7-110.

Statutory construction principles instruct that specific statutory provisions control over conflicting general ones. *See Dobbins v. Terrazo Mach. & Supply Co.*, 479 S.W.2d 806, 809 (Tenn. 1972); *Johnson v. John Hancock Funds*, 217 S.W.3d 414, 423 (Tenn. Ct. App. 2006). "[W]here the mind of the legislature has been turned to the details of a subject and they have acted upon it, a statute treating the subject in a general manner should not be considered as intended to affect the more particular provision." *Woodruff v. City of Nashville*, 192 S.W.2d 1013, 1015 (Tenn. 1946). Consequently, if the three self-insured governmental plans administered by committees pursuant to Tenn. Code Ann. §§ 8-27-101, *et seq.*, are not "health insurance entities" under Tenn. Code Ann. § 56-7-110, we think that the specific statutes addressing their contractual authority would control over the more general statute addressing the recovery of payments to health care providers by health insurance entities.

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