

Senate Bill 291

By: Senators Hill of the 32nd, Hill of the 6th, Hufstetler of the 52nd, Watson of the 1st and Harbin of the 16th

A BILL TO BE ENTITLED
AN ACT

1 To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to
2 provide definitions; to provide that physician agreements are not insurance; to exempt such
3 agreements from regulation as insurance; to provide for discontinuance of services under
4 certain circumstances; to revise certain premium taxes; to provide the Commissioner of
5 Insurance with certain duties and powers regarding comprehensive major medical plans; to
6 provide that insurers may offer additional health improvement incentives; to provide for
7 certain standards for preferred provider arrangements; to provide that certain health care
8 providers may become preferred providers under health care plans under certain
9 circumstances; to provide for exclusive provider arrangements; to provide for legislative
10 intent with regard to such arrangements; to provide for definitions, standards, requirements,
11 and participation in such arrangements; to authorize the Commissioner of Insurance to
12 promulgate rules and regulations regarding such arrangements; to provide certain exemptions
13 with regard to health reimbursement arrangement only plans; to provide for related matters;
14 to amend Title 48 of the Official Code of Georgia Annotated, relating to revenue and
15 taxation, so as to provide for certain income tax deductions for certain insurance premiums;
16 to provide for certain tax credits for employers offering HSA eligible major medical plans
17 to employees under certain circumstances; to provide a short title; to provide for related
18 matters; to provide for effective dates and applicability; to repeal conflicting laws; and for
19 other purposes.

20 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

21 SECTION 1.

22 This Act shall be known and may be cited as the "Georgia Affordable Free Market Health
23 Care Act."

24 **SECTION 2.**

25 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
 26 adding a new Code section to read as follows:

27 "33-7-2.1.

28 (a) As used in this Code section, the term:

29 (1) 'Physician' means a person licensed to practice medicine pursuant to Article 2 of
 30 Chapter 34 of Title 43.

31 (2) 'Physician agreement' means a contract between a physician and an individual patient
 32 or his or her legal representative in which the physician or the physician's medical
 33 practice agrees to provide health care services to the individual patient for an agreed-upon
 34 fee and period of time.

35 (3) 'Physician practice' means a physician or physician's medical practice that charges
 36 a periodic fee for services, does not bill any third parties on a fee for service basis, and
 37 whose per visit charge is less than the monthly equivalent of the periodic fee.

38 (b) A physician agreement is not insurance, shall not be deemed an insurance arrangement
 39 nor agreement, and is not subject to state insurance laws so long as the direct financial
 40 relationship with a patient does not exceed a fee of \$6,000.00, adjusted annually by the rate
 41 of change in the Consumer Price Index as reported by the Bureau of Labor Statistics of the
 42 United States Department of Labor.

43 (c) A physician offering, marketing, selling, or entering into a physician agreement shall
 44 not be required to obtain a certificate of authority or license other than to maintain a current
 45 license to practice medicine with the State of Georgia.

46 (d) To be considered a physician agreement for the purposes of this Code section, such
 47 agreement shall:

48 (1) Be in writing;

49 (2) Be signed by a physician or agent of the physician and the individual patient or his
 50 or her legal representative;

51 (3) Allow either party to terminate such agreement upon written notice to the other party
 52 of no more than 30 days;

53 (4) Describe the scope of health care services that are covered by the periodic fee;

54 (5) Specify the periodic fee and any additional fees outside of the periodic fee for
 55 ongoing care;

56 (6) Specify the duration of such agreement and any automatic renewal periods and
 57 require that no more than 12 months of the periodic fee be paid in advance; and

58 (7) Prominently state in writing that such agreement is not health insurance.

59 (e) A physician providing health care services under a physician agreement may decline
 60 to accept a patient if, in the physician's opinion, such patient's medical condition is such

61 that the provider is unable to provide the appropriate level and type of health care services
 62 such patient requires. The physician may discontinue care for patients under the physician
 63 agreement if:

- 64 (1) The patient fails to pay the periodic fee;
 65 (2) The patient has performed an act of fraud;
 66 (3) The patient repeatedly fails to adhere to the recommended treatment plan;
 67 (4) The patient is abusive and presents an emotional or physical danger to the staff or
 68 other patients of the direct practice; or
 69 (5) The physician or the physician's medical practice discontinues operation as a
 70 physician practice."

71 **SECTION 3.**

72 Said title is further amended by revising subsection (c) of Code Section 33-8-4, relating to
 73 amount and method of computing tax on insurance premiums generally and exclusion of
 74 annuity considerations, as follows:

75 "(c) Insurers in this state shall be exempt from otherwise applicable state premium taxes
 76 as provided for in subsection (a) of this Code section on premiums paid by Georgia
 77 residents for ~~high deductible~~ health savings account eligible health plans as defined by
 78 Section 223 of the Internal Revenue Code sold or maintained under applicable provisions
 79 of Georgia law that do not otherwise have premium subsidies under the federal Patient
 80 Protection and Affordable Care Act."

81 **SECTION 4.**

82 Said title is further amended in Article 1 of Chapter 24, relating to insurance generally, by
 83 adding a new Code section to read as follows:

84 "33-24-9.1.

85 (a) The Commissioner shall develop flexible guidelines for coverage and approval of
 86 health savings account eligible comprehensive major medical plans.

87 (b) The Commissioner shall be authorized to encourage and promote the marketing of
 88 health savings account eligible plans by accident and sickness insurers in this state;
 89 provided, however, that nothing in this Code section shall be construed to authorize the sale
 90 of insurance in violation of the requirements of law relating to the transaction of insurance
 91 in this state or prohibiting the interstate sale of insurance.

92 (c) The Commissioner shall be authorized to conduct a national study of individual and
 93 group health savings account eligible comprehensive major medical plans, cost-effective
 94 designs, and health promotion features available in other states and to determine if and how

95 these products serve the uninsured and if they should be made available to the citizens of
 96 this state.

97 (d) The Commissioner shall be authorized to develop an automatic or fast track approval
 98 process for individual and group health savings account eligible comprehensive major
 99 medical plans already approved under the laws and regulations of this state or other states.

100 (e) The Commissioner shall be authorized to promulgate such rules and regulations as he
 101 or she deems necessary and appropriate for the design, promotion, and regulation of
 102 individual and health savings account eligible group plans, including rules and regulations
 103 for the expedited review of standardized policies, advertisements and solicitations, and
 104 other matters deemed relevant by the Commissioner.

105 (f) The Commissioner shall be authorized to define services that shall be included as
 106 preventive care during any deductible phase of coverage, including appropriate diagnostics
 107 and medications related to such preventive care.

108 (g) The Commissioner shall establish guidelines for health plans to allow for consumers
 109 to be well informed about their health coverage options and to understand the services that
 110 are covered, including cost-sharing provisions related to their care."

111 **SECTION 5.**

112 Said title is further amended by revising Code Section 33-24-59.13, relating to exemptions
 113 from certain unfair trade practices for certain wellness and health improvement programs and
 114 incentives, as follows:

115 "33-24-59.13.

116 (a) An insurer issuing ~~life~~, comprehensive, major medical group, or individual health
 117 insurance benefit plans may, in keeping with federal requirements, offer wellness,
 118 condition management, disease management, or health improvement programs, including
 119 voluntary wellness or health improvement programs that provide for rewards or incentives,
 120 including, but not limited to, merchandise, gift cards, debit cards, premium discounts;
 121 ~~credits~~ or rebates, contributions towards a member's health savings account, modifications
 122 to copayment, deductible, or coinsurance amounts, ~~cash value~~ employee contributions, or
 123 any combination of these incentives, to encourage enrollment or participation in, or
 124 improved outcomes or improved health status from, ~~in~~ such wellness or health
 125 improvement programs and to reward insureds for participation in such programs.

126 (b) The offering of such rewards or incentives to insureds under such wellness or health
 127 improvement programs shall not be considered an unfair trade practice under Code
 128 Section 33-6-4 if such programs are filed with the Commissioner and made a part of the
 129 ~~life or~~ health insurance master policy and certificates or the individual ~~life or~~ health
 130 insurance evidence of coverage as a policy amendment, endorsement, rider, or other form

131 of policy material as agreed upon by the Commissioner. ~~The Commissioner shall be~~
 132 ~~authorized to develop an automatic or expedited approval process for review of such~~
 133 ~~wellness or health improvement programs, including those programs already approved~~
 134 ~~under the laws and regulations of other states~~ The availability and implementation of
 135 wellness incentives provided for under this Code section shall not be available for plans
 136 otherwise eligible for federal subsidies as sold under the federal Patient Protection and
 137 Affordable Care Act."

138 **SECTION 6.**

139 Said title is further amended by revising subsection (b) of Code Section 33-30-23, relating
 140 to standards, payments or reimbursement for noncontracting provider of covered services,
 141 filing requirements for unlicensed entities, and provision for payment solely to provider, as
 142 follows:

143 "(b) Such arrangements shall not:

- 144 (1) Unfairly deny health benefits for medically necessary covered services;
 145 (2) Have differences in benefit levels payable to preferred providers compared to other
 146 providers which unfairly deny benefits for covered services;
 147 (3) Have differences in coinsurance percentages applicable to benefit levels for services
 148 provided by preferred and nonpreferred providers which differ by more than 30
 149 percentage points;
 150 (4) Have a coinsurance percentage applicable to benefit levels for services provided by
 151 nonpreferred providers which exceeds ~~40~~ 50 percent of the benefit levels under the policy
 152 for such services;
 153 (5) Have an adverse effect on the availability or the quality of services; and
 154 (6) Be a result of a negotiation with a primary care physician to become a preferred
 155 provider unless ~~that~~ such physician shall be furnished, beginning on and after January 1,
 156 2001, with a schedule showing common office based fees payable for services under that
 157 arrangement."

158 **SECTION 7.**

159 Said title is further amended by revising Code Section 33-30-25, relating to reasonable limits
 160 on number or classes of preferred providers, as follows:

161 "33-30-25.

- 162 (a) Subject to the approval of the Commissioner under such procedures as he or she may
 163 develop, health care insurers may place reasonable limits on the number or classes of
 164 preferred providers which satisfy the standards set forth by the health care insurer, provided
 165 that there be no discrimination against providers on the basis of religion, race, color,

166 national origin, age, sex, or marital or corporate status; and provided, further, that all
 167 health care providers within any defined service area who are licensed and qualified to
 168 render the services covered by the preferred provider arrangement and who satisfy the
 169 standards set forth by the health care insurer shall be given the opportunity to apply and to
 170 become a preferred provider.

171 (b) Every health care provider that provides health care services covered under any health
 172 benefit plan offered by a health care insurer shall have the right to become a preferred
 173 provider subject to compliance with the following:

174 (1) The health care provider shall satisfy any reasonable standards prescribed by the
 175 health care insurer;

176 (2) The health care provider shall be appropriately licensed and in good standing; and

177 (3) The health care provider shall accept the same terms and conditions as are imposed
 178 on preferred providers that provide similar services and have similar qualifications.

179 (c) Insurers shall not be required to admit health care providers as preferred providers in
 180 geographical areas where the health care insurer does not operate.

181 (d) Insurers shall not be required to admit any health care provider as a preferred provider
 182 if they can demonstrate and file proof with the Commissioner that the inclusion of such
 183 provider is adverse to the quality of services or to the premiums that would be charged to
 184 its members. A health care provider declined as a preferred provider can appeal the
 185 insurer's decision to the Commissioner for review.

186 (e) Health care insurers shall not use standards that discriminate against health care
 187 providers on the basis of religion, race, color, national origin, age, sex, or marital or
 188 corporate status."

189 **SECTION 8.**

190 Said title is further amended in Chapter 30, relating to group or blanket accident and sickness
 191 insurance, by adding a new article to read as follows:

192 "ARTICLE 3

193 33-30-40.

194 This article shall be known and may be cited as the 'Exclusive Provider Arrangements Act.'

195 33-30-41.

196 It is the intent of the General Assembly to encourage health care cost containment while
 197 preserving quality of care by allowing health care insurers to enter into exclusive provider

198 arrangements and by establishing minimum standards for exclusive provider arrangements
199 and the health benefit plans associated with such arrangements.

200 33-30-42.

201 As used in this article, the term:

202 (1) 'Basic health care services' means health care services an enrolled population might
203 reasonably require in order to maintain good health, including as a minimum, but not
204 restricted to, preventive care, emergency care, inpatient hospital and physician care, and
205 outpatient medical services.

206 (2) 'Comprehensive health plan' means the health insurance policy or subscriber
207 agreement between the covered person or the policyholder and the health care insurer
208 which defines the benefit levels available, covers at least basic health care services, and
209 has a lifetime policy limit of \$1 million or greater.

210 (3) 'Emergency care' or 'emergency services' means those health care services that are
211 provided for a condition of recent onset and sufficient severity, including but not limited
212 to severe pain, that would lead a prudent layperson, possessing an average knowledge of
213 medicine and health, to believe that his or her condition, sickness, or injury is of such a
214 nature that failure to obtain immediate medical care could result in:

215 (A) Placing the patient's health in serious jeopardy;

216 (B) Serious impairment to bodily functions; or

217 (C) Serious dysfunction of any bodily organ or part.

218 (4) 'Exclusive provider' means a health care provider or group of providers who have
219 contracted to provide specified covered services.

220 (5) 'Exclusive provider arrangement' means a contract between or on behalf of the health
221 care insurer and an exclusive provider which complies with all the requirements of this
222 article.

223 (6) 'Health benefit plan' means the health insurance policy or subscriber agreement
224 between the covered person or the policyholder and the health care insurer which defines
225 the covered services and benefit levels available.

226 (7) 'Health care insurer' means an insurer, a fraternal benefit society, a health care plan,
227 a nonprofit medical service corporation, a nonprofit hospital service corporation, or a
228 health maintenance organization authorized to sell accident and sickness insurance
229 policies, subscriber certificates, or other contracts of insurance by whatever name called
230 under this title.

231 (8) 'Health care provider' means any person duly licensed or legally authorized to
232 provide health care services.

233 (9) 'Health care services' means services rendered or products sold by a health care
 234 provider within the scope of the provider's license or legal authorization. The term
 235 includes, but is not limited to, hospital, medical, surgical, dental, vision, chiropractic,
 236 psychological, and pharmaceutical services or products.

237 33-30-43.

238 (a) Notwithstanding any provisions of law to the contrary, any health care insurer may
 239 enter into exclusive provider arrangements as provided in this article. Such arrangements
 240 shall:

- 241 (1) Establish the amount and manner of payment to the exclusive provider;
 242 (2) Include mechanisms which are designed to minimize the cost of the health benefit
 243 plan such as the review or control of utilization of health care services;
 244 (3) Include procedures for determining whether health care services rendered are
 245 medically necessary;
 246 (4) Provide to covered persons eligible to receive health care services under such
 247 arrangement a statement of benefits under the arrangement and, at least every 60 days,
 248 an updated listing of physicians who are exclusive providers under the arrangement; such
 249 statement and listing may be made available by mail or by publication on an Internet
 250 service site by the health care insurer at no cost to such covered persons; and
 251 (5) Require that the covered person, or that person's agent, parent, or guardian if the
 252 covered person is a minor, be permitted to appeal to a physician agent or employee of the
 253 health care insurer any decision to deny coverage for health care services recommended
 254 by a physician.

255 (b) Such arrangements shall not:

- 256 (1) Unfairly deny health benefits for medically necessary covered services;
 257 (2) Have an adverse effect on the availability or the quality of services; and
 258 (3) Be a result of a negotiation with a primary care physician to become an exclusive
 259 provider unless that physician shall be furnished, beginning on and after July 1, 2016,
 260 with a schedule showing common office based fees payable for services under that
 261 arrangement.

262 (c) Any other provision of law to the contrary notwithstanding, if a covered person
 263 provides in writing to a health care provider, whether the health care provider is an
 264 exclusive provider or not, that payment for health care services shall be made solely to the
 265 health care provider and be sent directly to the health care provider by the health care
 266 insurer, and the health care provider certifies to same upon filing a claim for the delivery
 267 of health care services, the health care insurer shall make payment solely to the health care
 268 provider and shall send payment directly to the health care provider. This subsection shall

269 not be construed to extend coverages or to require payment for services not otherwise
270 covered.

271 33-30-44.

272 Health care insurers may issue health benefit plans that require covered persons to use the
273 health care services of exclusive providers. Such policies or subscriber certificates shall
274 contain at least the following provisions:

275 (1) A provision that the health care insurer shall be responsible for the assumption of the
276 full financial risk of providing health care services to covered persons;

277 (2) A provision that if a covered person receives emergency care for services specified
278 in the exclusive provider arrangement and cannot reasonably reach an exclusive provider,
279 then emergency care rendered during the course of the emergency will be paid for in
280 accordance with the terms of the health benefit plan at benefit levels at least equal to
281 those applicable to treatment by exclusive providers for emergency care; and

282 (3) A provision that if a health care insurer does not have an exclusive provider
283 arrangement with a provider to provide health care services for a benefit covered by the
284 health plan, then the covered person may receive health care services from a provider that
285 does provide health care services associated with a covered benefit, and the health care
286 service will be paid for in accordance with the terms of the health benefit plan at benefit
287 levels at least equal to those applicable to treatment by exclusive providers for that
288 benefit.

289 33-30-45.

290 (a) Every health care provider that provides health care services which are covered under
291 any health benefit plan offered by a health care insurer shall have the right to become an
292 exclusive provider subject to compliance with the following:

293 (1) The health care provider shall satisfy any reasonable standards prescribed by the
294 health care insurer;

295 (2) The health care provider shall be appropriately licensed and in good standing; and

296 (3) The health care provider shall accept the same terms and conditions as are imposed
297 on exclusive providers that provide similar services and have similar qualifications.

298 (b) Health care insurers shall not be required to admit health care providers as exclusive
299 providers in geographical areas where the health care insurer does not operate.

300 (c) Health care insurers shall not be required to admit any health care provider as an
301 exclusive provider if they can demonstrate and file proof with the Commissioner that the
302 inclusion of such provider is adverse to the quality of services or to the premiums that

303 would be charged to its members. A health care provider declined as a preferred provider
 304 can appeal the insurer's decision to the Commissioner for review.

305 (d) Health care insurers may not use standards that discriminate against health care
 306 providers on the basis of religion, race, color, national origin, age, sex, or marital or
 307 corporate status.

308 33-30-46.

309 Health care insurers as defined in this article are managed care entities and shall be subject
 310 and required to comply with all other applicable provisions of this title and rules and
 311 regulations promulgated pursuant to this title.

312 33-30-47.

313 The Commissioner shall promulgate all rules and regulations necessary or appropriate to
 314 the administration and enforcement of this article, including the restriction of the use of
 315 exclusive provider arrangements to health plans that are comprehensive health plans, dental
 316 only, or vision only."

317 **SECTION 9.**

318 Said title is further amended by revising Code Section 33-51-7, relating to health
 319 reimbursement arrangement only plans, as follows:

320 "33-51-7.

321 (a) The Commissioner shall be authorized to allow health reimbursement arrangement
 322 only plans that encourage employer financial support of health insurance or health related
 323 expenses recognized under the rules of the federal Internal Revenue Service to be approved
 324 for sale in connection with or packaged with individual health insurance policies otherwise
 325 approved by the Commissioner.

326 (b) Health reimbursement arrangement only plans that are not sold in connection with or
 327 packaged with individual health insurance policies shall not be considered insurance under
 328 this title if the plans purchased are not otherwise eligible for federal subsidies.

329 (c) Individual insurance policies offered or funded through health reimbursement
 330 arrangements shall not be considered employer sponsored or group coverage for purposes
 331 of this title, and nothing in this Code section shall be interpreted to require an insurer to
 332 offer an individual health insurance policy for sale in connection with or packaged with a
 333 health reimbursement arrangement or to accept premiums from health reimbursement
 334 arrangement plans for individual health insurance policies.

335 (d) Employer actions to accommodate the collection, packaging, or submittal of funds
 336 from health reimbursement only arrangements, sometimes referred to as list billing, for the

337 purchase of individual policies shall not constitute the establishment of a group plan. The
 338 availability and implementation of health reimbursement arrangements provided for under
 339 this Code section shall not be available to plans otherwise eligible for federal subsidies as
 340 sold under the federal Patient Protection and Affordable Care Act."

341 **SECTION 10.**

342 Title 48 of the Official Code of Georgia Annotated, relating to revenue and taxation, is
 343 amended by adding a new paragraph to subsection (a) of Code Section 48-7-27, relating to
 344 computation of taxable net income, to read as follows:

345 "(13.3) One hundred percent of the premium paid by the taxpayer during the taxable year
 346 for HSA eligible comprehensive major medical plans to the extent the deduction has not
 347 been included in federal adjusted gross income, as defined under the federal Internal
 348 Revenue Code of 1986, and the expenses have not been provided from a health
 349 reimbursement arrangement and have not been included in itemized nonbusiness
 350 deductions that shall be excluded from such taxpayer's taxable income. The availability
 351 and implementation of the state income tax deduction provided for under this paragraph
 352 shall not be available to plans otherwise eligible for federal subsidies as sold under the
 353 federal Patient Protection and Affordable Care Act;"

354 **SECTION 11.**

355 Said title is further amended by revising Code Section 48-7-29.13, relating to tax credits for
 356 qualified health insurance expenses, as follows:

357 "48-7-29.13.

358 (a) As used in this Code section, the term:

359 (1) 'Qualified health insurance' means a ~~high deductible~~ health savings account eligible
 360 comprehensive major medical health plan as defined by Section 223 of the Internal
 361 Revenue Code.

362 (2) 'Qualified health insurance expense' means the expenditure of funds of at least
 363 \$250.00 annually for health insurance premiums for qualified health insurance.

364 (3) 'Taxpayer' means an employer who employs directly, or who pays compensation to
 365 individuals whose compensation is reported on Form 1099; ~~for~~ for 50 or fewer persons and
 366 for whom the taxpayer provides ~~high deductible~~ health savings account eligible
 367 comprehensive major medical health plans as defined by Section 223 of the Internal
 368 Revenue Code and in which such employees are enrolled.

369 (b) A taxpayer shall be allowed a credit against the tax imposed by Code Section 48-7-20
 370 or 48-7-21, as applicable, for qualified health insurance expenses in an amount of \$250.00
 371 for each employee enrolled for 12 consecutive months in a qualified health insurance

372 comprehensive major medical plan if such qualified health insurance is made available to
373 all of the employees and compensated individuals of the employer pursuant to the
374 applicable provisions of Section 125 of the Internal Revenue Code.

375 (c) In no event shall the total amount of the tax credit under this Code section for a taxable
376 year exceed the taxpayer's income tax liability. Any unused tax credit shall be allowed the
377 taxpayer against succeeding years' tax liability. No such credit shall be allowed the
378 taxpayer against prior years' tax liability.

379 (d) The commissioner shall be authorized to promulgate any rules and regulations
380 necessary to implement and administer the provisions of this Code section.

381 (e) The credit allowed by this Code section shall apply only with regard to qualified health
382 insurance expenses.

383 (f) The tax credit provided for under this Code section shall apply to a maximum of three
384 years of the group plan offering comprehensive major medical coverage to employees.

385 (g) This Code section shall expire ten years following its effective date.

386 (h) The availability and implementation of the small employer tax credit provided for
387 under this Code section shall not be available to plans otherwise eligible for federal
388 subsidies as sold under the federal Patient Protection and Affordable Care Act."

389 **SECTION 12.**

390 Sections 10 and 11 of this Act shall become effective on January 1, 2017, and shall apply to
391 all tax years beginning on and after that date. The remaining provisions of this Act shall
392 become effective on July 1, 2016.

393 **SECTION 13.**

394 All laws and parts of laws in conflict with this Act are repealed.