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

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

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

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

SECTION 2.

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

"33-7-2.1.

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

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

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

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

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

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

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

(1) Be in writing;

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

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

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

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

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

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

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

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

(1) The patient fails to pay the periodic fee;

(2) The patient has performed an act of fraud;

(3) The patient repeatedly fails to adhere to the recommended treatment plan;

(4) The patient is abusive and presents an emotional or physical danger to the staff or other patients of the direct practice; or

(5) The physician or the physician's medical practice discontinues operation as a physician practice."

SECTION 3.

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

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

SECTION 4.

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

"33-24-9.1.

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

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

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

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

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

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

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

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

SECTION 5.

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

″33-24-59.13.

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

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

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

SECTION 6.

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

"(b) Such arrangements shall not:

(1) Unfairly deny health benefits for medically necessary covered services;

(2) Have differences in benefit levels payable to preferred providers compared to other providers which unfairly deny benefits for covered services;

(3) Have differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers which differ by more than 30 percentage points;

(4) Have a coinsurance percentage applicable to benefit levels for services provided by nonpreferred providers which exceeds ~~40~~ 50 percent of the benefit levels under the policy for such services;

(5) Have an adverse effect on the availability or the quality of services; and

(6) Be a result of a negotiation with a primary care physician to become a preferred provider unless ~~that~~ such physician shall be furnished, beginning on and after January 1, 2001, with a schedule showing common office based fees payable for services under that arrangement."

SECTION 7.

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

"33-30-25.

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

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

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

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

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

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

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

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

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

SECTION 8.

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

″ARTICLE 3

33-30-40.

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

33-30-41.

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

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

33-30-42.

As used in this article, the term:

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

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

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

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

(B) Serious impairment to bodily functions; or

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

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

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

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

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

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

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

33-30-43.

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

(1) Establish the amount and manner of payment to the exclusive provider;

(2) Include mechanisms which are designed to minimize the cost of the health benefit plan such as the review or control of utilization of health care services;

(3) Include procedures for determining whether health care services rendered are medically necessary;

(4) Provide to covered persons eligible to receive health care services under such arrangement a statement of benefits under the arrangement and, at least every 60 days, an updated listing of physicians who are exclusive providers under the arrangement; such statement and listing may be made available by mail or by publication on an Internet service site by the health care insurer at no cost to such covered persons; and

(5) Require that the covered person, or that person's agent, parent, or guardian if the covered person is a minor, be permitted to appeal to a physician agent or employee of the health care insurer any decision to deny coverage for health care services recommended by a physician.

(b) Such arrangements shall not:

(1) Unfairly deny health benefits for medically necessary covered services;

(2) Have an adverse effect on the availability or the quality of services; and

(3) Be a result of a negotiation with a primary care physician to become an exclusive provider unless that physician shall be furnished, beginning on and after July 1, 2016, with a schedule showing common office based fees payable for services under that arrangement.

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

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

33-30-44.

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

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

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

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

33-30-45.

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

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

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

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

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

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

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

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

33-30-46.

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

33-30-47.

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

SECTION 9.

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

″33-51-7.

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

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

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

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

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

SECTION 10.

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

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

SECTION 11.

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

"48-7-29.13.

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 12.

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

SECTION 13.

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