AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to require certain insurers to maintain accurate provider directories; to provide for definitions; to provide for electronic and printed provider directories; to require certain information in provider directories; to provide for related matters; to provide for exemptions; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

**SECTION 1.**

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

"CHAPTER 20C

33-20C-1.

As used in this chapter, the term:

(1) 'Covered person' means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

(2) 'Facility' means an institution providing physical, mental, or behavioral health care services or a health care setting, including, but not limited to, hospitals; licensed inpatient centers; ambulatory surgical centers; skilled nursing facilities; residential treatment centers; diagnostic, treatment, or rehabilitation centers; imaging centers; and rehabilitation and other therapeutic health settings.

(3) 'Health benefit plan' means a policy, contract, certificate, or agreement entered into, offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a standalone dental plan.

(4) 'Health care professional' means a physician or other health care practitioner licensed, accredited, or certified to perform specified physical, mental, or behavioral health care services consistent with his or her scope of practice under state law.

(5) 'Health care provider' or 'provider' means a health care professional, pharmacy, or facility.

(6) 'Health care services' means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental, or behavioral health condition, illness, injury, or disease, including mental health and substance abuse disorders.

(7) 'Insurer' means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an accident and sickness insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, a health care plan, or any other entity providing a health insurance plan, a health benefit plan, or health care services.

(8) 'Network' means the group or groups of participating health care providers providing services under a network plan.

(9) 'Network plan' means a health benefit plan of an insurer that either requires a covered person to use health care providers managed by, owned by, under contract with, or employed by the insurer or that creates incentives, including financial incentives, for a covered person to use such health care providers.

(10) 'Standalone dental plan' means a plan of an insurer that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

(11) 'Tiers' or 'tiered network' means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost sharing, or provider access requirements, or any combination thereof, apply for the same services.

33-20C-2.

(a)(1) An insurer shall post on its website a current and accurate electronic provider directory for each of its network plans with the information described in Code Section 33-20C-4. Such online provider directory shall be easily accessible in a standardized, downloadable, searchable, and machine readable format.

(2) In making the provider directory available online, the insurer shall ensure that the general public is able to view all of the current providers for a network plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(3) The insurer shall update each network plan on the online provider directory no less than every 30 days.

(b) An insurer shall provide a print copy of a current provider directory, or a print copy of the requested directory information, with the information described in Code Section 33-20C-5 upon request by a covered person or a prospective covered person.

(c) For each network plan, an insurer shall include in plain language, in both the online and print directory, the following general information:

(1) A description of the criteria the insurer has used to build its provider network;

(2) If applicable, a description of the criteria the insurer has used to tier providers;

(3) If applicable, how the insurer designates the different provider tiers or levels, such as by name, symbols, or grouping, in the network and for each specific provider in the network, which tier each is placed in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(4) If applicable, a notice that authorization or referral may be required to access some providers.

(d) The insurer shall make clear for both its online and print directories the provider directory that applies to each network plan by identifying the specific name of the network plan as marketed and issued in this state.

(e) The insurer shall make available through its online and print directories the source of the information required pursuant to Code Sections 33-20C-4 and 33-20C-5 pertaining to each health care provider and any limitations, if applicable.

(f) Provider directories, whether in electronic or print format, shall be accessible to individuals with disabilities and individuals with limited English proficiency as defined in 45 C.F.R. Section 92.201 and 45 C.F.R. Section 155.205(c).

33-20C-3.

(a) The insurer shall include in both its online and print directories a clearly identifiable telephone number and either a dedicated email address or a link to a dedicated webpage that covered persons or the general public may use to report to the insurer inaccurate information listed in the provider directory. Whenever an insurer receives such a report, it shall promptly investigate such report and no later than 30 days following receipt of such report either verify the accuracy of the information or update the information, as applicable.

(b)(1) An insurer shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the insurer's provider directory and shall, no later than January 1, 2017, review and update the entire provider directory for each network plan offered. Thereafter, the insurer shall, at least annually, audit at least a reasonable sample size of its provider directories for accuracy, retain documentation of such an audit to be made available to the Commissioner upon request, and based on the results of such an audit, verify the accuracy of the information or update the information, if applicable.

(2) The insurer shall notify any provider in its network that has not submitted claims to the insurer or otherwise communicated intent to continue participation in the insurer's network within a 12 month period. Such notice shall be accomplished in accordance with

provisions of the contract entered into between the insurer and the provider regarding notice, if applicable. If the insurer does not receive a response from the provider within 30 days of such notification confirming that the information regarding the provider is current and accurate or, as an alternative, updating any information, the insurer shall remove the provider from the network; provided, however, that prior to removal, the insurer may use any other available information or means to determine if the provider is still participating in the insurer's network, including any means delineated in the contract entered into between the insurer and the provider.

(c) The insurer shall report to the Commissioner, in accordance with timeframes and requirements established by the Commissioner:

(1) The number of reports received pursuant to subsection (a) of this Code section, the timeliness of the insurer's response, and the corrective actions taken; and

(2) All auditing reports conducted by the insurer pursuant to subsection (b) of this Code section.

(d) In circumstances where the Commissioner finds that a covered person reasonably relied upon materially inaccurate information contained in an insurer's provider directory, the Commissioner may require the insurer to provide coverage for all covered health care services provided to the covered person and to reimburse the covered person for any amount that he or she would have paid, had the services been delivered by an in-network provider under the insurer's network plan; provided, however, that the Commissioner shall take into consideration that insurers are relying on health care providers to report changes to their information prior to requiring any reimbursement to a covered person. Prior to requiring reimbursement in these circumstances, the Commissioner shall conclude that the services received by the insurer were covered services under the covered person's network plan. In such circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-network provider shall not be used as a basis to deny reimbursement to the covered person.

33-20C-4.

(a) The insurer shall make available through an online provider directory, for each network plan, the following information, in a searchable format:

(1) For health care professionals:

(A) Name;

(B) Gender;

(C) Contact information;

(D) Participating office location or locations;

(E) Specialty, if applicable;

(F) Board certifications, if applicable;

(G) Medical group affiliations, if applicable;

(H) Participating facility affiliations, if applicable;

(I) Languages spoken other than English by the health care professional or clinical staff, if applicable;

(J) Tier; and

(K) Whether they are accepting new patients;

(2) For hospitals:

(A) Hospital name;

(B) Hospital type, such as acute, rehabilitation, children's, or cancer;

(C) Participating hospital location;

(D) Hospital accreditation status; and

(E) Telephone number; and

(3) For facilities other than hospitals:

(A) Facility name;

(B) Facility type;

(C) Types of services performed;

(D) Participating facility location or locations; and

(E) Telephone number.

(b) Paragraphs (2) and (3) of subsection (a) of this Code section shall not apply to standalone dental plans.

33-20C-5.

(a) The insurer shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) For health care professionals:

(A) Name;

(B) Contact information;

(C) Participating office location or locations;

(D) Specialty, if applicable;

(E) Languages spoken other than English, if applicable; and

(F) Whether accepting new patients;

(2) For hospitals:

(A) Hospital name;

(B) Hospital type, such as acute, rehabilitation, children's, or cancer; and

(C) Participating hospital location and telephone number; and

(3) For facilities other than hospitals:

(A) Facility name;

(B) Facility type;

(C) Types of services performed; and

(D) Participating facility location or locations and telephone number.

(b) The insurer shall include a disclosure in the print directory that the information in subsection (a) of this Code section and included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the insurer's electronic provider directory on its website or call a specified customer service telephone number to obtain current provider directory information.

33-20C-6.

This chapter shall not apply to the provision of health care services pursuant to a contract entered into by an insurer and the Department of Community Health for recipients of Medicaid or PeachCare for Kids and the state health benefit plan under Article 1 of Chapter 18 of Title 45.″

**SECTION 2.**

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