Senate Bill 382

By: Senator Unterman of the 45th

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 for consumer protections regarding health insurance; to provide for definitions; to provide for disclosure requirements of providers, hospitals, and insurers; to provide for billing and reimbursement of out-of-network services; to provide for procedures for dispute resolution for surprise bills for nonemergency services; to provide for payment of emergency services; to provide for an out-of-network reimbursement rate workgroup; to provide for related matters; 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 referred to as the "Surprise Billing and Consumer Protection Act."

SECTION 2.

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 an individual who is covered under a health care plan.

(2) 'Emergency services' or 'emergency care' 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.

(3) 'Enrollee' means a policyholder, subscriber, covered person, or other individual participating in a health benefit plan.

(4) 'Health care plan' means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy; but health care plan shall not include policies issued in accordance with Chapter 31 of this title, relating to credit life insurance and credit accident and sickness insurance, Chapter 9 of Title 34, relating to workers' compensation, Chapter 20A of this title, relating to managed health care plans, or disability income policies.

(5) 'Health care provider' or 'provider' means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced practice registered nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist, speech-language pathologist, audiologist, dietitian, or physician assistant.

(6) 'Health care services' means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from illness, injury, or other human physical problem and includes, but is not limited to:

(A) Hospital services which include the general and usual care, services, supplies, and equipment furnished by hospitals;

(B) Medical services which include the general and usual services and care rendered and administered by doctors of medicine, doctors of dental surgery, and doctors of podiatry; and

(C) Other health care services which include appliances and supplies; nursing care by a registered nurse or a licensed practical nurse; institutional services, including the general and usual care, services, supplies, and equipment furnished by health care institutions and agencies or entities other than hospitals; physiotherapy; ambulance services; drugs and medications; therapeutic services and equipment, including oxygen and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and appliances, including wheelchairs, trusses, braces, crutches, and prosthetic devices, including artificial limbs and eyes; and any other appliance, supply, or service related to health care.

(7) 'Health center' means an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements for required primary health services and as may be appropriate for particular centers, additional health services necessary for the adequate support of the primary health services for all residents of the area served by the health center.

(8) 'Insurer' means any person engaged as indemnitor, surety, or contractor who issues insurance, annuity or endowment contracts, subscriber certificates, or other contracts of insurance by whatever name called. Hospital service nonprofit corporations, nonprofit medical service corporations, health care plans, and health maintenance organizations are insurers within the meaning of this chapter.

(9) 'Medically underserved population' means the population of an urban or rural area designated by the United States Secretary of Health and Human Services as an area with a shortage of personal health services or a population group designated by the Secretary in consultation with the state as having a shortage of such services.

(10) 'Out of network' or 'point of service' refers to health care items or services provided to an enrollee by providers who do not belong to the provider network in the health care plan.

(11) 'Patient' means a person who seeks or receives health care services under a health benefit plan.

(12) 'Precertification' or 'preauthorization' means any written or oral determination made at any time by an insurer or any agent of such insurer that an enrollee's receipt of health care services is a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as prerequisites for payment for such services have been satisfied. 'Agent' as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.

(13) 'Required primary health services' means health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and when appropriate, physician assistants, nurse practitioners, and nurse midwives; diagnostic laboratory and radiologic services; preventive health care services including prenatal and perinatal services; appropriate cancer screening; well child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, or cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; family planning services; and preventive dental services.

(14) 'Surprise bill' means a bill for health care services, other than emergency services, received by:

(A) An insured for services rendered by a nonparticipating physician at a participating hospital or ambulatory surgical center when a participating physician is unavailable or a nonparticipating physician renders services without the insured's knowledge or when unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a nonparticipating physician;

(B) An insured for services rendered by a nonparticipating provider when the services were referred by a participating physician to a nonparticipating provider without the explicit written consent of the insured acknowledging that the participating physician is referring the insured to a nonparticipating provider and that the referral may result in costs not covered by the health care plan; or

(C) A patient who is not an insured for services rendered by a physician at a hospital or ambulatory surgical center when the patient has not timely received all of the disclosures required by Code Section 31-20C-2.

(15) 'Usual and customary cost' means the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area reported in a benchmarking data base maintained by the department.

(16) 'Verification of benefits' means any written or oral determination by an insurer or agent of such insurer as to whether given health care services are a covered benefit under the enrollee's health benefit plan without a determination of precertification or preauthorization of such services. 'Agent' as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.

33-20C-2.

(a) A health care provider, group practice of health care providers, diagnostic and treatment center, or health center on behalf of health care providers rendering services at a group practice, diagnostic and treatment center, or health center shall disclose to patients or prospective patients in writing or through an Internet website the health care plans in which the health care provider, group practice, diagnostic and treatment center, or health center is a participating provider and the hospitals with which the health care provider is affiliated prior to the provision of nonemergency services and verbally at the time an appointment is scheduled.

(b) If a health care provider, group practice of health care providers, diagnostic and treatment center, or health center on behalf of health care providers rendering services at a group practice, diagnostic and treatment center, or health center does not participate in the network of a patient's or prospective patient's health care plan, the health care provider, group practice, diagnostic and treatment center, or health center shall:

(1) Prior to the provision of nonemergency services, inform a patient or prospective patient that the estimated amount the health care provider will bill the patient for health care services is available upon request; and

(2) Upon receipt of a request from a patient or prospective patient, disclose to the patient or prospective patient in writing the amount or estimated amount or, with respect to a health center, a schedule of fees that the health care provider, group practice, diagnostic and treatment center, or health center will bill the patient or prospective patient for health care services provided or anticipated to be provided to the patient or prospective patient absent unforeseen medical circumstances that may arise when the health care services are provided.

(c) A health care provider who is a physician shall provide a patient or prospective patient with the name, practice name, mailing address, and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office for the patient or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such provider.

(d) A health care provider who is a physician shall, for a patient's scheduled hospital admission or scheduled outpatient hospital services, provide a patient and the hospital with the name, practice name, mailing address, and telephone number of any other physician whose services will be arranged for by the physician and are scheduled at the time of the preadmission testing, registration, or admission at the time nonemergency services are scheduled; and information as to how to determine the health care plans in which the physician participates.

(e) A hospital shall establish, update, and make public through posting on the hospital's website, to the extent required by federal guidelines, a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis related groups established under Section 1886(d)(4) of the federal Social Security Act.

(f) A hospital shall post on the hospital's website:

(1) The health care plans in which the hospital is a participating provider;

(2) A statement that physician services provided in the hospital are not included in the hospital's charges, that physicians who provide services in the hospital may or may not participate with the same health care plans as the hospital, and that the prospective patient

should check with the physician arranging for the hospital services to determine the health care plans in which the physician participates;

(3) As applicable, the name, mailing address, and telephone number of the physician groups that the hospital has contracted with to provide services, including anesthesiology, pathology, or radiology, and instructions on how to contact these groups to determine the health care plan participation of the physicians in these groups; and

(4) As applicable, the name, mailing address, and telephone number of physicians employed by the hospital and whose services may be provided at the hospital with the health care plans in which they participate.

(g) In registration or admission materials provided in advance of nonemergency hospital services, a hospital shall:

(1) Advise the patient or prospective patient to check with the physician arranging the hospital services to determine:

(A) The name, practice name, mailing address, and telephone number of any other physician whose services will be arranged for by the physician; and

(B) Whether the services of physicians who are employed or contracted by the hospital to provide services including anesthesiology, pathology, and radiology, are reasonably anticipated to be provided to the patient; and

(2) Provide patients or prospective patients with information as to how to timely determine the health care plans participated in by physicians who are reasonably anticipated to provide services to the patient at the hospital, as determined by the physician arranging the patient's hospital services, and who are employees of the hospital or contracted by the hospital to provide services, including anesthesiology, radiology, and pathology.

33-20C-3.

(a) An insurer shall provide to an enrollee:

(1) Information that an enrollee may obtain a referral to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider who is geographically accessible to the enrollee and who has appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee can obtain such referral;

(2) Notice that the enrollee shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy;

(3) All appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization; and

(4) A listing by specialty, which may be in a separate document, that is updated annually of the name, address, and telephone number of all participating providers, including facilities, and in the case of physicians, the board certification, languages spoken, and any affiliations with participating hospitals. The listing shall also be posted on the health maintenance organization's website and the health maintenance organization shall update the website within 15 days of the addition or termination of a provider from the health maintenance organization's network or a change in a physician's hospital affiliation;

(5) Where applicable, a description of the method by which an enrollee may submit a claim for health care services;

(6) With respect to out-of-network coverage:

(A) A clear description of the methodology used by the health maintenance organization to determine reimbursement for out-of-network health care services;

(B) The amount that the health maintenance organization will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services;

(C) Examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services;

(7) Information in writing and through an Internet website that reasonably permits an enrollee or prospective enrollee to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or ZIP code based upon the difference between what the health maintenance organization will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services;

(8) The written application procedures and minimum qualification requirements for health care providers to be considered by the insurer; and

(9) Other information as required by the Commissioner.

(b) An insurer shall disclose whether a health care provider scheduled to provide a health care service is an in-network provider and, with respect to out-of-network coverage, disclose the approximate dollar amount that the insurer will pay for a specific out-of-network health care service. Insurers shall also inform an enrollee through such disclosure that such approximation is not binding on the insurer and that the approximate dollar amount that the insurer will pay for a specific out-of-network health care service may change.

33-20C-4.

An out-of-network referral denial means a denial of a request for an authorization or referral to an out-of-network provider on the basis that the health care plan has a health care provider in the network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an enrollee and who is able to provide the requested health service. The notice of an out-of network referral denial provided to an enrollee shall have information explaining what information the enrollee must submit in order to appeal the out-of-network referral denial. An out-of-network denial shall not constitute an adverse determination.

33-20C-5.

(a) An insurer shall provide a description of the method by which an enrollee may submit a claim for health care services.

(b) An insurer shall provide a clear description of the methodology used by such insurer to determine reimbursement for out-of-network health care services and the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services.

(c) An insurer shall provide examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services and information in writing and through an Internet website that reasonably permits an enrollee or prospective enrollee to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or ZIP code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

(d) An insurer shall disclose whether a health care provider scheduled to provide a health care service is an in-network provider and, with respect to out-of-network coverage, disclose the approximate dollar amount that the health maintenance organization will pay for a specific out-of-network health care service. The insurer shall also inform an enrollee through such disclosure that such approximation is not binding on the health maintenance organization and that the approximate dollar amount that the health maintenance organization will pay for a specific out-of-network health care service may change.

33-20C-6.

(a) The Commissioner shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The Commissioner shall

have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process.

(b) The Commissioner shall promulgate regulations establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process. To the extent practicable, the physician shall be licensed in this state.

(c) This chapter shall not apply to health care services, including emergency services, where physician fees are subject to schedules or other monetary limitations under any other law, including workers' compensation law.

(d) The dispute resolution process established in this chapter shall not apply when:

(1) The amount billed for American Medical Association current procedural terminology (CPT) codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and 99234 through 99236 meets the requirements set forth in subsection (f) of this Code section, after any applicable coinsurance, copayment and deductible; and

(2) The amount billed for any such CPT code does not exceed 120 percent of the usual and customary cost for such CPT code.

(e) The health care plan shall ensure that an insured shall not incur any greater out-of-pocket costs for emergency services billed under a CPT code as set forth in this Code section than the insured would have incurred if such emergency services were provided by a participating physician.

(f) Beginning January 1, 2017, and on each January 1 thereafter, the Commissioner shall publish on a website maintained by the department, and provide in writing to each health care plan, a dollar amount for which bills for the procedure codes identified in this Code section shall be exempt from the dispute resolution process established in this chapter. Such amount shall equal the amount from the prior year, beginning with $600.00 in 2016, adjusted by the average of the annual average inflation rates for the medical care commodities and medical care services components of the Consumer Price Index. In no event shall an amount exceeding $1,200.00 for a specific CPT code billed be exempt from the dispute resolution process established in this chapter.

33-20C-7.

In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including whether there is a

gross disparity between the fee charged by the physician for services rendered as compared to:

(1) Fees paid to the involved physician for the same services rendered by the physician to other patients in health care plans in which the physician is not participating;

(2) In the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating in the health care plan;

(3) The level of training, education, and experience of the physician;

(4) The physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating;

(5) The circumstances and complexity of the particular case, including time and place of the service;

(6) Individual patient characteristics; and

(7) The usual and customary cost of the service.

33-20C-8.

(a) When a health care plan receives a bill for emergency services from a nonparticipating physician, the health care plan shall pay an amount that it determines is reasonable for the emergency services rendered by the nonparticipating physician in accordance with Code Section 33-20C-7 except for the insured's copayment, coinsurance, or deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating physician.

(b) A nonparticipating physician or a health care plan may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity. The independent dispute resolution entity shall make a determination within 30 days of receipt of the dispute for review.

(c) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health care plan's payment or the nonparticipating physician's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in Code Section 33-20C-7 of this chapter. If an independent dispute resolution entity determines, based on the health care plan's payment and the nonparticipating physician's fee, that a settlement between the health care plan and nonparticipating physician is reasonably likely, or that both the health care plan's payment and the nonparticipating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and nonparticipating

physician may be granted up to ten business days for this negotiation, which shall run concurrently with the 30 day period for dispute resolution.

(d) A patient who is not an insured or the patient's physician may submit a dispute regarding a fee for emergency services for review to an independent dispute resolution entity upon approval of the Commissioner. An independent dispute resolution entity shall determine a reasonable fee for the services based upon the same conditions and factors pursuant to Code Section 33-20C-7 of this chapter.

(e) A patient who is not an insured shall not be required to pay the physician's fee in order to be eligible to submit the dispute for review to an independent dispute resolution entity.

(f) The determination of an independent dispute resolution entity shall be binding on the health care plan, physician, and patient and shall be admissible in any court proceeding between the health care plan, physician, or patient, or in any administrative proceeding between this state and the physician.

33-20C-9.

When an insured assigns benefits for a surprise bill in writing to a nonparticipating physician who knows that the insured is insured under a health care plan, the nonparticipating physician shall not bill the insured except for any applicable copayment, coinsurance, or deductible that would be owed if the insured utilized a participating physician.

33-20C-10.

(a) If an insured assigns benefits to a nonparticipating physician, the health care plan shall pay the nonparticipating physician in accordance with subsections (c) and (d) of this Code section.

(b) The nonparticipating physician may bill the health care plan for the health care services rendered, and the health care plan shall pay the nonparticipating physician the billed amount or attempt to negotiate reimbursement with the nonparticipating physician.

(c) If the health care plan's attempts to negotiate reimbursement for health care services provided by a nonparticipating physician does not result in a resolution of the payment dispute between the nonparticipating physician and the health care plan, the health care plan shall pay the nonparticipating physician an amount the health care plan determines is reasonable for the health care services rendered, except for the insured's copayment, coinsurance, or deductible.

(d) Either the health care plan or the nonparticipating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity; provided,

however, that the health care plan may not submit the dispute unless it has complied with the requirements of subsections (a), (b), and (c) of this Code section.

(e) The independent dispute resolution entity shall make a determination within 30 days of receipt of the dispute for review.

(f) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health care plan's payment or the nonparticipating physician's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in Code Section 33-20C-7. If an independent dispute resolution entity determines, based on the health care plan's payment and the nonparticipating physician's fee, that a settlement between the health care plan and nonparticipating physician is reasonably likely, or that both the health care plan's payment and the nonparticipating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and nonparticipating physician may be granted up to ten business days for this negotiation, which shall run concurrently with the 30 day period for dispute resolution.

(g) An insured who does not assign benefits under subsection (a) of this Code section or a patient who is not an insured and who receives a surprise bill may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity.

(h) The independent dispute resolution entity shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in Code Section 33-20C-7.

(i) A patient or insured who does not assign benefits in accordance with subsection (a) of this Code section shall not be required to pay the physician's fee to be eligible to submit the dispute for review to the independent dispute entity.

(j) The determination of an independent dispute resolution entity shall be binding on the patient, physician, and health care plan, and shall be admissible in any court proceeding between the patient or insured, physician or health care plan, or in any administrative proceeding between this state and the physician.

(k) In disputes involving an insured, when the independent dispute resolution entity determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the nonparticipating physician. When the independent dispute resolution entity determines the nonparticipating physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan. When a good faith negotiation directed by the independent dispute resolution entity pursuant to Code Sections 31-20C-8 and 31-20C-9 of this chapter results in a settlement between the health care plan and nonparticipating physician, the health care plan and the

nonparticipating physician shall evenly divide and share the prorated cost for dispute resolution.

(l) When there is a dispute involving a patient who is not an insured and the independent dispute resolution entity determines the physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient. The Commissioner shall promulgate a regulation to determine payment for the dispute resolution process in cases of hardship. When the independent dispute resolution entity determines the physician's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the physician.

33-20C-11.

(a) An out-of-network reimbursement rate workgroup shall be established consisting of nine members appointed by the Governor. Two members shall be appointed on the recommendation of the Speaker of the House of Representatives and two members shall be appointed on the recommendation of the President of the Senate. The workgroup shall consist of two physicians, two representatives of health plans, and three consumers and shall be chaired by the Commissioner. Such representatives of the workgroup shall represent different regions of the state. The members shall receive no compensation for their services but shall be allowed their actual and necessary expenses incurred in the performance of their duties.

(b) The workgroup shall review the current out-of-network reimbursement rates used by health insurers licensed under this title and make recommendations regarding an alternative rate methodology, taking into consideration the following factors:

(1) Current physician charges for out-of-network services;

(2) Trends in medical care and the actual costs of medical care;

(3) Regional differences regarding medical costs and trends;

(4) The current methodologies and levels of reimbursement for out-of-network services currently paid by health plans, including insurers, health maintenance organizations, medicare, and Medicaid;

(5) The current in-network rates paid by health plans, including insurers, health maintenance organizations, medicare, and Medicaid for the same service and by the same provider;

(6) The impact different rate methodologies would have on out-of-pocket costs for consumers who access out-of-network services;

(7) The impact different rate methodologies would have on premium costs in different regions of the state;

(8) Reimbursement data from all health plans, both public and private, as well as charge data from medical professionals and hospitals available through an all-payor data base to be developed and maintained by the department; and

(9) Other issues deemed appropriate by the Commissioner.

(c) The workgroup shall review out-of-network coverage in the individual and small group markets and make recommendations regarding the availability and adequacy of the coverage, taking into consideration the following factors:

(1) The extent to which out-of-network coverage is available in each rating region in this state;

(2) The extent to which a significant level of out-of-network benefits is available in every rating region in this state, including the prevalence of coverage based on the usual and customary cost as well as coverage based on other set reimbursement methodologies, such as medicare; and

(3) Other issues deemed appropriate by either the commissioner of revenue or the commissioner of public health.

(e) The workgroup shall report its findings and make recommendations for legislation and regulations to the Governor, the Speaker of the House of Representative, the President of the Senate, and the chairpersons of the House Committee on Insurance and the Senate Insurance and Labor Committee no later than January 1, 2017.″

SECTION 3.

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