

House Bill 342

By: Representatives Rogers of the 26th, Knox of the 24th, Rice of the 51st, Cooper of the 41st,
and Heard of the 114th

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 certain definitions; to include plan administrators in prompt pay requirements; to
3 provide for penalties; to provide for related matters; to provide for an effective date; to repeal
4 conflicting laws; and for other purposes.

5 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

6 style="text-align:center">**SECTION 1.**

7 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
8 revising Code Section 33-23-100, relating to the definition of administrator, as follows:

9 "33-23-100.

10 (a) As used in this article, the term:

11 (1) 'Administrator' means any business entity that, directly or indirectly, collects charges,
12 fees, or premiums; adjusts or settles claims, including investigating or examining claims
13 or receiving, disbursing, handling, or otherwise being responsible for claim funds; ~~and~~
14 or provides underwriting or precertification and preauthorization of hospitalizations or
15 medical treatments for residents of this state for or on behalf of any insurer, including
16 business entities that act on behalf of ~~multiple~~ a single or multiple employer
17 self-insurance health plans, and plan or a self-insured municipalities municipality or other
18 political subdivisions subdivision. Licensure is also required for administrators who act
19 on behalf of self-insured plans providing workers' compensation benefits pursuant to
20 Chapter 9 of Title 34. For purposes of this article, each activity undertaken by the
21 administrator on behalf of an insurer or the client of the administrator is considered a
22 transaction and is subject to the provisions of this title.

23 (2) 'Business entity' means a corporation, association, partnership, sole proprietorship,
24 limited liability company, limited liability partnership, or other legal entity.

25 (3) 'Standard financial quarter' means a three-month period ending on March 31, June
26 30, September 30, or December 31 of any calendar year.

27 (b) Notwithstanding the provisions of subsection (a) of this Code section, the following
 28 are exempt from licensure ~~as~~ so long as such entities are acting directly through their
 29 officers and employees:

30 (1) An employer on behalf of its employees or the employees of one or more subsidiary
 31 or affiliated corporations of such employer;

32 (2) A union on behalf of its members;

33 (3) An insurance company licensed in this state or its affiliate unless the affiliate
 34 administrator is placing business with a nonaffiliate insurer not licensed in this state;

35 (4) An insurer which is not authorized to transact insurance in this state if such insurer
 36 is administering a policy lawfully issued by it in and pursuant to the laws of a state in
 37 which it is authorized to transact insurance;

38 (5) A life or accident and sickness insurance agent or broker licensed in this state whose
 39 activities are limited exclusively to the sale of insurance;

40 (6) A creditor on behalf of its debtors with respect to insurance covering a debt between
 41 the creditor and its debtors;

42 (7) A trust established in conformity with 29 U.S.C. Section 186 and its trustees, agents,
 43 and employees acting thereunder;

44 (8) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and
 45 its trustees and employees acting thereunder or a custodian and its agents and employees
 46 acting pursuant to a custodian account which meets the requirements of Section 401(f)
 47 of the Internal Revenue Code;

48 (9) A bank, credit union, or other financial institution which is subject to supervision or
 49 examination by federal or state banking authorities;

50 (10) A credit card issuing company which advances for and collects premiums or charges
 51 from its credit card holders who have authorized it to do so, provided that such company
 52 does not adjust or settle claims;

53 (11) A person who adjusts or settles claims in the normal course of his or her practice or
 54 employment as an attorney and who does not collect charges or premiums in connection
 55 with life or accident and sickness insurance coverage or annuities;

56 ~~(12) A business entity that acts solely as an administrator of one or more bona fide~~
 57 ~~employee benefit plans established by an employer or an employee organization, or both,~~
 58 ~~for whom the insurance laws of this state are preempted pursuant to the federal Employee~~
 59 ~~Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. An insurance~~
 60 ~~company licensed in this state or its affiliate if such insurance company or its affiliate is~~
 61 ~~solely administering limited benefit insurance. For the purpose of this paragraph, the~~
 62 ~~term 'limited benefit insurance' means accident or sickness insurance designed,~~
 63 ~~advertised, and marketed to supplement major medical insurance, specifically: accident~~

64 only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or
 65 specified disease; or

66 (13) An association that administers workers' compensation claims solely on behalf of
 67 its members.

68 (c) A business entity claiming an exemption shall submit an exemption notice on a form
 69 provided by the Commissioner. This form must be signed by an officer of the company
 70 and submitted to the department by December 31 of the year prior to the year for which an
 71 exemption is to be claimed. Such exemption notice shall be updated in writing within 30
 72 days if the basis for such exemption changes. An administrator claiming an exemption
 73 pursuant to paragraphs (3) and (4) of subsection (b) of this Code section shall be subject
 74 to the provisions of Code Sections 33-24-59.5 and 33-24-59.13.

75 (d) Obtaining a license as an administrator does not exempt the applicant from other
 76 licensing requirements under this title.

77 (e) Obtaining a license as an administrator subjects the applicant to the provisions of Code
 78 Sections 33-24-59.5 and 33-24-59.13.

79 (f) An administrator shall be subject to Code Sections 33-24-59.5 and 33-24-59.13 unless
 80 the administrator provides sufficient evidence that the self-insured health plan failed to
 81 properly fund the plan to allow the administrator to pay any outside claim."

82 **SECTION 2.**

83 Said title is further amended by revising Code Section 33-24-59.5, relating to timely payment
 84 of health benefits, as follows:

85 "33-24-59.5.

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

87 (1) 'Benefits' means the coverages provided by a health benefit plan for financing or
 88 delivery of health care goods or services; but such term does not include capitated
 89 payment arrangements under managed care plans.

90 (2) 'Health benefit plan' means any hospital or medical insurance policy or certificate,
 91 health care plan contract or certificate, qualified higher deductible health plan, health
 92 maintenance organization subscriber contract, any health benefit plan established
 93 pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy,
 94 or managed care plan or self-insured plan; but health benefit plan does not include
 95 policies issued in accordance with Chapter 31 of this title; disability income policies; or
 96 Chapter 9 of Title 34, relating to workers' compensation.

97 (3) 'Insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit
 98 hospital service corporation, nonprofit medical service corporation, health care
 99 corporation, health maintenance organization, provider sponsored health care corporation,

100 or any similar entity and any self-insured health benefit plan ~~not subject to the exclusive~~
101 ~~jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C.~~
102 ~~Section 1001, et seq.~~, which entity provides for the financing or delivery of health care
103 services through a health benefit plan, the plan administrator of any health plan, or the
104 plan administrator of any health benefit plan established pursuant to Article 1 of Chapter
105 18 of Title 45 or any other administrator as defined in paragraph (1) of subsection (a) of
106 Code Section 33-23-100.

107 (b)(1) All benefits under a health benefit plan will be payable by the insurer which is
108 obligated to finance or deliver health care services under that plan upon such insurer's
109 receipt of written or electronic proof of loss or claim for payment for health care goods
110 or services provided. The insurer shall within 15 working days for electronic claims or
111 30 calendar days for paper claims after such receipt mail or send electronically to the
112 insured or other person claiming payments under the plan payment for such benefits or
113 a letter or electronic notice which states the reasons the insurer may have for failing to
114 pay the claim, either in whole or in part, and which also gives the person so notified a
115 written itemization of any documents or other information needed to process the claim
116 or any portions thereof which are not being paid. Where the insurer disputes a portion
117 of the claim, any undisputed portion of the claim shall be paid by the insurer in
118 accordance with this chapter. When all of the listed documents or other information
119 needed to process the claim has been received by the insurer, the insurer shall then have
120 15 working days for electronic claims or 30 calendar days for paper claims within which
121 to process and either mail payment for the claim or a letter or notice denying it, in whole
122 or in part, giving the insured or other person claiming payments under the plan the
123 insurer's reasons for such denial.

124 (2) Receipt of any proof, claim, or documentation by an entity which administrates or
125 processes claims on behalf of an insurer shall be deemed receipt of the same by the
126 insurer for purposes of this Code section.

127 (c) Each insurer shall pay to the insured or other person claiming payments under the
128 health benefit plan interest equal to ~~18~~ 12 percent per annum on the proceeds or benefits
129 due under the terms of such plan for failure to comply with subsection (b) of this Code
130 section.

131 (d) An insurer may only be subject to an administrative penalty by the Commissioner as
132 authorized by the insurance laws of this state when such insurer processes less than 95
133 percent of all claims in a standard financial quarter in compliance with paragraph (1) of
134 subsection (b) of this Code section. Such penalty shall be assessed on data collected by the
135 Commissioner.

136 (e) This Code section shall be applicable when an insurer is adjudicating claims for its
 137 fully insured business or its business as a third-party administrator."

138 **SECTION 3.**

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

141 "33-24-59.13.

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

143 (1) 'Administrator' shall have the same meaning as provided in Code Section 33-23-100.

144 (2) 'Benefits' shall have the same meaning as provided in Code Section 33-24-59.5.

145 (3) 'Facility' shall have the same meaning as provided in Code Section 33-20A-3.

146 (4) 'Health benefit plan' shall have the same meaning as provided in Code
 147 Section 33-24-59.5.

148 (5) 'Health care provider' shall have the same meaning as provided in Code
 149 Section 33-20A-3.

150 (6) 'Insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit
 151 hospital service corporation, nonprofit medical service corporation, health care
 152 corporation, health maintenance organization, provider sponsored health care corporation,
 153 or any similar entity, which entity provides for the financing or delivery of health care
 154 services through a health benefit plan, the plan administrator of any health plan, or the
 155 plan administrator of any health benefit plan established pursuant to Article 1 of
 156 Chapter 18 of Title 45.

157 (b)(1) All benefits under a health benefit plan will be payable by the insurer or
 158 administrator which is obligated to finance or deliver health care services or process
 159 claims under that plan upon such insurer's or administrator's receipt of written or
 160 electronic proof of loss or claim for payment for health care goods or services provided.
 161 The insurer or administrator shall within 15 working days for electronic claims or 30
 162 calendar days for paper claims after such receipt mail or send electronically to the facility
 163 or health care provider claiming payments under the plan payment for such benefits or
 164 a letter or notice which states the reasons the insurer or administrator may have for failing
 165 to pay the claim, either in whole or in part, and which also gives the facility or health care
 166 provider so notified a written itemization of any documents or other information needed
 167 to process the claim or any portions thereof which are not being paid. Where the insurer
 168 or administrator disputes a portion of the claim, any undisputed portion of the claim shall
 169 be paid by the insurer or administrator in accordance with this chapter. When all of the
 170 listed documents or other information needed to process the claim have been received by
 171 the insurer or administrator, the insurer or administrator shall then have 15 working days

172 for electronic claims or 30 calendar days for paper claims within which to process and
173 either mail payment for the claim or a letter or notice denying it, in whole or in part,
174 giving the facility or health care provider claiming payments under the plan the insurer's
175 or administrator's reasons for such denial.

176 (2) Receipt of any proof, claim, or documentation by an entity which administers or
177 processes claims on behalf of an insurer shall be deemed receipt of the same by the
178 insurer for purposes of this Code section.

179 (c) Each insurer or administrator shall pay to the facility or health care provider claiming
180 payments under the health benefit plan interest equal to 12 percent per annum on the
181 proceeds or benefits due under the terms of such plan for failure to comply with subsection
182 (b) of this Code section.

183 (d) An insurer or administrator may only be subject to an administrative penalty by the
184 Commissioner as authorized by the insurance laws of this state when such insurer or
185 administrator processes less than 95 percent of all claims in a standard financial quarter in
186 compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall
187 be assessed on data collected by the Commissioner.

188 (e) This Code section shall be applicable when an insurer is adjudicating claims for its
189 fully insured business or its business as a third-party administrator."

190 **SECTION 4.**

191 This Act shall become effective on January 1, 2010.

192 **SECTION 5.**

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