

The Senate Insurance and Labor Committee offered the following substitute to HB 321:

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 for changes in the definitions of the terms "group accident and sickness insurance"
3 and "true association"; to provide a short title; to provide certain definitions; to include plan
4 administrators in prompt pay requirements; to provide for penalties; to provide an effective
5 date; to provide for related matters; to repeal conflicting laws; and for other purposes.

6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

7 This Act shall be known and may be cited as the "Insurance Delivery Enhancement Act of
8 2009."
9

SECTION 2.

10 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
11 revising paragraphs (2) and (3) of subsection (a) of Code Section 33-30-1 as follows:

12 "(2) Under a policy issued to an association, including a labor union, which shall have
13 a constitution and bylaws and which has been organized and is maintained in good faith
14 for purposes other than that of obtaining insurance, insuring at least ~~25~~ 10 members,
15 employees, or employees of members of the association for the benefit of persons other
16 than the association or its officers or trustees. As used in this paragraph, the term
17 'employees' may include retired employees;

18 (3) Under a policy issued to the trustees of a fund established by two or more employers
19 in the same industry, by one or more labor unions, by one or more employers and one or
20 more labor unions, or by an association, as defined in paragraph (2) of this Code section,
21 which trustees shall be deemed the policyholder, to insure not less than ~~25~~ 10 employees
22 of the employers or members of the union or of such association or of members of such
23 association for the benefit of persons other than the employers or other unions or such
24

25 associations. As used in this paragraph, the term 'employees' includes the officers,
 26 managers, and employees of the employer and the individual proprietor or partners, if the
 27 employer is an individual proprietor or partnership. The term may include retired
 28 employees. The policy may provide that the term 'employees' shall include the trustees
 29 or their employees, or both, if their duties are principally connected with such
 30 trusteeship;"

31 SECTION 3.

32 Said title is further amended by revising subparagraph (a)(7)(A) of Code Section 33-30-1 as
 33 follows:

34 "(7)(A) Under a policy issued to a legal entity providing a multiple employer welfare
 35 arrangement, which means any employee benefit plan which is established or
 36 maintained for the purpose of offering or providing accident and sickness benefits to
 37 the employees of two or more employers, including self-employed individuals,
 38 individuals whose compensation is reported on federal Internal Revenue Service Form
 39 1099, and their spouses or dependents. The term ~~does~~ shall not apply to any plan or
 40 arrangement which is established or maintained by a tax-exempt rural electric
 41 cooperative or a collective bargaining agreement."

42 SECTION 4.

43 Said title is further amended by revising Code Section 33-23-100, relating to the definition
 44 of administrator, as follows:

45 "33-23-100.

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

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

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

61 (3) 'Standard financial quarter' means a three-month period ending on March 31, June
62 30, September 30, or December 31 of any calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

92 ~~(12) A business entity that acts solely as an administrator of one or more bona fide~~
93 ~~employee benefit plans established by an employer or an employee organization, or both,~~
94 ~~for whom the insurance laws of this state are preempted pursuant to the federal Employee~~
95 ~~Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. An insurance~~

96 company licensed in this state or its affiliate if such insurance company or its affiliate is
 97 solely administering limited benefit insurance. For the purpose of this paragraph, the
 98 term 'limited benefit insurance' means accident or sickness insurance designed,
 99 advertised, and marketed to supplement major medical insurance, specifically: accident
 100 only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or
 101 specified disease; or

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

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

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

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

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

118 SECTION 5.

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

121 "33-24-59.5.

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

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

126 (2) 'Health benefit plan' means any hospital or medical insurance policy or certificate,
 127 health care plan contract or certificate, qualified higher deductible health plan, health
 128 maintenance organization subscriber contract, any health benefit plan established
 129 pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy,
 130 or managed care plan or self-insured plan; but health benefit plan does not include

131 policies issued in accordance with Chapter 31 of this title; disability income policies; or
 132 Chapter 9 of Title 34, relating to workers' compensation.

133 (3) 'Insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit
 134 hospital service corporation, nonprofit medical service corporation, health care
 135 corporation, health maintenance organization, provider sponsored health care corporation,
 136 or any similar entity and any self-insured health benefit plan ~~not subject to the exclusive~~
 137 ~~jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C.~~
 138 ~~Section 1001, et seq.~~, which entity provides for the financing or delivery of health care
 139 services through a health benefit plan, the plan administrator of any health plan, or the
 140 plan administrator of any health benefit plan established pursuant to Article 1 of Chapter
 141 18 of Title 45 or any other administrator as defined in paragraph (1) of subsection (a) of
 142 Code Section 33-23-100.

143 (b)(1) All benefits under a health benefit plan will be payable by the insurer which is
 144 obligated to finance or deliver health care services under that plan upon such insurer's
 145 receipt of written or electronic proof of loss or claim for payment for health care goods
 146 or services provided. The insurer shall within 15 working days for electronic claims or
 147 30 calendar days for paper claims after such receipt mail or send electronically to the
 148 insured or other person claiming payments under the plan payment for such benefits or
 149 a letter or electronic notice which states the reasons the insurer may have for failing to
 150 pay the claim, either in whole or in part, and which also gives the person so notified a
 151 written itemization of any documents or other information needed to process the claim
 152 or any portions thereof which are not being paid. Where the insurer disputes a portion
 153 of the claim, any undisputed portion of the claim shall be paid by the insurer in
 154 accordance with this chapter. When all of the listed documents or other information
 155 needed to process the claim has been received by the insurer, the insurer shall then have
 156 15 working days for electronic claims or 30 calendar days for paper claims within which
 157 to process and either mail payment for the claim or a letter or notice denying it, in whole
 158 or in part, giving the insured or other person claiming payments under the plan the
 159 insurer's reasons for such denial.

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

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

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

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

174 **SECTION 6.**

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

177 "33-24-59.13.

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

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

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

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

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

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

186 (6) 'Insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit
 187 hospital service corporation, nonprofit medical service corporation, health care
 188 corporation, health maintenance organization, provider sponsored health care corporation,
 189 or any similar entity, which entity provides for the financing or delivery of health care
 190 services through a health benefit plan, the plan administrator of any health plan, or the
 191 plan administrator of any health benefit plan established pursuant to Article 1 of Chapter
 192 18 of Title 45.

193 (b)(1) All benefits under a health benefit plan will be payable by the insurer or
 194 administrator which is obligated to finance or deliver health care services or process
 195 claims under that plan upon such insurer's or administrator's receipt of written or
 196 electronic proof of loss or claim for payment for health care goods or services provided.
 197 The insurer or administrator shall within 15 working days for electronic claims or 30
 198 calendar days for paper claims after such receipt mail or send electronically to the facility
 199 or health care provider claiming payments under the plan payment for such benefits or
 200 a letter or notice which states the reasons the insurer or administrator may have for failing
 201 to pay the claim, either in whole or in part, and which also gives the facility or health care
 202 provider so notified a written itemization of any documents or other information needed

203 to process the claim or any portions thereof which are not being paid. Where the insurer
 204 or administrator disputes a portion of the claim, any undisputed portion of the claim shall
 205 be paid by the insurer or administrator in accordance with this chapter. When all of the
 206 listed documents or other information needed to process the claim have been received by
 207 the insurer or administrator, the insurer or administrator shall then have 15 working days
 208 for electronic claims or 30 calendar days for paper claims within which to process and
 209 either mail payment for the claim or a letter or notice denying it, in whole or in part,
 210 giving the facility or health care provider claiming payments under the plan the insurer's
 211 or administrator's reasons for such denial.

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

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

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

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

226 **SECTION 7.**

227 (a) Except as otherwise provided by subsection (b) of this section, this Act shall become
 228 effective on July 1, 2009.

229 (b) Sections 4, 5, and 6 of this Act shall become effective January 1, 2011.

230 **SECTION 8.**

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