Senate Bill 472

By: Senator Hill of the 32nd

A BILL TO BE ENTITLED

AN ACT

To provide a short title; to amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide an exemption from insurance laws for certain physician arrangements; 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 comprehensive major medical plans to employees under certain circumstances; to provide for an offset for sales and use taxes by certain dealers who provide certain health insurance to their employees under certain circumstances; to provide for related matters; to provide for an effective date 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 "Flexible Choices Act."

SECTION 2.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by revising Code Section 33-7-2, relating to accident and sickness insurance, as follows:

″33-7-2.

Accident and sickness insurance is insurance against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness and every insurance appertaining thereto. Physicians entering into direct financial arrangements with their customers for specified services for a fee of less than $3,000.00 annually shall not be subject to state insurance laws.″

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 on insurance premiums ~~as provided for in subsection (a) of this Code section on premiums~~ paid by ~~Georgia~~ residents ~~for high deductible health plans as defined by Section 223 of the Internal Revenue Code~~ of this state for comprehensive major medical plans sold or maintained under applicable provisions of Georgia law.″

SECTION 4.

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

″33-24-9.1.

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

(b) The Commissioner shall be authorized to encourage and promote the marketing of comprehensive major medical 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 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 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 group comprehensive major medical 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 should be included as preventive care during any deductible phase of coverage, including appropriate diagnostics and medications related to that 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 those 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 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 or rebates, contributions towards a member's health savings account, modifications to copayment, deductible, ~~or~~ coinsurance amounts, or employee contributions or any combination of these incentives, to encourage enrollment, participation, 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~~ these 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 health insurance master policy and certificates or the individual 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."

SECTION 6.

Said title is further amended by revising subsection (b) of Code Section 33-30-23, relating to standards for preferred provider arrangements, 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)~~(3) 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)~~(4) Have an adverse effect on the availability or the quality of services; and

~~(6)~~(5) Be a result of a negotiation with a primary care physician to become a preferred provider unless that 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.

~~Subject to the approval of the Commissioner under such procedures as he 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.~~ (a) 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 must be appropriately licensed and in good standing; and

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

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

(c) Insurers shall not be required to admit health care providers as preferred providers 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 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 by adding a new article to Chapter 30, relating to group or blanket accident and sickness insurance, 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 those 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 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.

(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, 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 that 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 made available 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, 2012, 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 health care providers as exclusive providers 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 to and shall be 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 the 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, 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.

(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.″

SECTION 10.

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

″(13.2) One hundred percent of the premium paid by the taxpayer during the taxable year for comprehensive major medical plans to the extent the deduction has not been included in federal adjusted gross income, as defined under the 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;".

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 plan as defined by Section 223 of the Internal Revenue Code~~ comprehensive major medical plan.

(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, ~~50~~ ten or fewer persons and for whom the taxpayer provides ~~high deductible health~~ comprehensive major medical 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~~ comprehensive major medical expenses.

(f) The tax credit provided by 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 the effective date of this Code section."

SECTION 12.

Said title is further amended by adding a new Code section to Part 2 of Article 1 of Chapter 8, relating to imposition, rate, collection, and assessment of sales and use taxes, to read as follows:

"48-8-50.1.

(a) As used in this Code section, the term 'eligible employer' means an employer that contributes at least 50 percent of the total premiums for comprehensive major medical plans for each of such employer's employees and who collects and remits to the state sales and use taxes on products or services provided by the employer.

(b) An eligible employer shall be authorized to take an offsetting credit and retain the sales and use taxes otherwise owed to the state in an amount up to the eligible employer's premium contributions for a comprehensive major medical plan which shall be limited to sales tax amounts of:

(1) One hundred percent during the first 12 months after incorporation of the eligible employer;

(2) Seventy-five percent during the second 12 months after incorporation of the eligible employer;

(3) Fifty percent during the third 12 months after incorporation of the eligible employer; and

(4) Twenty-five percent during the fourth 12 months after incorporation of the eligible employer.

This offset shall not available to an otherwise eligible employer 48 months following incorporation of the eligible employer.

(c) To qualify for the retail sales tax offset the employer shall employ directly, or pay compensation to individuals whose compensation is reported on Form 1099, ten or fewer persons for whom the employer provides comprehensive major medical plans and in which such employees are enrolled.

(d) The retail sales tax offset shall not be available if the employer uses the tax credits under Code Section 48-7-29.13.

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

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

SECTION 13.

Sections 10, 11, and 12 of this Act shall become effective on January 1, 2013, and shall apply to all tax years on and after that date. The remaining sections of this Act shall become effective on July 1, 2012.

SECTION 14.

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