The House Committee on Insurance offers the following substitute to SB 302:

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	require certain insurers to maintain accurate provider directories; to provide for definitions;
3	to provide for electronic and printed provider directories; to require certain information in
4	provider directories; to provide for related matters; to provide for exemptions; to repeal
5	conflicting laws; and for other purposes.
6	BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:
7	SECTION 1.
8	Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
9	adding a new chapter to read as follows:
10	" <u>CHAPTER 20C</u>
11	
11	<u>33-20C-1.</u>
12	As used in this chapter, the term:
13	(1) 'Covered person' means a policyholder, subscriber, enrollee or other individual
14	participating in a health benefit plan.
15	(2) 'Facility' means an institution providing physical, mental, or behavioral health care
16	services or a health care setting, including, but not limited to, hospitals; licensed inpatient
17	centers; ambulatory surgical centers; skilled nursing facilities; residential treatment
18	centers; diagnostic, treatment, or rehabilitation centers; imaging centers; and
19	rehabilitation and other therapeutic health settings.
20	(3) 'Health benefit plan' means a policy, contract, certificate, or agreement entered into,
21	offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse
22	any of the costs of health care services, including a standalone dental plan.

23	(4) 'Health care professional' means a physician or other health care practitioner licensed,
24	accredited, or certified to perform specified physical, mental, or behavioral health care
25	services consistent with his or her scope of practice under state law.
26	(5) 'Health care provider' or 'provider' means a health care professional, pharmacy, or
27	facility.
28	(6) 'Health care services' means services for the diagnosis, prevention, treatment, cure,
29	or relief of a physical, mental, or behavioral health condition, illness, injury, or disease,
30	including mental health and substance abuse disorders.
31	(7) 'Insurer' means an entity subject to the insurance laws and regulations of this state,
32	or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or
33	enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the
34	costs of health care services, including an accident and sickness insurance company, a
35	health maintenance organization, a nonprofit hospital and health service corporation, a
36	health care plan, or any other entity providing a health insurance plan, a health benefit
37	plan, or health care services.
38	(8) 'Network' means the group or groups of participating health care providers providing
39	services under a network plan.
40	(9) 'Network plan' means a health benefit plan of an insurer that either requires a covered
41	person to use health care providers managed by, owned by, under contract with, or
42	employed by the insurer or that creates incentives, including financial incentives, for a
43	covered person to use such health care providers.
44	(10) 'Standalone dental plan' means a plan of an insurer that provides coverage
45	substantially all of which is for treatment of the mouth, including any organ or structure
46	within the mouth, which is provided under a separate policy, certificate, or contract of
47	insurance or is otherwise not an integral part of a group benefit plan.
48	(11) 'Tiers' or 'tiered network' means a network that identifies and groups some or all
49	types of providers and facilities into specific groups to which different provider
50	reimbursement, covered person cost sharing, or provider access requirements, or any
51	combination thereof, apply for the same services.
52	<u>33-20C-2.</u>
53	(a)(1) An insurer shall post on its website a current and accurate electronic provider
54	directory for each of its network plans with the information described in Code Section
55	33-20C-4. Such online provider directory shall be easily accessible in a standardized,

56 <u>downloadable</u>, searchable, and machine readable format.

- 57 (2) In making the provider directory available online, the insurer shall ensure that the
- 58 general public is able to view all of the current providers for a network plan through a

59	clearly identifiable link or tab and without creating or accessing an account or entering
60	a policy or contract number.
61	(3) The insurer shall update each network plan on the online provider directory no less
62	than every 30 days.
63	(b) An insurer shall provide a print copy of a current provider directory, or a print copy of
64	the requested directory information, with the information described in Code Section
65	<u>33-20C-5 upon request by a covered person or a prospective covered person.</u>
66	(c) For each network plan, an insurer shall include in plain language, in both the online and
67	print directory, the following general information:
68	(1) A description of the criteria the insurer has used to build its provider network;
69	(2) If applicable, a description of the criteria the insurer has used to tier providers;
70	(3) If applicable, how the insurer designates the different provider tiers or levels, such
71	as by name, symbols, or grouping, in the network and for each specific provider in the
72	network, which tier each is placed in order for a covered person or a prospective covered
73	person to be able to identify the provider tier; and
74	(4) If applicable, a notice that authorization or referral may be required to access some
75	providers.
76	(d) The insurer shall make clear for both its online and print directories the provider
77	directory that applies to each network plan by identifying the specific name of the network
78	plan as marketed and issued in this state.
79	(e) The insurer shall make available through its online and print directories the source of
80	the information required pursuant to Code Sections 33-20C-4 and 33-20C-5 pertaining to
81	each health care provider and any limitations, if applicable.
82	(f) Provider directories, whether in electronic or print format, shall be accessible to
83	individuals with disabilities and individuals with limited English proficiency as defined in
84	45 C.F.R. Section 92.201 and 45 C.F.R. Section 155.205(c).
85	<u>33-20C-3.</u>
86	(a) The insurer shall include in both its online and print directories a clearly identifiable
87	telephone number and either a dedicated email address or a link to a dedicated webpage
88	that covered persons or the general public may use to report to the insurer inaccurate
89	information listed in the provider directory. Whenever an insurer receives such a report,
90	it shall promptly investigate such report and no later than 30 days following receipt of such
91	report either verify the accuracy of the information or update the information, as applicable.
92	(b)(1) An insurer shall take appropriate steps to ensure the accuracy of the information
93	concerning each provider listed in the insurer's provider directory and shall, no later than
94	January 1, 2017, review and update the entire provider directory for each network plan

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95	offered. Thereafter, the insurer shall, at least annually, audit at least a reasonable sample
96	size of its provider directories for accuracy, retain documentation of such an audit to be
97	made available to the Commissioner upon request, and based on the results of such an
98	audit, verify the accuracy of the information or update the information, if applicable.
99	(2) The insurer shall notify any provider in its network that has not submitted claims to
100	the insurer or otherwise communicated intent to continue participation in the insurer's
101	network within a 12 month period. Such notice shall be accomplished in accordance with
102	provisions of the contract entered into between the insurer and the provider regarding
103	notice, if applicable. If the insurer does not receive a response from the provider within
104	30 days of such notification confirming that the information regarding the provider is
105	current and accurate or, as an alternative, updating any information, the insurer shall
106	remove the provider from the network; provided, however, that prior to removal, the
107	insurer may use any other available information or means to determine if the provider is
108	still participating in the insurer's network, including any means delineated in the contract
109	entered into between the insurer and the provider.
110	(c) The insurer shall report to the Commissioner, in accordance with timeframes and
111	requirements established by the Commissioner:
112	(1) The number of reports received pursuant to subsection (a) of this Code section, the
113	timeliness of the insurer's response, and the corrective actions taken; and
114	(2) All auditing reports conducted by the insurer pursuant to subsection (b) of this Code
115	section.
116	(d) In circumstances where the Commissioner finds that a covered person reasonably
117	relied upon materially inaccurate information contained in an insurer's provider directory,
118	the Commissioner may require the insurer to provide coverage for all covered health care
119	services provided to the covered person and to reimburse the covered person for any
120	amount that he or she would have paid, had the services been delivered by an in-network
121	provider under the insurer's network plan; provided, however, that the Commissioner shall
122	take into consideration that insurers are relying on health care providers to report changes
123	to their information prior to requiring any reimbursement to a covered person. Prior to
124	requiring reimbursement in these circumstances, the Commissioner shall conclude that the
125	services received by the insurer were covered services under the covered person's network
126	plan. In such circumstances, the fact that the services were rendered or delivered by a
127	noncontracting or out-of-network provider shall not be used as a basis to deny
128	reimbursement to the covered person.

129	<u>33-20C-4.</u>
130	(a) The insurer shall make available through an online provider directory, for each network
131	plan, the following information, in a searchable format:
132	(1) For health care professionals:
133	(A) Name;
134	(B) Gender:
135	(C) Contact information;
136	(D) Participating office location or locations;
137	(E) Specialty, if applicable;
138	(F) Board certifications, if applicable;
139	(G) Medical group affiliations, if applicable;
140	(H) Participating facility affiliations, if applicable;
141	(I) Languages spoken other than English by the health care professional or clinical
142	staff, if applicable;
143	(J) Tier; and
144	(K) Whether they are accepting new patients;
145	(2) For hospitals:
146	(A) Hospital name;
147	(B) Hospital type, such as acute, rehabilitation, children's, or cancer;
148	(C) Participating hospital location;
149	(D) Hospital accreditation status; and
150	(E) Telephone number; and
151	(3) For facilities other than hospitals:
152	(A) Facility name;
153	(B) Facility type;
154	(C) Types of services performed;
155	(D) Participating facility location or locations; and
156	(E) Telephone number.
157	(b) Paragraphs (2) and (3) of subsection (a) of this Code section shall not apply to
158	standalone dental plans.
159	<u>33-20C-5.</u>
160	(a) The insurer shall make available in print, upon request, the following provider
161	directory information for the applicable network plan:
162	(1) For health care professionals:
163	(A) Name;
164	(B) Contact information;

SECTION 2.
<u>18 of Title 45."</u>
Medicaid or PeachCare for Kids and the state health benefit plan under Article 1 of Chapter
entered into by an insurer and the Department of Community Health for recipients of
This chapter shall not apply to the provision of health care services pursuant to a contract
<u>33-20C-6.</u>
telephone number to obtain current provider directory information.
insurer's electronic provider directory on its website or call a specified customer service
of printing and that covered persons or prospective covered persons should consult the
subsection (a) of this Code section and included in the directory is accurate as of the date
(b) The insurer shall include a disclosure in the print directory that the information in
(D) Participating facility location or locations and telephone number.
(C) Types of services performed; and
(B) Facility type;
(A) Facility name;
(3) For facilities other than hospitals:
(C) Participating hospital location and telephone number; and
(B) Hospital type, such as acute, rehabilitation, children's, or cancer; and
(A) Hospital name;
(2) For hospitals:
(F) Whether accepting new patients;
(E) Languages spoken other than English, if applicable; and
(D) Specialty, if applicable;
(C) Participating office location or locations;

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