The Senate Committee on Insurance and Labor offers the following substitute to HB 162:

A BILL TO BE ENTITLED
AN ACT

To amend Chapter 2 of Title 33 of the Official Code of Georgia Annotated, relating to the department and Commissioner of Insurance, so as to provide for insurance compliance self-evaluative privilege; to provide for intent; to provide for definitions; to provide for an insurance compliance self-evaluative audit document as privileged information; to provide for inadmissibility in certain legal actions; to provide for applications and exceptions; to provide for the burden of proof; to provide for applicability; to amend Code Section 33-24-59.10 of the Official Code of Georgia Annotated, relating to insurance coverage for autism, so as to provide for certain insurance coverage of autism spectrum disorders; to provide for definitions; to provide for limitations; to provide for premium cap and other conditions; to provide for applicability; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 2 of Title 33 of the Official Code of Georgia Annotated, relating to the department and Commissioner of Insurance, is amended by adding a new Code section to read as follows:

"33-2-34.

(a) To encourage insurance companies and persons conducting activities regulated under this title, both to conduct voluntary internal audits of their compliance programs and management systems and to assess and improve compliance with state and federal statutes, rules, and orders, an insurance compliance self-evaluative privilege is recognized to protect the confidentiality of communications relating to voluntary internal compliance audits. The General Assembly hereby finds and declares that protection of insurance consumers is enhanced by companies' voluntary compliance with this state's insurance and other laws and that the public will benefit from incentives to identify and remedy insurance and other compliance issues. It is further declared that limited expansion of the protection against

disclosure will encourage voluntary compliance and improve insurance market conduct quality and that the voluntary provisions of this Code section will not inhibit the exercise of the regulatory authority by those entrusted with protecting insurance consumers.

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

(1) 'Insurance compliance audit' means a voluntary, internal evaluation, review, assessment, or audit not otherwise expressly required by law of an insurer or an activity regulated under this title, or other state or federal law applicable to an insurer, or of management systems related to the insurer or activity, that is designed to identify and prevent noncompliance and to improve compliance with those statutes, rules, or orders. An insurance compliance audit may be conducted by the insurer, its employees, or independent contractors.

(2) 'Insurance compliance self-evaluative audit document' means any document prepared as a result of or in connection with and not prior to an insurance compliance audit. An insurance compliance self-evaluative audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, computer generated or electronically recorded information, phone records, maps, charts, graphs, and surveys, provided that this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit. An insurance compliance self-evaluative audit document may also include any of the following:

(A) An insurance compliance audit report prepared by an auditor, who may be an employee of the insurer or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices;

(B) Memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues;

(C) An implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance; or

(D) Analytic data generated in the course of conducting the insurance compliance audit.

(c)(1) An insurance compliance self-evaluative audit document is privileged information and is not admissible as evidence in any legal action in any civil, criminal, or administrative proceeding, except as provided in subsections (d) and (e) of this Code section. Documents, communications, data, reports, or other information created as a result of a claim involving personal injury or workers' compensation made against an

insurance policy are not insurance compliance self-evaluative audit documents and are admissible as evidence in civil proceedings as otherwise provided by applicable rules of evidence or civil procedure, subject to any applicable statutory or common law privilege, including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

(2) If any insurer, person, or entity performs or directs the performance of an insurance compliance audit, an officer or employee involved with the insurance compliance audit, or any consultant who is hired for the purpose of performing the insurance compliance audit, shall not be examined in any civil, criminal, or administrative proceeding as to the insurance compliance audit or any insurance compliance self-evaluative audit document, as defined in this Code section. This paragraph shall not apply if the privilege set forth in paragraph (1) of this subsection is determined under subsection (d) or (e) of this Code section not to apply.

(3) An insurer may voluntarily submit, in connection with examinations conducted under this Code section, an insurance compliance self-evaluative audit document to the Commissioner, or his or her designee, as a confidential document under subsection (g) of Code Section 33-2-14 without waiving the privilege set forth in this Code section to which the insurer would otherwise be entitled. However, the provision permitting the Commissioner to provide access to the National Association of Insurance Commissioners shall not apply to the insurance compliance self-evaluative audit document so voluntarily submitted. Nothing contained in this subsection shall give the Commissioner any authority to compel an insurer to disclose involuntarily or otherwise provide an insurance compliance self-evaluative audit document.

(d)(1) The privilege set forth in subsection (c) of this Code section shall not apply to the extent that it is expressly waived by the insurer that prepared or caused to be prepared the insurance compliance self-evaluative audit document.

(2) In a civil or administrative proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in subsection (c) of this Code section is asserted, if the court determines that:

(A) The privilege is asserted for a fraudulent purpose;

(B) The material is not subject to the privilege; or

(C) Even if subject to the privilege, the material shows evidence of noncompliance with state or federal statutes, rules, and orders and the insurer failed to undertake reasonable corrective action or eliminate the noncompliance within a reasonable time.

(3) In a criminal proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege described in subsection (c) of this Code section is asserted, if the court determines that:

(A) The privilege is asserted for a fraudulent purpose;

(B) The material is not subject to the privilege;

(C) Even if subject to the privilege, the material shows evidence of noncompliance with state or federal statutes, rules, and orders and the insurer failed to undertake reasonable corrective action or eliminate such noncompliance within a reasonable time; or

(D) The material contains evidence relevant to the commission of a criminal offense under this title and:

(i) The Commissioner has a compelling need for the information;

(ii) The information is not otherwise available; and

(iii) The Commissioner is unable to obtain the substantial equivalent of the information by any means without incurring unreasonable cost and delay.

(e)(1) Within 30 days after the Commissioner makes a written request by certified mail for disclosure of an insurance compliance self-evaluative audit document under this subsection, the insurer that prepared or caused the document to be prepared may file with the appropriate court a petition requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Code section or subject to disclosure. The court has jurisdiction over a petition filed by an insurer under this subsection requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged or subject to disclosure. Failure by the insurer to file a petition waives the privilege.

(2) An insurer asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall include in its petition for an in camera hearing all of the information set forth in paragraph (5) of this subsection.

(3) Upon the filing of a petition under this subsection, the court shall issue an order scheduling, within 45 days after the filing of the petition, an in camera hearing to determine whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Code section or subject to disclosure.

(4) The court, after an in camera review, may require disclosure of material for which the privilege in subsection (c) of this Code section is asserted if the court determines, based upon its in camera review, that any one of the conditions set forth in paragraph (2) of subsection (d) of this Code section is applicable as to a civil or administrative proceeding or that any one of the conditions set forth in paragraph (3) of subsection (d) of this Code section is applicable as to a criminal proceeding. Upon making such a determination, the court may only compel the disclosure of those portions of an insurance compliance self-evaluative audit document relevant to issues in dispute in the underlying

proceeding. Any compelled disclosure will not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal, or administrative proceeding. A party unsuccessfully opposing disclosure may apply to the court for an appropriate order protecting the document from further disclosure.

(5) An insurer asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall provide to the Commissioner at the time of filing any objection to the disclosure:

(A) The date of the insurance compliance self-evaluative audit document;

(B) The identity of the entity conducting the audit;

(C) The general nature of the activities covered by the insurance compliance audit; and

(D) An identification of the portions of the insurance compliance self-evaluative audit document for which the privilege is being asserted.

(f)(1) An insurer asserting the insurance compliance self-evaluative privilege set forth in subsection (c) of this Code section has the burden of demonstrating the applicability of the privilege. Once an insurer has established the applicability of the privilege, a party seeking disclosure under paragraph (2) or (3) of subsection (d) of this Code section has the burden of proving that the privilege is asserted for a fraudulent purpose or that the insurer failed to undertake reasonable corrective action or eliminate the noncompliance within a reasonable time. The Commissioner, in seeking disclosure under paragraph (3) of subsection (d) of this Code section, has the burden of proving the elements set forth in paragraph (3) of subsection (d) of this Code section.

(2) The parties may at any time stipulate in proceedings under subsection (d) or (e) of this Code section to entry of an order directing that specific information contained in an insurance compliance self-evaluative audit document is or is not subject to the privilege provided under subsection (c) of this Code section.

(g) The privilege set forth in subsection (c) of this Code section shall not extend to:

(1) Documents, communications, data, reports, or other information required to be collected, developed, maintained, reported, or otherwise made available to a regulatory agency pursuant to this title or other federal or state law, rule, or order;

(2) Information obtained by observation or monitoring by any regulatory agency; or

(3) Information obtained from a source independent of the insurance compliance audit.

(h) Nothing in this Code section shall limit, waive, or abrogate the scope or nature of any statutory or common law privilege including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

(i) This Code section shall apply to self-evaluative audits completed before June 30, 2018, but shall not apply to any such audits completed on or after July 1, 2018, unless authorized by the General Assembly prior to that date."

SECTION 2.

Code Section 33-24-59.10 of the Official Code of Georgia Annotated, relating to insurance coverage for autism, is amended as follows:

"33-24-59.10.

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

(1) 'Accident and sickness contract, policy, or benefit plan' shall have the same meaning as found in Code Section 33-24-59.1. Accident and sickness contract, policy, or benefit plan shall also include without limitation any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45. Accident and sickness contract, policy, or benefit plan shall not include limited benefit insurance policies designed, advertised, and marketed to supplement major medical insurance such as accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and any other type of accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, or major medical insurance.

(2) ~~'Autism' means a developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills~~ 'Applied behavior analysis' means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(3) 'Autism spectrum disorder' means autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(4) 'Treatment of autism spectrum disorder' includes the following types of care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder:

(A) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis shall be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(B) Counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and

(C) Therapy services provided by a licensed or certified speech therapist,

speech-language pathologist, occupational therapist, physical therapist, or marriage and family therapist.

(b) ~~An insurer that provides benefits for neurological disorders, whether under a group or individual accident and sickness contract, policy, or benefit plan, shall not deny providing benefits in accordance with the conditions, schedule of benefits, limitations as to type and scope of treatment authorized for neurological disorders, exclusions, cost-sharing arrangements, or copayment requirements which exist in such contract, policy, or benefit plan for neurological disorders because of a diagnosis of autism. The provisions of this subsection shall not expand the type or scope of treatment beyond that authorized for any other diagnosed neurological disorder.~~ Accident and sickness contracts, policies, or benefit plans shall provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is six years of age or under in accordance with the following:

(1) The policy or contract shall provide coverage for any assessments, evaluations, or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder;

(2) The policy or contract shall provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this Code section at least annually;

(3) The policy or contract shall not include any limits on the number of visits;

(4) The policy or contract may limit coverage for applied behavior analysis to $35,000.00 per year. An insurer shall not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph; and

(5) This subsection shall not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy or contract. Coverage for prescription drugs for the treatment of autism spectrum disorders shall be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy or contract.

(c) Except as otherwise provided in this Code section, any policy or contract that provides coverage for services under this Code section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles, and exclusions to the extent that these provisions are not inconsistent with the requirements of this Code section.

(d) This Code section shall not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized family service plan, an individualized education plan as required by the federal Individuals with Disabilities Education Act, or an individualized service plan. This Code section also shall

not be construed to limit benefits that are otherwise available to an individual under an accident and sickness contract, policy, or benefit plan.

(e)(1) An insurer, corporation, or health maintenance organization, or a governmental entity providing coverage for such treatment pursuant to this Code section, is exempt from providing coverage for behavioral health treatment required under this Code section and not covered by the insurer, corporation, health maintenance organization, or governmental entity providing coverage for such treatment pursuant to this Code section as of December 31, 2016, if:

(A) An actuary, affiliated with the insurer, corporation, or health maintenance organization, who is a member of the American Academy of Actuaries and meets the American Academy of Actuaries' professional qualification standards for rendering an actuarial opinion related to health insurance rate making, certifies in writing to the Commissioner that:

(i) Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, or health maintenance organization, or such governmental entity, for the most recent experience period of at least one year's duration, the costs associated with coverage of behavioral health treatment required under this Code section, and not covered as of December 31, 2016, exceeded 1 percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

(ii) Those costs solely would lead to an increase in average premiums charged of more than 1 percent for all insurance policies, subscription contracts, or health care plans commencing on inception or the next renewal date, based on the premium rating methodology and practices the insurer, corporation, or health maintenance organization, or such governmental entity, employs; and

(B) The Commissioner approves the certification of the actuary.

(2) An exemption allowed under paragraph (1) of this subsection shall apply for a one-year coverage period following inception or next renewal date of all insurance policies, subscription contracts, or health care plans issued or renewed during the one-year period following the date of the exemption, after which the insurer, corporation, or health maintenance organization, or such governmental entity, shall again provide coverage for behavioral health treatment required under this subsection.

(3) An insurer, corporation, or health maintenance organization, or such governmental entity, may claim an exemption for a subsequent year, but only if the conditions specified in this subsection again are met.

(4) Notwithstanding the exemption allowed under paragraph (1) of this subsection, an insurer, corporation, or health maintenance organization, or such governmental entity,

may elect to continue to provide coverage for behavioral health treatment required under this subsection.

(f) Beginning January 1, 2016, to the extent that this Code section requires benefits that exceed the essential health benefits required under Section 1302(b) of the federal Patient Protection and Affordable Care Act, P. L. 111-148, the specific benefits that exceed the required essential health benefits shall not be required of a 'qualified health plan' as defined in such act when the qualified health plan is offered in this state through the exchange. Nothing in this subsection shall nullify the application of this Code section to plans offered outside the state's exchange.

(g) This Code section shall not apply to any accident and sickness contract, policy, or benefit plan offered by any employer with ten or fewer employees.

(h) Nothing in this Code section shall be construed to limit any coverage under any accident and sickness contract policy or benefit plan, including, but not limited to, speech therapy, occupational therapy, or physical therapy otherwise available under such plan.

(i) By January 15, 2017, and every January 15 thereafter, the department shall submit a report to the General Assembly regarding the implementation of the coverage required under this Code section. The report shall include, but shall not be limited to, the following:

(1) The total number of insureds diagnosed with autism spectrum disorder;

(2) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this Code section;

(3) The cost of such coverage per insured per month; and

(4) The average cost per insured for coverage of applied behavior analysis.

All health carriers and health benefit plans subject to the provisions of this Code section shall provide the department with all data requested by the department for inclusion in the annual report."

SECTION 3.

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