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INSURANCE

Insurance Generally: Define Minimum In-Patient Care that Health Insurers Must Provide for a Mother and Newborn; Require that if the Physician and Mother Choose an Earlier Discharge, Health Insurers Must Cover up to Two Follow-up Visits

CODE SECTIONS:	O.C.G.A. §§ 33-24-58 to -60 (new)
BILL NUMBER:	SB 482
ACT NUMBER:	739
GEORGIA LAWS:	1996 Ga. Laws 409
SUMMARY:	The Act requires all health insurers providing coverage in Georgia, including publicly funded health plans, to provide coverage for at least forty-eight hours of inpatient care for a mother and newborn following an uncomplicated vaginal birth and at least ninety-six hours of care following a cesarean delivery. The Act provides that if a mother and her physician decide upon a shorter length of stay, the insurer must provide coverage for up to two visits, either in an office or the home as desired by the mother and her physician, by the physician, a physician's assistant, or a registered nurse. The Act also prevents insurers from penalizing doctors either monetarily or by excluding them from providing care under the insurer's plan when they prescribe patient care in conformity with the Act.
EFFECTIVE DATE:	July 1, 1996

History

The face of health care in the United States is rapidly changing from that of the individual health care professional to the face of corporate America. Large corporations and insurers are gaining greater control over the health care market both directly, through the purchase and operation of doctors' practices, hospitals, clinics, and other health care outlets, and indirectly, through informal operating arrangements and managed care networks, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs).[1] As the control of

1. Lee Ann Bundren, *State Consumer Fraud Legislation Applied to the Health*

Produced by The Berkeley Electronic Press, 1996
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health care delivery moves into the corporate, for-profit sector, the profitability of providing health care services has become a major focus of the industry.[2] Emphasis on the economics of health care delivery has led, in many cases, to the transfer of decisions about patient care from the hands of health care professionals to the hands of large insurers whose interests are often more dominated by the good of the insurer than the good of the patient.[3] Where a large insurer owns the health care delivery system, controls the flow of patients and access to services, and also controls the payment for services, health care professionals have little discretion as to the level of service a patient receives; rather, insurance company protocol defines the type and level of service that patients will receive.[4] This restricts the physician from providing the type and amount of care he or she believes the patient requires, based on his or her knowledge of the patient's individual situation, because the patient's insurance company protocol will not provide coverage for the desired type, level, or amount of care.[5] One clear example of this tension between insurer protocol and the best judgment of health care professionals is in the delivery of inpatient care to mothers and newborns.[6]

The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend specific guidelines to physicians caring for mothers and newborns as to the medical criteria and conditions that should exist before releasing a mother and her newborn from a hospital.[7] Physicians find it difficult, if not impossible, to meet these guidelines when health insurers reduce the amount of inpatient coverage for mothers and newborns to less than forty-eight hours for a normal vaginal birth and less than ninety-six hours for a cesarean birth.[8] The practitioner needs to evaluate not only the health of the mother, but also the health of the newborn.[9] Hospital stays allow health care professionals to identify problems with the newborn, prevent disabilities through metabolic screening, and help ensure that the family is able and prepared to care for the baby at home.[10] When mothers and infants are forced to leave the hospital too soon, health care personnel do not have sufficient opportunity to detect problems with the infant or the mother that "if undiagnosed may pose life-

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Care Industry, 16 J. LEGAL MED. 133, 157-61 (Mar. 1995).

2. *See generally id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. *See* O.C.G.A. § 33-24-59 (1996).
7. *See id.* § 33-24-59(3).
8. *See id.*
9. *See id.* § 33-24-59(4).
10. *See id.* § 33-24-59(5).

HeinOnline -- 13 Ga. St. U. L. Rev. 202 1996-1997

threatening and costly complications and may require a longer period of observation by skilled personnel" after the mother or child is readmitted than if treated during the first forty-eight hours after the birth.[11]

Many insurers now refuse payment for hospital stays that extend beyond twenty-four hours after an uncomplicated delivery and forty-eight hours after a cesarean delivery.[12] "Drive-through" delivery has become commonplace in many parts of the country, including Georgia.[13] Concern over early discharge has led to the introduction of legislation in the United States Senate and forty-two states, and the promulgation of regulations in two additional states.[14] Of those states introducing legislation, twenty-three (including Georgia) passed the legislation, and the legislation of ten others was pending final action as of May 31, 1996.[15] Like many other state legislatures, the Georgia General Assembly questioned the safety and appropriateness of early releases[16] and, as a result, enacted the "Newborn Baby and Mother Protection Act."[17]

SB 482

Evolution of the Act

The Newborn Baby and Mother Protection Act was passed to ensure that patients and doctors rather than insurers make decisions as to the length of inpatient hospital care following the birth of a child.[18] Three bills targeting the practice of drive-through delivery were introduced at the beginning of the 1996 legislative session.[19] SB 482, ultimately

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11. *Id.* § 33-24-59(2) to (4).
12. *See id.* § 33-24-59(1).
13. Editorial, *1996 Georgia General Assembly Ensuring Babies' Healthy Start*, ATLANTA J. & CONST., Feb. 25, 1996, at D6 [herainafter *Healthy Start*].
14. The Maternal and Child Health Institute, Survey of State Legislation and Regulations Requiring Insurance Coverage for Postpartum Care, 1995-96 (available in Georgia State University College of Law Library).
15. *Id.*
16. *See* O.C.G.A. § 33-24-59(2) (1996).
17. *Id.* § 33-24-58.
18. *See id.* § 33-24-59(4). The Act states:

> The length of postdelivery inpatient stay should be a clinical decision made by a physician based on the unique characteristics of each mother and her infant, taking into consideration the health of the mother, the health and stability of the baby, the ability and confidence of the mother to care for her baby, the adequacy of support systems at home, and access to appropriate follow-up care.

Id.

19. Interview with Sen. Nadine Thomas, Senate District No. 10 and Cynthia Tucker, Legislative Assistant (Aug. 7, 1996) [hereinafter Thomas Interview]; *see* HB 1189, as introduced, 1996 Ga. Gen. Assem.; HB 1114, as introduced, 1996 Ga. Gen.

passed by the General Assembly, was authored and sponsored by Senator Thomas, a registered nurse and director of Grady Health System of Atlanta's Community Outreach Service.[20] Her medical knowledge and skills, her experience in identifying and serving the needs of the community, and her commitment to improving the health of Georgians motivated her to introduce and work extensively on this bill.[21] In addition to her own knowledge, Senator Thomas, who works daily with pediatricians, obstetricians, and other health care professionals, was able to question her colleagues and gain their insight and thus add the practitioner's perspective.[22]

Representatives Burkhalter and Wiles, the sponsors of HB 1189 and HB 1114, agreed to withdraw their bills and become part of a team effort with Senator Thomas to create a comprehensive law to improve post-delivery health care service in Georgia.[23] In addition to this endorsement, a strong endorsement and lobbying effort by the bipartisan Women's Caucus of the Georgia General Assembly and its Chairperson, Representative Michele Henson of the 65th District, was also instrumental in the passage of the Act.[24]

On October 4, 1995, the Subcommittee on Health Care Professionals and Facilities of the Senate Health and Human Services Committee held hearings on draft legislation that would later become SB 482.[25] This draft, which was prefiled on November 29, 1995, was based on similar federal legislation, United States Senate Bill 969, sponsored by Senator Bill Bradley of New Jersey and Senator Nancy Kassebaum of Kansas.[26] After SB 482 was prefiled, Senator Thomas held a press conference to generate interest and invite discussion on the subject of early discharge for new mothers and infants.[27] She then convened hearings to allow interested parties to express their support and their concerns.[28] Proponents and opponents expressed their opinions in these hearings and in discussions with Senator Thomas between January 10, 1996, when the bill was first read in the Senate and January 22, 1996, when the bill went to the Senate Health and Human Services Committee.[29] During the hearings and discussions, speakers and representatives from many organizations involved in maternal and

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Assem.; SB 482, as introduced, 1996 Ga. Gen. Assem.

20. Thomas Interview, *supra* note 19.
21. *Id.* Georgia has one of the highest infant mortality rates in the nation. *Id.*
22. *Id.*
23. *Id.; Healthy Start, supra* note 13.
24. Thomas Interview, *supra* note 19.
25. *Id.*
26. *Id.; see* S. 969, 104th Cong., 2d Sess. (1995).
27. Thomas Interview, *supra* note 19.
28. *Id.*
29. *Id.*

HeinOnline -- 13 Ga. St. U. L. Rev. 204 1996-1997

child health care expressed their support.[30] Opponents of the bill, primarily insurance-related entities, expressed their concerns.[31] As a result of the input of these groups, Senator Thomas changed the original version of SB 482 and presented a substitute to the Senate Health and Human Services Committee on January 22, 1996 that incorporated and addressed some of the concerns expressed through public comment.[32] The substitute was discussed and passed by the Committee with two amendments, both proposed by Senator Charles W. Walker of the 22nd District.[33] The first amendment altered the bill's purpose statement. The original version stated that "[t]he length of post-delivery inpatient stay should be based on the unique characteristics of each mother and her infant, taking into consideration the health of the mother, the health and stability of the baby, . . . and access to appropriate follow-up care."[34] Senator Walker's amendment added that the length of stay should be a "clinical decision made by a physician based on medical necessity."[35]

The second amendment removed from the bill the ability for a mother to request a longer hospital stay.[36] As amended by Senator Walker, the bill only required a longer stay when deemed "medically

30. *Id.* The organizations included the following: American Academy of Pediatrics, Georgia Chapter; American Association of University Women of Georgia; Chatham-Savannah Youth Futures Authority; Council on Maternal and Infant Health, State of Georgia; Dekalb County Teenage Pregnancy Task Force; Georgia Academy of Family Physicians; Georgia Advocates of Battered Women and Children; March of Dimes Birth Defects Foundation, Georgia Chapter; Georgia Council on Child Abuse; Georgia Federation of Teachers; Georgia Homemakers Council; Georgia National Organization for Women; Georgians for Children; Georgia Nurses Association; Georgia Perinatal Organization; Georgia Obstetrical and Gynecological Society; Healthy Mothers/Healthy Babies Coalition of Georgia, Inc.; Junior League of Georgia, State Public Affairs Committee; League of Women Voters of Georgia; Planned Parenthood of East Central Georgia; Planned Parenthood of the Atlanta Area; Save The Children Childcare Support Center; The Maternal and Child Health Institute, Inc.; Tift County Commission on Children and Youth; and Worth County Community Preservation, Inc. *Id.*

31. *Id.* The chief objections to the bill were its legislation of time frames for medical care that could result in higher medical costs, government intervention in protocol traditionally determined by hospitals and physicians, and the potentially high cost of implementation. *Id.* The legislation's primary opponents included many Georgia insurers, the Health Insurance Association of America, the Georgia Hospital Association, and the Georgia Chamber of Commerce (whose concern was limited to the cost of SB 482's provisions). *Id.*

32. *Id.*

33. *Id.*

34. SB 482, as introduced, 1996 Ga. Gen. Assem.

35. SB 482 (SCS), 1996 Ga. Gen. Assem.

36. *Compare* SB 482, as introduced, 1996 Ga. Gen. Assem. *with* SB 482 (SCS), 1996 Ga. Gen. Assem.

appropriate" by the attending physician.[37] This language and that added by the first amendment changed the focus of the bill; it potentially placed the decision as to "medical necessity" and when to provide longer hospital stays back into the hands of insurers.[38]

The bill was read for the second time on January 24, 1996 and put to a Senate vote the next day.[39] During the Senate debate on the bill, Senator Thomas proposed a floor amendment that essentially withdrew Senator Walker's changes and reinstated the language allowing a mother to request a longer stay.[40] Senator Mary Margaret Oliver of the 42nd District proposed an amendment to make the Act effective upon approval by the Governor and applicable to all health care contracts in effect on that date.[41] This insured that all mothers and babies would be covered by the provisions of the Act, even if they contracted for insurance coverage prior to the effective date of the legislation.[42] The substitute, as amended, passed the Senate with fifty-four votes for and only one vote against it.[43]

At the request of Senator Thomas for expedience, SB 482 went to the House on January 26th, where it was referred to the House Insurance Committee.[44] Representative Jimmy Lord, Chairperson of the House Insurance Committee, referred the bill to a subcommittee chaired by Representative Ronnie Culbreth.[45] By the time the General Assembly recessed in February, it appeared that concerns over the cost to the state of adding Medicaid to those covered by the bill might prevent the bill from leaving committee.[46] During this recess, Senator Thomas toured the state to garner the support of practitioners, women's groups, and Georgia women, who lobbied the General Assembly and urged the bill's passage.[47] The House Insurance Subcommittee held hearings for SB 482 during the recess, and discussed whether to support the House bills that addressed early discharge.[48] After lengthy discussion, the subcommittee members agreed that Senator Thomas' bill was more workable; however, they wanted to insure that their colleagues who

37. SB 482 (SCS), 1996 Ga. Gen. Assem.
38. Thomas Interview, *supra* note 19.
39. Final Composite Status Sheet, Mar. 18, 1996.
40. SB 482 (SCSFA), 1996 Ga. Gen. Assem.; Thomas Interview, *supra* note 19.
41. SB 482 (SCSFA), 1996 Ga. Gen. Assem. The House amended the bill to make the effective date July 1, 1996, rather than upon its approval. SB 482 (HCS), 1996 Ga. Gen. Assem.
42. Thomas Interview, *supra* note 19.
43. Georgia Senate Voting Record, SB 482 (Jan. 25, 1996). Senator A. C. Guhl, Senate District No. 45, voted against the Act. *Id.*
44. Thomas Interview, *supra* note 19.
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.*

HeinOnline -- 13 Ga. St. U. L. Rev. 206 1996-1997

shared Senator Thomas' concern would have the opportunity to shape the legislation.[49] The subcommittee recommended that Representatives Burkhalter and Wiles collaborate with Senator Thomas on any final revisions that were necessary.[50]

Representatives Burkhalter and Wiles were primarily concerned with the aspects of the legislation that dealt with home care visits.[51] In HB 1114, Representative Wiles had proposed a single follow-up visit within forty-eight hours of discharge and did not specify a location for that visit.[52] In HB 1189, Representative Burkhalter had proposed coverage for up to two follow-up visits either in the home or an office, with the first visit required within forty-eight hours of discharge.[53] SB 482, as passed by the Senate, required coverage for one home visit no earlier than forty-eight hours and no later than seventy-two hours after delivery, and for an additional visit if deemed necessary by the health care practitioner.[54] During House Insurance Subcommittee hearings, pediatricians, obstetrician/gynecologists, and other health care professionals testified that babies and mothers must be evaluated soon after an early discharge because those who leave the hospital before forty-eight hours postpartum cannot be properly evaluated.[55] Professionals also testified that obtaining an early evaluation is often difficult for patients on Medicaid who may experience difficulty in finding a physician who accepts Medicaid and can schedule an office visit within such a short time after birth.[56] These same mothers may also have difficulty in arranging transportation to go to an office visit even when one can be arranged.[57] The professionals who testified advocated a requirement for a first visit within forty-eight hours after discharge, and a second visit, if necessary.[58] Members of the subcommittee were more comfortable with the less rigid language of HB 1189 that did not restrict the time frame for visits to between forty-eight and seventy-two hours.[59] Because either version would meet the

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49. *Id.*
50. *Id.*
51. *Id.*
52. HB 1114, as introduced, 1996 Ga. Gen. Assem.
53. HB 1189, as introduced, 1996 Ga. Gen. Assem.
54. SB 482 (SCSFA), 1996 Ga. Gen. Assem. SB 482 as introduced had required coverage for three home visits, but Senator Thomas changed the number of visits in her substitute based on the results of hearings in which both proponents and opponents of the legislation agreed that two visits—one required and one optional if necessary—was sufficient. Thomas Interview, *supra* note 19.
55. Thomas Interview, *supra* note 19.
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*

need for early visits expressed by experts during the hearings, Senator Thomas adopted the language of HB 1189 and amended SB 482.[60]

Provisions of the Act

The Act applies to all insurers providing insurance coverage in the state.[61] As introduced, SB 482 did not apply to insurers providing coverage under state-sponsored public insurance plans and "for profit" entities.[62] However, in a Senate committee substitute, Senator Thomas added insurers of state-sponsored health plans to those subject to the Act so that the Act provides all mothers and babies with adequate post-delivery care, not merely those covered by private insurance.[63] Also, before the bill reached the Senate Health and Human Services Committee, Senator Thomas learned that state employees' insurance funds were authorized under Title 45 rather than Title 33.[64] Therefore, those fulfilling "contracts executed by the State of Georgia on behalf of indigents and on behalf of state employees under Article 1 of Chapter 18 of Title 45" were added to the insurers subject to the Act.[65] Also recognizing that the original version inadvertently excluded some "for profit" entities, Senator Thomas removed the word "nonprofit" in the Senate committee substitute so that both for profit and nonprofit hospital service corporations and medical service corporations are obligated to provide coverage as defined under the Act.[66] Senator Thomas also determined that the original bill inadvertently excluded state programs, such as Medicaid, funded by the federal government under Title XIX, and therefore, she and Senator Oliver proposed a floor amendment, adopted by the Senate, that applied the provisions of the Act to "any state program funded under Title XIX of the federal Social Security Act, 42 U.S.C.A. section 1396 et. seq., and any other publicly funded state health care program."[67] Thus, the Act applies to *all* public and private insurers operating in Georgia, defined to include "accident and sickness insurer[s], fraternal benefit societ[ies], hospital service corporation[s], medical service corporation[s], health care corporation[s], health maintenance organization[s], or any similar entity authorized to issue contracts under [Title 33]."[68]

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60. *Id.*
61. O.C.G.A. § 33-24-60(a), (b) (1996).
62. SB 482, as introduced, 1996 Ga. Gen Assem.
63. Thomas Interview, *supra* note 19; SB 482 (SCSFA), 1996 Ga. Gen. Assem.
64. Thomas Interview, *supra* note 19.
65. SB 482 (SCS), 1996 Ga. Gen. Assem.
66. *Id.*
67. SB 482 (SCSFA), 1996 Ga. Gen. Assem.
68. O.C.G.A. § 33-24-60(a)(3) (1996).

HeinOnline -- 13 Ga. St. U. L. Rev. 208 1996-1997

Under the provisions of the Act, insurers who provide maternal health benefits in Georgia must provide coverage for at least forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of care following a cesarean section.[69] The Act's minimum stay requirements are based on guidelines developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.[70] The Act does not require all mothers and infants to stay in the hospital for forty-eight hours, but places the decision in the hands of the mother and her attending physician rather than in the hands of her insurer.[71]

For mothers who choose early release after consulting with their doctors, the Act requires insurers to provide coverage for up to two follow-up visits; one of those visits must occur within forty-eight hours of discharge and the second is covered if determined to be necessary by the health care provider.[72] The requirement that the first visit occur within forty-eight hours was added for the following reasons: (1) to give health care professionals the opportunity to provide an early evaluation of the health of the infant and mother and to detect and treat health problems at a time when intervention can still prevent or limit the severity of those problems; and (2) to prevent insurers from classifying later follow-up "wellness" visits already provided to most mothers and babies under existing plans as visits that place them in compliance with the Act.[73] "Wellness" visits occurring later than forty-eight hours after delivery evaluate different aspects of the newborn's and mother's health and circumstances than are contemplated by the Act.[74]

All follow-up visits must be conducted by a "physician, a physician's assistant, or a registered professional nurse with experience and training in maternal and child health nursing."[75] SB 482, as introduced, required that the follow-up visits be conducted by a registered nurse with at least three years experience in maternal and child nursing or a certified nurse midwife.[76] The intent of requiring three years of experience was to ensure that professionals conducting visits had enough expertise in maternal and child nursing to identify potential problems and recommend appropriate remedial measures.[77] However, many professional organizations and health care professionals, particularly physician's assistants and groups that

69. *Id.* § 33-24-60(b).
70. *Id.* § 33-24-59(3).
71. *Id.* § 33-24-60(c).
72. *Id.* § 33-24-60(d).
73. Thomas Interview, *supra* note 19.
74. *Id.*
75. O.C.G.A. § 33-24-60(d) (1996).
76. SB 482, as introduced, 1996 Ga. Gen. Assem.
77. Thomas Interview, *supra* note 19.

HeinOnline -- 13 Ga. St. U. L. Rev. 209 1996-1997

represent them, expressed their concern with requiring such a specific type and level of experience.[78] Because other health care professionals are also well-qualified to provide maternal and child home care services, these organizations and the professionals they represent urged Senator Thomas to consider the role that other types of providers could fill.[79] Senator Thomas revised SB 482 for the House committee substitute to allow physicians, physician's assistants, and registered nurses to perform follow-up visits.[80] The Act requires experience and training in maternal and child health nursing, without defining a specific level of experience;[81] details will be defined through regulations promulgated by the Insurance Commission.[82]

The follow-up visit may be conducted in either the home or office, as determined by the health care professional making the visit after conferring with the mother.[83] SB 482 originally did not contain a specific provision for substituting office-based follow-up visits for home visits.[84] The unintended effect was that if the mother refused a home visit, the insurance company would not be required to provide follow-up care within forty-eight hours after delivery.[85] The option of allowing either a home or office visit at the discretion of the mother and her provider had been included in HB 1189.[86] For some mothers who do not want to leave home with a newborn soon after delivery or who have difficulty with transportation, a home visit may be most appropriate.[87] But, for mothers or newborns who require procedures that cannot be performed at home or who prefer to visit the office, the option needed to be available.[88] Senator Thomas included this option when she revised the bill for the House committee substitute, and this version was incorporated into the Act.[89]

Regardless of where the visit occurs, the Act requires that specific minimum services be covered by insurance providers.[90] These services include "physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, and the performance of any medically necessary

78. *Id.*
79. *Id.*
80. *Id.*; SB 482 (HCS), 1996 Ga. Gen. Assem.
81. O.C.G.A. § 33-24-60(d) (1996).
82. *See id.* § 33-24-60(e); Thomas Interview, *supra* note 19.
83. O.C.G.A. § 33-24-60(d) (1996).
84. SB 482, as introduced, 1996 Ga. Gen. Assem.
85. Thomas Interview, *supra* note 19.
86. HB 1189, as introduced, 1996 Ga. Gen. Assem.
87. Thomas Interview, *supra* note 19.
88. *Id.*
89. O.C.G.A. § 33-24-60(d) (1996); SB 482 (HCS), 1996 Ga. Gen. Assem.
90. O.C.G.A. § 33-24-60(d) (1996).

HeinOnline -- 13 Ga. St. U. L. Rev. 210 1996-1997

and appropriate clinical tests."[91] The Act does not prevent providers and insurers from providing additional services.[92] The Act does require, however, that services provided during the visit be administered in a manner "consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations."[93] As a result of committee hearings and other research, and at the urging of professional associations, Senator Thomas recognized a need for including language that mandated care based on professional standards.[94] The application of professional standards was added to the House committee substitute[95] to provide guidance to health care professionals and insurers as to how the General Assembly intends that the services required under the Act be performed.[96]

The Act also prevents insurers from penalizing attending physicians or other health care professionals for complying with the law.[97] Specifically, insurers may not "deselect, terminate the services of, require additional utilization review, reduce capitation payment, or otherwise penalize" an attending physician, certified nurse midwife, or hospital that orders care consistent with the Act.[98] While the original version of SB 482 prevented insurers from imposing penalties on providers acting in compliance with the law, the House committee substitute added prohibitions against deselecting a provider and against requiring additional utilization review[99] in recognition that insurers also utilize these additional methods to penalize providers that do not follow insurer protocol.[100]

Under the Act, each insurer must notify its policyholders of the coverage provided by these new Code sections.[101] This must be in writing and positioned prominently in either the next mailing to the policyholder, yearly informational packets sent to all policyholders, or other literature mailed before January 1, 1997.[102]

Susan D. Hargus

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91. *Id.*
92. *Id.*
93. *Id.*
94. Thomas Interview, *supra* note 19.
95. SB 482 (HCS), 1996 Ga. Gen. Assem.
96. Thomas Interview, *supra* note 19.
97. O.C.G.A. § 33-24-60(g) (1996).
98. *Id.*
99. *Compare* SB 482, as introduced, 1996 Ga. Gen. Assem. *with* SB 482 (HCS), 1996 Ga. Gen. Assem.
100. Thomas Interview, *supra* note 19.
101. O.C.G.A. § 33-24-60(f) (1996).
102. *Id.*