Senate Bill 476

By: Senators Thompson of the 33rd, Stokes of the 43rd, Tanksley of the 32nd and Hecht of the 34th

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 define certain terms; to provide standards and procedures for verification of benefits and precertifications relating to managed health benefit plans; to provide for liability and personnel; to provide for applicability; to include among unfair insurance practices certain practices of insurers and managed care entities with regard to health benefit plans; to require that certain persons shall be notified of the cancellation, nonrenewal, or other termination of their insurance; 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 "Consumers´ Health Insurance Protection Act."

SECTION 2.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by inserting between paragraphs (12) and (13) of Code Section 33-6-5, relating to unfair insurance practices, the following:

"(12.1) No insurer or managed care entity subject to licensing by the Commissioner shall violate any provision of Chapter 20A of Title 33;".

SECTION 3.

Said title is further amended by striking in its entirety Code Section 33-20A-3, relating to definitions, and inserting in lieu thereof the following:

"33-20A-3.

As used in this article, the term:

(1) 'Commissioner' means the Commissioner of Insurance.

(2) '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.

~~(2.1)~~(3) 'Enrollee' means an individual who has elected to contract for or participate in a managed care plan for that individual or for that individual and that individual´s eligible dependents.

(4) 'Facility' means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, or similar institution for examination, diagnosis, treatment, surgery, or maternity care but does not include physicians´ or dentists´ private offices and treatment rooms in which such physicians or dentists primarily see, consult with, and treat patients.

(5) 'Health benefit plan' has the same meaning as provided in Code Section 33-24-59.5.

~~(3)~~(6) 'Health care provider' or 'provider' means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advance practice nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer qualified pursuant to paragraph (1) or (2) of subsection (a) of Code Section 43-5-8, occupational therapist, speech language pathologist, audiologist, dietitian, or physician´s assistant.

~~(4)~~(7) 'Limited utilization incentive plan' means any compensation arrangement between the plan and a health care provider or provider group that has the effect of reducing or limiting services to patients.

~~(5)~~(8) 'Managed care contractor' means a person who:

(A) Establishes, operates, or maintains a network of participating providers;

(B) Conducts or arranges for utilization review activities; and

(C) Contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

~~(6)~~(9) 'Managed care entity' includes an insurance company, hospital or medical service plan, hospital, health care provider network, physician hospital organization, health care provider, health maintenance organization, health care corporation, employer or employee organization, or managed care contractor that offers a managed care plan.

~~(7)~~(10) 'Managed care plan' means a major medical, hospitalization, or dental plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(A) Arrangements with selected providers to furnish health care services;

(B) Explicit standards for the selection of participating providers; and

(C) Cost savings for persons enrolled in the plan to use the participating providers and procedures provided for by the plan; provided, however, that the term 'managed care plan' does not apply to Chapter 9 of Title 34, relating to workers´ compensation.

~~(8)~~(11) 'Out of network' or 'point of service' refers to health care items or services provided to an enrollee by providers who do not belong to the provider network in the managed care plan.

~~(8.1)~~(12) 'Patient' means a person who seeks or receives health care services under a managed care plan.

(13) 'Precertification' or 'preauthorization' means a determination made by an insurer or agent thereof prior to or subsequent to an enrollee´s receiving health care services that such services are a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as prerequisites for payment for such services have been satisfied.

~~(9)~~(14) 'Qualified managed care plan' means a managed care plan that the Commissioner certifies as meeting the requirements of this article.

(15) 'Verification of benefits' means a determination by an insurer or agent thereof of whether given health care services are a covered benefit under the enrollee´s health benefit plan without a determination of precertification or preauthorization as to such services.″

SECTION 4.

Said title is further amended by inserting immediately following Code Section 33-20A-7, relating to penalties, a new Code section to read as follows:

″33-20A-7.1.

(a) The provisions of this chapter shall apply to any managed care plan offered pursuant to Article 1 of Chapter 18 of Title 45 and to any managed care plan offered by any managed care entity.

(b) When an enrollee, a provider, or a facility requests verification of benefits from a managed care plan, an employee or agent of such managed care plan shall advise the caller in a nonrecorded statement that:

(1) Such verification is only a determination of whether given health care services are a covered benefit under the health benefit plan and is not a guarantee of payment for those services; and

(2) If the health care services so verified are a covered benefit, whether precertification is required and the phone number to request precertification.

(c) When an enrollee, provider, or facility obtains precertification for any covered health care service, the managed care plan is liable for such services at the reimbursement level provided under the health benefit plan for such services where rendered within the time limits set by the plan unless the enrollee is no longer covered under the plan at the time the services are received by the enrollee or there exists substantiation of fraud by the enrollee.

(d) Any managed care plan which requires precertification shall have personnel available 24 hours a day, seven days a week, to provide such precertifications by telephone to advise of rejection of precertification and to explain the reasons for any such rejection. Such acceptance or rejection of precertification shall be provided by an employee or agent of the managed care plan and may not be a recorded or computer generated communication.

(e) No managed care plan may impose financial penalties against an enrollee for failure to obtain timely precertification.

(f) This Code section shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after July 1, 2002.″

SECTION 5.

Said title is further amended by striking Code Section 33-24-47.1, relating to notice prior to cancellation or nonrenewal of individual or group accident and sickness policy, and inserting in lieu thereof a new Code Section 33-24-47.1 to read as follows:

″33-24-47.1.

(a) This Code section shall apply only to policies, contracts, or certificates of insurance insuring against loss resulting from sickness or from bodily injury or death by accident, or both, or any contract to furnish ambulance service in the future governed by the provisions of Chapters 15, 18, 19, 20, 21, ~~and~~ 30, and 42 of this title.

(b) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the group policyholder. Such notice stating the time when nonrenewal will be effective, which shall not be less than 60 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered in person or by depositing the notice in the United States mails to be dispatched by at least first-class mail to the last address of record of the group policyholder and receiving the receipt provided

by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(c) Notice to the group policyholder shall not be required by this Code section ~~when a group or blanket accident and sickness policy is canceled by an insurer for nonpayment of any premium at the expiration of the 31 day grace period as required by Code Section 33-30-4 or~~ when the group policyholder has given any required written notice of termination to the insurer. Notice to the group members shall be required by this Code section when a group or blanket accident and sickness policy is canceled or not renewed by an insurer for nonpayment of any premium at the expiration of the 31 day grace period as required by Code Section 33-30-4. Such notice of cancellation shall be delivered to each group member affected either in person or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the group member and receiving the receipt provided by the United States Postal Service, or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(d) A notice of termination of a policy to which subsections (a) and (b) of this Code section ~~applies~~ apply shall be mailed or delivered to the group policyholder and to each employer group or subgroup insured under the policy not less than 60 days prior to the effective date of the termination of the policy. A notice of termination of a policy to which subsection (c) of this Code section applies shall be mailed or delivered to the group policyholder, each group member, and each employer group or subgroup insured at the beginning of the 31 day grace period required by Code Section 33-30-4. A notice of termination shall be mailed or delivered in the same manner provided in subsection (b) of this Code section for a notice of nonrenewal."

SECTION 6.

Said title is further amended by adding a new subsection (d) to Code Section 33-24-59.5, relating to timely payment of health benefits, to read as follows:

"(d) Once any claim submitted by an insured, or other person claiming payments under a plan, to an insurer has been paid or settled, the insurer shall be prohibited from contesting, requesting repayment, or reopening such claim or portion thereof more than one year after the date such claim was submitted or the service was rendered, whichever was earlier; provided, however, that this prohibition shall not apply to a claim submitted by the insurer in violation of Code Section 33-1-9."

SECTION 7.

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