Senate Bill 476

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

**AS PASSED SENATE**

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 require any managed care entity offering a plan to obtain a signed acknowledgment form from each enrollee acknowledging that the enrollee has been informed of specific elements of the plan; to specify that an enrollee shall acknowledge a list of the participating providers, the limitations on choices of providers, and any contracts between the plan and any provider or hospital; 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) 'Elective procedure' means any nonemergency care that can be scheduled at least 24 hours prior to the service without posing a significant threat to the patient's health or well-being.

(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.

~~(2.1)~~(4) '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.

(5) 'Facility' means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, 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.

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

~~(3)~~(7) '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)~~(8) '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)~~(9) '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)~~(10) '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)~~(11) '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)~~(12) '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)~~(13) 'Patient' means a person who seeks or receives health care services under a managed care plan.

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

(16) '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 adding a new subparagraph (C.1) to paragraph (1) of Code Section 33-20A-5, relating to standards for certification, to read as follows:

"(C.1) Any managed care plan licensed in this state shall obtain a signed acknowledgment form from each enrollee at the time of enrollment and at least

annually thereafter acknowledging that the enrollee has been informed of the following:

(i) The number, mix, and distribution of participating providers. An enrollee shall be entitled to a list of individual participating providers and the list shall be updated at least every 30 days and may be published on an Internet service site made available by the managed care entity at no cost to such enrollee;

(ii) The existence of limitations and disclosure of such limitations on choices of health care providers; and

(iii) A summary of any agreements or contracts between the managed care plan and any health care provider or hospital as they pertain to the provisions of Code Sections 33-20A-6 and 33-20A-7. Such summary shall not be required to include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by the managed care plan and any health care provider or hospital; provided, however, such summary may include a disclosure of the category or type of compensation, whether capitation, fee for service, per diem, discounted charge, global reimbursement payment, or otherwise, paid by the managed care plan to each class of health care provider or hospital under contract with the managed care plan."

**SECTION 5.**

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 calls during regular business hours to request verification of benefits from a managed care plan, the caller shall have the clear and immediate option to speak to an employee or agent of such managed care plan who shall advise the caller 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 such health 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, facility, or provider.

(d) Any managed care plan which requires precertification shall have sufficient personnel available 24 hours a day, seven days a week, to provide such precertifications by telephone for all procedures, other than elective procedures; to advise of acceptance or rejection of such request for precertification; and to explain the reasons for any such rejection. Such acceptance or rejection of precertification request 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 reduce the amount that would otherwise be paid under the health benefit plan for a covered service, had the service been properly precertified, to an enrollee, facility, provider, or home health care provider for failure to obtain timely precertification. For the purposes of this article, 'home health care provider' shall mean any provider or agency that provides medical services in a patient´s home or durable medical equipment for use in a patient´s home.

(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 6.**

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.

(d) 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, at the expiration of the 31 day grace period, by an insurer for nonpayment of any premium 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)~~(e) A notice of termination of a policy to which subsection (b) of this Code section applies 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 (d) of this Code section applies shall be mailed or delivered to the group policyholder, each group member, and each employer group or subgroup insured five days prior to the end 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 7.**

Said title is further amended by striking paragraph (2) of Code Section 33-20A-5, relating to standards for certification, and inserting in lieu thereof a new paragraph (2) to read as follows:

"(2) ACCESS TO SERVICES. A managed care entity must demonstrate that its plan:

(A) Makes benefits available and accessible to each enrollee electing the managed care plan in the defined service area with reasonable promptness and in a manner ~~which~~ that promotes continuity in the provision of health care services, including continuity in the provision of health care services after termination of a physician´s contract as provided in Code Section 33-20A-61;

(B) When medically necessary provides health care services 24 hours a day and seven days a week;

(C) Provides payment or reimbursement for emergency services and out-of-area services; and

(D) Complies with the provisions of Code Section 33-20A-9.1 relating to nomination and reimbursement of out of network health care providers and hospitals; and″.

**SECTION 8.**

Said title is further amended in Chapter 20A, relating to managed health care plans, by adding a new Article 3 to read as follows:

″ARTICLE 3

33-20A-60.

As used in this article, the term:

(1) 'Carrier' means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of health care services through a health benefit plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

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

(3) 'Enrollee' means any individual who is eligible to receive benefits under a health benefit plan.

(4) 'Health benefit plan' means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, any dental or vision care plan or policy, or any managed care plan.

(5) 'Physician contract' means any contract between a physician and a carrier or a carrier´s network, physician panel, intermediary, or representative providing the terms under which the physician agrees to provide health care services to an enrollee pursuant to a health benefit plan.

(6) 'Retroactive denial of a previously paid claim' or 'retroactive denial of payment' means any attempt by a carrier retroactively to collect payments already made to a claimant with respect to a claim, or any portion thereof, by requiring repayment of such payments, by reducing other payments currently owed to the claimant, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the claimant.

33-20A-61.

(a) Every physician contract entered into, amended, extended, or renewed after July 1, 2002, by a carrier shall contain a specific provision which shall provide that, in the event that an insurance carrier, plan, network, panel, or any agent thereof should terminate a physician´s contract and thereby affect any enrollee´s opportunity to continue receiving health care services from that physician under the plan, any such enrollee who is suffering from a chronic or terminal illness, who is beyond the first trimester of pregnancy, or who is an inpatient shall have the right to continue to receive health care services from that physician for a period of up to 60 days from the date of the termination of the physician´s contract, during which time period the physician shall continue providing such services in accordance with the terms of the contract and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician´s contract. The enrollee shall not have the right to the continuation provisions provided in this Code section if the physician´s contract is terminated for reasons related to the quality of health care services rendered or issues related to the health, safety, or welfare of enrollees.

(b) Every physician contract entered into, amended, extended, or renewed after July 1, 2002, by a carrier shall contain a specific provision which shall provide that, in the event that a physician should terminate his or her contract with an insurance carrier, plan, network, panel, or any agent thereof and thereby affect any enrollee´s opportunity to continue receiving health care services from that physician under the plan, any such enrollee who is suffering from a terminal illness, who is beyond the first trimester of pregnancy, or who is an inpatient shall have the right to receive health care services from that physician for a period of up to 60 days from the date of the termination of the physician´s contract, during which time period the physician shall continue providing such services in accordance with the terms of the contract and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician´s contract.

33-20A-62.

(a) No carrier, plan, network, panel, or any agent thereof may conduct an audit or impose a retroactive denial of payment on any claim by a claimant unless:

(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific reason for the audit or retroactive denial of payment;

(2) Not more than 12 months have elapsed since the last date of service or discharge covered by the claim prior to the delivery to the claimant of such written notice; and

(3) Any such audit or retroactive denial of payment must be completed within 18 months of the last date of service or discharge covered by such claim.

However, where the insured or other person claiming payments under a plan has obtained precertification pursuant to subsection (c) of Code Section 33-20A-7.1, the insurer shall be prohibited from contesting, requesting payment, or reopening such claim, or portion thereof, at any time following such precertification.

(b) No carrier, plan, network, panel, or any agent thereof shall have any obligation to respond to a health care provider´s request for additional payment or to adjust any previously paid health care provider´s claim or any part thereof unless:

(1) The health care provider has made a request in writing to the carrier, plan, network, panel, or any agent thereof specifically identifying the previously paid claim or any part thereof and has provided the specific reason for additional payment; and

(2) Not more than 12 months have elapsed since the date of the payment of the original claim, or 18 months since the date of service, prior to the delivery to the carrier, plan, network, panel, or any agent thereof of the written request for additional payment on a previously paid claim or any part thereof.″

**SECTION 9.**

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