House Bill 716 (COMMITTEE SUBSTITUTE)

By: Representatives Harbin of the 113th, Graves of the 125th, Watson of the 70th and Parrish of the 144th

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 20A of Title 33 of the Official Code of Georgia Annotated, relating to managed health care plans, so as to provide for the regulation of health insurance carriers who secure for their enrollees the professional services of physicians through physician contracts; to provide for continuation of the provision of health care services by physicians after termination of their contracts under certain circumstances; to provide procedures, limitations, and other provisions concerning the audit, retroactive denial, request for additional payment, and adjustment of previously paid claims by health care providers and insurers; 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 20A of Title 33 of the Official Code of Georgia Annotated, relating to managed health care plans, is 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 for 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 2.

Said chapter is further amended by adding a new Article 3 to read as follows;

″ARTICLE 3

33-20A-60.

As used in this article, the term:

(1) 'Carrier' shall mean 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' shall mean the Commissioner of Insurance.

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

(4) 'Health benefit plan' shall mean 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' shall mean 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' shall mean any attempt by a carrier retroactively to collect payments already made to a health care provider with respect to a claim, or any portion thereof, by requiring repayment of such payments, by reducing other payments currently owed to the health care provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the health care provider.

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 and receiving active treatment for a chronic or terminal illness, or who is an inpatient, at the time of the termination of the physician´s contract shall have the right to continue receiving health care services from that physician for a period of 60 days from the date of the termination of the physician´s contract. Any enrollee who is more than 12 weeks pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that enrollee´s physician´s contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six-weeks´ postdelivery care. During such continuation of coverage 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 and receiving active treatment for a chronic or terminal illness, or who is an inpatient, at the time of the termination of the physician´s contract shall have the right to continue receiving health care services from that physician for a period of 60 days from the date of the termination of the physician´s contract. Any enrollee who is more than 12 weeks pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that enrollee´s physician´s contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six-weeks´ postdelivery care. During such continuation of coverage 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 on any health care provider´s claim submitted within 90 days of the last date of service or discharge covered by such claim unless:

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

(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 health care provider of such written notice; and

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

(b) No carrier, plan, network, panel, or any agent thereof may conduct an audit or impose a retroactive denial on any health care provider´s claim submitted more than 90 days after the last date of service or discharge covered by such claim unless:

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

(2) Not more than 12 months have elapsed since such claim was initially submitted by the health care provider prior to the delivery to the health care provider of such written notice; and

(3) Any such audit or retroactive denial must be completed within 18 months following the health care provider´s initial submission of such a claim.

(c) 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 and any part thereof and has provided the specific reason for additional payment; and

(2) Not more than nine months have elapsed since the date of the payment of the original claim 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 3.

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