The Senate Insurance and Labor Committee offered the following substitute to HB 716:

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 certain health care providers and insurers; to provide for related matters; to provide an effective date; 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) 'Claimant' shall mean an enrollee, physician, or facility or any agent thereof requesting payment on behalf of an enrollee for covered services under a health benefit plan.

(3) 'Commissioner' shall mean the Commissioner of Insurance.

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

(5) 'Facility' shall mean 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' 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.

(7) '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.

(8) 'Post-payment audit' shall mean an investigation by a health benefit plan, carrier, or agent thereof regarding whether a claim was properly previously paid.

(9) 'Retroactive denial of payment' shall mean any attempt by a health benefit plan or carrier or any agent thereof 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 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 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 of postdelivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination 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 because of the suspension or revocation of the physician´s license or 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 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 of postdelivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination 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 terminates his or her contract because of the suspension or revocation of the physician´s license or for reasons related to the quality of health care services rendered or issues related to the health, safety, or welfare of enrollees.

33-20A-62.

(a) Except as provided in subsection (e) of this Code section, no carrier, plan, network, panel, or any agent thereof may conduct a post-payment audit or impose a retroactive denial on any claim relating to the provision of health care services that was 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 claimant written notice of the intent to conduct such an audit or impose such a retroactive denial of such claim or of any part thereof and has provided in such notice the specific claim and any part thereof and 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 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.

(b) Except as provided in subsection (e) of this section, no carrier, plan, network, panel, or any agent thereof may conduct a post-payment audit or impose a retroactive denial on any claim relating to the provision of health care services that was 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 claimant written 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 claim and any part thereof and 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 claimant 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 the lesser of 18 months of the claimant´s initial submission of such a claim or 24 months of the date of service.

(c) Except as provided in subsection (e) of this section, no carrier, plan, network, panel, or any agent thereof shall be required to respond to a claimant´s request for additional payment or to adjust any previously paid claim or any part thereof following a final payment unless:

(1) The claimant makes 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 provides the specific reason for additional payment; and

(2) If the claimant´s claim was submitted within 90 days of the last date of service or discharge covered by such claim, the written request for additional payment or adjustment must be submitted within 12 months of the date at which both the claimant and the carrier, plan, network, panel, or agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been exhausted or waived by the claimant.

(d) Except as provided in subsection (e) of this section, no carrier, plan, network, panel, or any agent thereof shall be required to respond to a claimant´s request for additional payment or to adjust any previously paid claim or any part thereof following a final payment unless:

(1) The claimant makes 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 provides the specific reason for additional payment; and

(2) If the claimant´s claim was submitted more than 90 days after the last date of service or discharge covered by such claim, the written request for additional payment or adjustment must be submitted within 6 months of the date at which both the claimant and the carrier, plan, network, panel, or agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been exhausted or waived by the claimant.

(e) This Code section shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or any agent thereof conducting a post-payment audit or imposing a retroactive denial on any health care claim that was

initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or any part thereof, including the specific reason for the audit or retroactive denial, and shall complete any such audit or retroactive denial prior to January 1, 2004.

(f) Nothing in this Code section shall prevent a carrier, plan, network, panel, or any agent thereof from conducting a post-payment audit, imposing a retroactive denial, or adjusting a previously paid claim in the event a claimant has submitted a fraudulent claim."

SECTION 3.

This Act shall become effective on July 1, 2002.

SECTION 4.

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