Senate Bill 299

By: Senator Price of the 56th

A BILL TO BE ENTITLED

AN ACT

To amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, the "Georgia Medical Assistance Act of 1977," so as to provide for a pilot program of medical assistance accounts for recipients of medical assistance; to provide for a short title; to provide for legislative purpose; to provide for definitions; to provide for program eligibility; to provide for program administration and contracts; to provide for charges; to provide for benefits and explanations relating thereto; to provide for terms, conditions, and procedures regarding medical assistance accounts; to provide for fund payments, refunds, and vouchers; to provide for investments; to provide for reimbursements; to require preventive care; to provide for automatic repeal; to provide for reports and subcommittee recommendations; to provide for effective dates; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, the "Georgia Medical Assistance Act of 1977," is amended by adding after Code Section 49-4-152.4 a new Code section to read as follows:

"49-4-152.5.

(a) This Code section shall be known and may be cited as 'Market Based Medicaid Reform Act.'

(b) The purpose of this Code section is to:

(1) Provide a more cost effective means of providing health care coverage for certain Medicaid eligible individuals;

(2) Create patient awareness of the high cost of medical care;

(3) Reduce inappropriate use of health care services;

(4) Enable clients to take responsibility for healthy outcomes and lifestyles;

(5) Provide incentives to patients to seek preventive and primary care services; and

(6) Provide Medicaid recipients vouchers to purchase health care coverage, education, job training, or child care.

The department shall request a waiver for the establishment of the program if necessary to obtain federal funds therefor. The program shall be a pilot project which includes no more than 250,000 participants.

(c) As used in this Code section, the term:

(1) 'Health insurance policy' means any health insurance policy or contract issued by an insurer that is authorized to do business in this state.

(2) 'High deductible insurance' means an insurance policy with a deductible of not less than $1,000.00 for the individual and not less than $2,500.00 for the family, in any calendar year.

(3) 'Insurer' means any entity which provides health insurance in this state.

(4) 'Medical assistance account' means an account, electronic vouchers, or other account established for the participant to be administered by the department in his or her name to pay the eligible medical expenses of the account holder and his or her dependents.

(5) 'Participant' means an eligible recipient of medical assistance who participates in the program.

(6) 'Program' means the medical assistance account pilot program established by this Code section.

(d) Persons who would be eligible to be recipients of medical assistance and who are not aged, blind, or disabled may be eligible for coverage under the program. The department shall establish procedures for determining which recipients may become participants.

(e) The department shall provide health care coverage for participants in the program by entering into contracts or agreements with at least two insurers offering individual or group policies of health insurance with a high deductible. The department on behalf of the participant shall pay the policy premium. The department may enter into such contracts or agreements only after taking competitive bids as provided in Code Section 50-5-67.

(f) The contracts or agreements entered into pursuant to subsection (e) of this Code section shall provide that:

(1) The department shall pay any deductibles charged pursuant to the policy, if available from the medical assistance account, directly to the health care provider for participants in the program;

(2) The total of deductibles charged for a calendar year shall be not less than:

(A) One thousand dollars for a participant in an individual medical assistance account as established in subsection (i) of this Code section; or

(B) Twenty-five hundred dollars for a participant in a family medical assistance account as established in subsection (i) of this Code section.

(3) The participant shall be responsible for the payment of copayments after such participant has exceeded his or her medical assistance account, which copayment shall be determined by the department and shall be paid by the participant at the point of service in amounts not less than the following:

(A) One dollar per prescription for outpatient prescription drugs;

(B) Three dollars per office visit for physician services; and

(C) Ten dollars for nonemergency services, as defined by the department, delivered in a hospital emergency room or for nonemergency health transportation services;

(4) Coverage shall be provided for services as provided in subsection (g) of this Code section; and

(5) Health care providers shall charge program participants the same fee for services regardless of whether the service is reimbursed by the participant´s medical assistance account or directly by the department.

(g) The health insurance or health care policies and contracts for which recipients are eligible shall be provided in accordance with the following conditions:

(1) The policies or contracts shall not be subject to any previous state mandatory benefits; and

(2) Each policy or contract may include the following as determined by the department:

(A) Basic provisions for some mental health coverage;

(B) Prescription drugs;

(C) Prenatal care coverage;

(D) Inpatient and outpatient hospital services;

(E) Rural and urban health clinic services;

(F) Laboratory and X-ray services;

(G) Nurse practitioners´ services;

(H) Nursing facility services for individuals 21 years of age and older;

(I) Home care services and equipment;

(J) Early and periodic screening, diagnosis, and treatment for individuals under 21 years of age;

(K) Family planning services and supplies;

(L) Physicians´ services;

(M) Nurse-midwife services; and

(N) Inpatient psychiatric services for children under 18 years of age.

(h) The department shall provide each new enrollee in the program with an educational brochure explaining the options provided and the differences in these options.

(i)(1) The department shall establish medical assistance accounts as follows:

(A) An individual medical assistance account shall be established for any individual participant who does not qualify for a family medical assistance account under paragraph (2) of this subsection; and

(B) A family medical assistance account shall be established for any group of two or more participants who are related to each other by blood or marriage. One adult participant in a family medical assistance account or a parent or guardian of a participant shall be designated as responsible for the account;

(2) On January 1 of each calendar year, or on the day the recipient of medical assistance is enrolled, the department shall:

(A) Deposit in an individual medical assistance account the lesser of:

(i) The deductible established under paragraph (2) of subsection (f) of this Code section; or

(ii) The average amount spent on a Medicaid beneficiary who is not a participant, minus the policy premium for the contract under subsection (e) of this Code section; and

(B) Deposit in a family individual medical assistance account the lesser of:

(i) The deductible established under paragraph (2) of subsection (f) of this Code section; or

(ii) The average amount spent on a family of Medicaid beneficiaries who are not participants, minus the policy premium for the contract under subsection (e) of this Code section;

(3) The department may expend moneys deposited in medical assistance accounts pursuant to paragraph (2) of this subsection to pay deductible payments required under the applicable policy or plan;

(4) The moneys deposited in the medical assistance account will be prorated on a daily basis after January 1 of each calendar year;

(5) The department shall terminate an account whenever a person dies or no longer qualifies as a participant under subsection (d) of this Code section. Any sums remaining in the account shall be paid as follows:

(A) If a person dies, the remaining funds shall go into the general fund to be credited to the department;

(B) If a person no longer qualifies as a participant under subsection (d) of this Code section, the remaining amount, prorated on a daily basis, shall be divided between the account holder and the department. Not less than 25 percent nor more than 50 percent of the remaining balance will go to the account holder as a voucher for health care coverage, education, or job training, and the balance of any sums remaining in the account will go to the general fund to be credited to the department;

(C) Already existing funds within a person´s medical assistance account shall not be a factor in determining income, assets, or resources for purposes of eligibility for a public benefits program in this state; and

(D) Those who drop out of the medical assistance account program and receive a refund are not eligible for the medical assistance account option for one full calendar year;

(6) The department may consolidate all sums in all medical assistance accounts established under this Code section into one account for investment purposes. Interest from investments of sums in the accounts shall be paid into the general fund to be credited to the department;

(7) Health care providers shall submit claims for reimbursement to the department and the department shall debit the sum from the account holder´s medical assistance account and send reimbursement to the health care provider;

(8) On December 31 of the year in which sums are deposited into a medical assistance account, if any sums remain in the account, and if the person has met that person´s preventive health care requirements as stipulated in paragraph (10) of this subsection, a participant or person designated as responsible for an individual or family medical assistance account may choose one of the following options:

(A) Elect to receive any excess sums in the medical assistance account in the form of a voucher, not to exceed more than 50 percent of the remaining balance, depending on the amount the department deposits in the medical assistance accounts, with the balance of any sums remaining in the account paid into the general fund and credited to the department. A voucher provided pursuant to this paragraph may be used only for the following purposes:

(i) Education for one or more participants in an account;

(ii) Job training services for one or more participants included in an account;

(iii) Child care services for one or more participants included in an account in order for them to obtain additional education or training or in order for them to be employed; or

(iv) Other expenses as the department may allow;

(B) Elect to leave any excess sums in the medical assistance account to carry over for the next year, not to exceed more than 50 percent of the remaining balance, depending on the amount the department deposits in the medical assistance accounts, with the balance of any sums remaining in the account paid into the general fund and credited to the department; and

(C) Elect to receive any excess sums in the medical assistance account as a cash bonus in an amount equal to not less than 10 percent nor more than 20 percent of the excess funds, depending on the amount the department deposits in the medical assistance accounts, with the balance of any sums remaining in the account paid into the general fund and credited to the department;

(9) If a voucher is not used within eight months of being provided to a participant, the voucher shall expire and shall revert to the department to be credited to the department. Any attempted misuse of a voucher by a participant shall result in immediate loss of health benefits under the program for a period of not less than one year nor more than three years; and

(10) To qualify for reimbursement in the form of a voucher, cash bonus, or roll over at the end of the year, the account holder must demonstrate with a physician´s notice or a physician´s bill, or the department may verify such matters through the account holder´s computer record, that the account holder received his or her annual primary care check-up during the previous 12 months in which the participant was eligible for the program, and that he or she obtained prenatal care, immunizations, or preventive care for eligible children in accordance with schedules developed by the department. The account holder shall not be eligible for a voucher, cash bonus, or roll over at the end of the year if such person fails to obtain this care.

(j) This Code section is automatically repealed July 1, 2007.

(k) The department shall report by December 31 of each year on the effectiveness of the program. The report shall be provided to the chairperson of the Senate Committee on Health and Human Services and the House Committee on Children and Youth. Each chairperson shall establish a subcommittee of such committee to evaluate the program and make recommendations regarding changes, termination, or extension of the program.″

SECTION 2.

The Department of Medical Assistance shall determine by May 1, 2002, whether the provisions of this Act require a federal waiver and so notify the committee chairpersons specified in subsection (k) of Code Section 49-4-152.5. If the department determines a waiver is required, it shall request such waiver from the appropriate federal agencies, and Section 1 of this Act shall become effective the ninety-first day following receipt of such waivers. If the department determines a waiver is not required, Section 1 of this Act shall become effective September 1, 2002. The remaining provisions of this Act shall become effective upon the approval of this Act by the Governor or upon its becoming law without such approval.

SECTION 3.

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