The Senate Insurance and Labor Committee offered the following substitute to HB 169:

A BILL TO BE ENTITLED
AN ACT

To provide for a short title and legislative findings; 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 expressly provide that the amount of a penalty for violation of provisions relating to the timely payment of health benefits shall not apply toward any cap on benefits payable; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

This Act shall be known as and may be cited as the "Consumers´ Health Insurance Protection Act."

SECTION 2.

The General Assembly finds that the enactment of the "Consumers´ Health Insurance Protection Act" is needed to:

(1) Ensure that consumers receive benefits under health benefit plans fairly and equitably and in a manner based on reasonable expectations between consumers and their health benefit plans and health care providers;

(2) Maximize accountability and the consumer´s ability to comply with health benefit plan requirements; and

(3) Reduce unanticipated financial burdens upon consumers under such health benefit plans.

SECTION 3.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is 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' means a determination made by an insurer or agent thereof prior to an enrollee´s receiving health care services that such services are a medical necessity, as defined in Code Section 33-20A-31.

~~(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 as to whether the services are a medical necessity for an enrollee under the plan.″

SECTION 4.

Said title is further amended by inserting immediately following Code Section 33-20A-7 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, 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 unless the enrollee is no longer covered under the plan at the time the services are received 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.

(e) 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, 2001."

SECTION 5.

Said title is further 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 6.

Said title is further amended by striking subsection (c) of Code Section 33-24-59.5, relating to timely payment of health benefits, notification of failure to pay, and penalty for violation, and inserting in lieu thereof the following:

"(c) Each insurer shall pay to the insured or other person claiming payments under the health benefit plan interest equal to 18 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section. No amount of any such interest penalty shall be applied toward any cap on benefits payable to the insured or other person claiming payments under the health benefit plan."

SECTION 7.

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