The House Committee on Insurance offers the following substitute to HB 290:

A BILL TO BE ENTITLED
AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide an exception to the requirement that major medical insurance policies or plans provide for carry-over deductibles; to remove the requirement that managed care plans obtain certain acknowledgments; to enact the "Georgia Telemedicine Act"; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by striking paragraph (14) of Code Section 33-6-5, relating to other unfair methods of competition and unfair and deceptive acts or practices, and inserting in lieu thereof a new paragraph (14) to read as follows:

"(14) On and after July 1, 1992, no insurer, as defined in paragraph (4) of Code Section 33-1-2, shall issue, cause to be issued, renew, or provide coverage under any major medical insurance policy or plan containing a calendar year deductible or similar plan benefit period deductible which does not provide for a carry-over of the application of such deductible as provided in this paragraph. If all or any portion of an insured´s or member´s cash deductible for a calendar year or similar plan benefit period is applied against covered expenses incurred by the insured or member during the last three months of the deductible accumulation period, the insured´s or member´s cash deductible for the next ensuing calendar year or similar benefit plan period shall be reduced by the amount so applied. The provisions of this paragraph shall apply to major medical insurance policies or plans which have a benefit plan period of less than 24 months, except policies or plans designed and issued to be compatible with a health savings account as set out in 26 U.S.C. Section 223 or a spending account as defined in Chapter 30B of this title."

SECTION 2.

Said title is further amended by striking paragraph (1) of Code Section 33-20A-5, relating to standards for certification, and inserting in lieu thereof a new paragraph (1) to read as follows:

"(1) DISCLOSURE TO ENROLLEES AND PROSPECTIVE ENROLLEES.

(A) A managed care entity shall disclose to enrollees and prospective enrollees who inquire as individuals into a plan or plans offered by the managed care entity the information required by this paragraph. In the case of an employer negotiating for a health care plan or plans on behalf of his or her employees, sufficient copies of disclosure information shall be made available to employees upon request. Disclosure of information under this paragraph shall be readable, understandable, and on a standardized form containing information regarding all of the following for each plan it offers:

(i) The health care services or other benefits under the plan offered as well as limitations on services, kinds of services, benefits, or kinds of benefits to be provided, which disclosure may also be published on an Internet service site made available by the managed care entity at no cost to such enrollees;

(ii) Rules regarding copayments, prior authorization, or review requirements including, but not limited to, preauthorization review, concurrent review, postservice review, or postpayment review that could result in the patient´s being denied coverage or provision of a particular service;

(iii) Potential liability for cost sharing for ~~out of network~~ out-of-network services, including, but not limited to, providers, drugs, and devices or surgical procedures that are not on a list or a formulary;

(iv) The financial obligations of the enrollee, including premiums, deductibles, copayments, and maximum limits on out-of-pocket expenses for items and services (both in and out of network);

(v) The number, mix, and distribution of participating providers. An enrollee or a prospective enrollee shall be entitled to a list of individual participating providers upon request, and the list of individual participating providers shall also 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 enrollees;

(vi) Enrollee rights and responsibilities, including an explanation of the grievance process provided under this article;

(vii) An explanation of what constitutes an emergency situation and what constitutes emergency services;

(viii) The existence of any limited utilization incentive plans;

(ix) The existence of restrictive formularies or prior approval requirements for prescription drugs. An enrollee or a prospective enrollee shall be entitled, upon request, to a description of specific drug and therapeutic class restrictions;

(x) The existence of limitations on choices of health care providers;

(xi) A statement as to where and in what manner additional information is available;

(xii) A statement that a summary of the number, nature, and outcome results of grievances filed in the previous three years shall be available for inspection. Copies of such summary shall be made available at reasonable costs; and

(xiii) 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, that 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.

(B) Such information shall be disclosed to each enrollee under this article at the time of enrollment and at least annually thereafter.

(C) Any managed care plan licensed under Chapter 21 of this title is deemed to have met the certification requirements of this paragraph.

~~(C.1) Any managed care plan licensed in this state shall obtain a signed acknowledgment from each enrollee at the time of enrollment and upon any subsequent product change elected by an enrollee 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.~~

(D) A managed care entity which negotiates with a primary care physician to become a health care provider under a managed care plan shall furnish that physician, beginning on and after January 1, 2001, with a schedule showing fees payable for common office based services provided by such physicians under the plan;″

SECTION 3.

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