House Bill 799

By: Representatives Cooper of the 43rd, Smith of the 134th, Blackmon of the 146th, Hatchett of the 150th, Gardner of the 57th, and others

A BILL TO BE ENTITLED

AN ACT

To amend Article 1 of Chapter 20A of Title 33 of the Official Code of Georgia Annotated, relating to patient protection under managed health care plans, so as to provide certain requirements for out of network hospitals prior to providing post-stabilization care; to provide for definitions; to provide for contact with the patient's health benefit plan or the plan's contracted health care provider; to provide for transfer to an in network hospital; to provide for cost coverage associated with care and transfer; to provide for certain notice; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Article 1 of Chapter 20A of Title 33 of the Official Code of Georgia Annotated, relating to patient protection under managed health care plans, is amended by revising Code Section 33-20A-3, relating to definitions, as follows:

"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.

(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, 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.

(5) 'Health benefit plan' has the same meaning as provided in Code Section 33-24-59.5.

(6) 'Health care provider' or 'provider' means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced practice registered nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist, ~~speech language~~ speech-language pathologist, audiologist, dietitian, or physician assistant.

(7) 'Home health care provider' means any provider or agency that provides health care services in a patient's home, including the supply of durable medical equipment for use in a patient's home.

(7.1) 'Hospital' means a facility licensed as such under Chapter 7 of Title 31.

(8) '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.

(9) '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.

(10) '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.

(11) '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.

(12) 'Nonurgent procedure' means any nonemergency or elective care that can be scheduled at least 24 hours prior to the service without posing a significant threat to the patient's health or well-being.

(13) '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.

(14) 'Patient' means a person who seeks or receives health care services under a managed care plan.

(14.1) 'Post-stabilization care' means medically necessary care provided after an emergency medical condition has been stabilized as determined in the reasonable professional opinion of the health care provider.

(15) 'Precertification' or 'preauthorization' means any written or oral determination made at any time by an insurer or any agent thereof that an enrollee's receipt of health care services is a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as prerequisites for payment for such services have been satisfied. ~~'Agent'~~ The term 'agent' as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.

(16) 'Qualified managed care plan' means a managed care plan that the Commissioner certifies as meeting the requirements of this article.

(17) 'Verification of benefits' means any written or oral 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 of precertification or preauthorization as to such services. ~~'Agent'~~ The term 'agent' as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.″

SECTION 2.

Said article is further amended by revising Code Section 33-20A-9, relating to emergency services requirements and restrictive formulary requirements, as follows:

″33-20A-9.

(a) Every managed care plan shall include provisions that:

(1)(A) In the event that a patient seeks emergency services and if necessary in the opinion of the emergency health care provider responsible for the patient's emergency care and treatment and warranted by his or her evaluation, such emergency provider may initiate necessary intervention to stabilize the condition of the patient without seeking or receiving prospective authorization by the managed care entity or managed care plan. No managed care entity or private health benefit plan may subsequently deny payment for an evaluation, diagnostic testing, or treatment provided as part of

such intervention for an emergency condition. For purposes of this Code section, the term 'emergency health care provider' includes without limitation an emergency services provider and a licensed ambulance service providing 911 emergency medical transportation.

(B) No managed care entity or private health benefit plan which has given prospective authorization after the stabilization of a person's condition for an evaluation, diagnostic testing, or treatment may subsequently deny payment for the provision of such evaluation, diagnostic testing, or treatment. An acknowledgment of an enrollee's eligibility for benefits by the managed care entity or private health benefit plan shall not, by itself, be construed as a prospective authorization for the purposes of this Code section.

(C) If in the opinion of the emergency health care provider, a patient's condition has stabilized and the emergency health care provider certifies that the patient can be transported to another facility without suffering detrimental consequences or aggravating the patient's condition, the patient may be relocated to another facility which will provide continued care and treatment as necessary; and

(2) When a managed care plan uses a restrictive formulary for prescription drugs, such use shall include a written procedure whereby patients can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:

(A) The formulary's equivalent has been ineffective in the treatment of the patient's disease or condition; or

(B) The formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the patient.

(b)(1) An out of network hospital shall not bill a patient who is an enrollee of a health benefit plan for post-stabilization care, except for applicable copayments, coinsurance, and deductibles.

(2) If a patient being administered emergency services is covered by a health benefit plan that requires prior authorization for post-stabilization care, an out of network hospital shall, prior to providing post-stabilization care, do all of the following once the condition causing the administration of the emergency services has been stabilized:

(A) Attempt to obtain the name and contact information of the patient's health benefit plan;

(B) Document in the patient's medical record its attempt to obtain the name and contact information of the patient's health benefit plan; and

(C) Contact the patient's health benefit plan or such plan's contracted health care provider for authorization to provide post-stabilization care. The out of network hospital shall make the contact pursuant to this subparagraph by either following the

instructions on the membership card of the patient's health benefit plan or using the contact information provided by the plan. An out of network hospital representative shall contact by telephone and communicate to the health benefit plan or its contracted health care provider, provided that the health benefit plan or its contracted health care provider is able to reach a representative of the out of network hospital upon returning the call. A health benefit plan shall not be responsible for any post-stabilization costs incurred by one of its members in an out of network hospital if such out of network hospital fails to meet the requirements of this paragraph.

(3) Upon the request of a health benefit plan or such plan's contracted health care provider of a patient receiving emergency services at an out of network hospital, such out of network hospital shall provide the following to the patient's health benefit plan:

(A) The treating physician's or surgeon's diagnosis of the patient's condition; and

(B) Any other relevant information reasonably necessary for the health benefit plan or such plan's contracted health care provider to make a decision to authorize post-stabilization care or to assume management of the patient's care by prompt transfer to an in network hospital.

(4) An out of network hospital that is not able to obtain the name and contact information of the patient's health benefit plan pursuant to paragraph (2) of this subsection shall not be subject to this subsection's requirements.

(5)(A) A health benefit plan or its contracted health care provider that is contacted by an out of network hospital pursuant to paragraph (3) of this subsection shall, within six hours after the out of network hospital makes the initial contact, do one of the following:

(i) Authorize post-stabilization care; or

(ii) Inform the out of network hospital that it will arrange for the prompt transfer of the patient to an in network hospital.

(B) If the health benefit plan or its contracted health care provider does not notify the out of network hospital of its decision pursuant to subparagraph (A) of this paragraph within six hours of such decision or if the health benefit plan fails to transfer the patient within 12 hours after notifying the out of network hospital that it would arrange for such transfer, the post-stabilization care shall be deemed authorized to the extent that it is medically necessary, and the health benefit plan or its contracted health care provider shall pay for the post-stabilization care.

(6) If the health benefit plan or its contracted health care provider decides to assume management of the patient's care by prompt transfer to an in network hospital, the health benefit plan or its contracted health care provider shall do the following:

(A) Arrange for and pay for the transfer of the patient;

(B) Pay for all the immediately required, medically necessary care rendered to the patient prior to the transfer in order to maintain the patient's clinical stability; and

(C) Be responsible for making all arrangements for the patient's transfer, including, but not limited to, finding an in network hospital available for the transfer of the patient.

(7) If the patient or the patient's spouse or legal guardian does not consent to the patient's transfer pursuant to paragraph (6) of this subsection, the out of network hospital shall promptly provide a verbal notice to the patient or the patient's spouse or legal guardian, indicating that the patient may be financially responsible for any further post-stabilization care provided by the out of network hospital.″

SECTION 3.

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