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INSURANCE Insurance Generally: Prohibit Discriminatory Practices; Require Notification of Cancellation, Nonrenewal, or other Termination of Insurance to Certain Persons; Provide Standards and Procedures for Verification of Benefits and Precertifications Relating to Managed Health Benefit Plans; Provide for Liability and Personnel; Include Certain Practices Among Unfair Insurance Practices; Provide for Remedies for Violations

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INSURANCE

Insurance Generally: Prohibit Discriminatory Practices; Require Notification of Cancellation, Nonrenewal, or other Termination of Insurance to Certain Persons; Provide Standards and Procedures for Verification of Benefits and Precertifications Relating to Managed Health Benefit Plans; Provide for Liability and Personnel; Include Certain Practices Among Unfair Insurance Practices; Provide for Remedies for Violations

CODE SECTIONS:	O.C.G.A. §§ 33-6-4, -5, 33-20A-3, -5, (amended), -7.1, -60, -61, -62, (new), 33-24-21.1, -47.1 (amended)
BILL NUMBER:	SB 476
ACT NUMBER:	486
GEORGIA LAWS:	2002 Ga. Laws 441
SUMMARY:	The Act, titled the "Consumers Health Insurance Protection Act," provides that insurers must follow certain procedures when precertifying or verifying enrollee benefits. The Act requires insurers to provide continuity of care to certain individuals in the event they, or a physician, cancels a physician's contract. The Act also makes discrimination based on color, race, religion, and ethnic or national origin in the insurance industry generally an unfair practice. The Act requires insurers to notify enrollees of plan termination, cancellation, or nonrenewal, and of any resulting conversion or continuation rights.
EFFECTIVE DATE:	July 1, 2002. The Act applies to all health benefit plan contracts issued, delivered, issued for delivery, or renewed on or after October 1, 2002.

History

"Possibly the single most important thing a patient needs to know is how and when to communicate with their insurance company."[1] With this statement, Governor Roy Barnes announced his support of SB 476 because, according to the Governor, it would make the confusing precertification and verification of benefits process clear for consumers.[2] Since 1999, the Governor's Office of the Consumers' Insurance Advocate, established to act as an independent watchdog agency to protect insurance consumers, tracked calls from consumers regarding their confusion about the distinction between precertification and verification of benefits and what process they needed to go through to obtain either from their insurers.[3] Cathey Steinberg, the Consumers' Insurance Advocate, collaborated with Senator Greg Hecht during the Georgia General Assembly 2001 Session to introduce the precursor to SB 476.[4] However, after passing the Senate, that bill never left the House Insurance Committee.[5] Therefore, the Consumers' Insurance Advocate spearheaded the effort to include SB 476 in the Governor's legislative package.[6] The Consumers' Insurance Advocate and representatives from the Governor's office met with key individuals in the insurance and health fields, including members of the Medical Association of Georgia, the Georgia Hospital Association, and the Georgia Association of Health Plans, to negotiate the provisions of an insurance bill.[7] They were eventually able to find language suitable to all parties involved.[8]

Opposition to SB 476

Several House members opposed SB 476 because they believe it only imposed additional burdensome mandates on the insurance and

1. Remarks Prepared for Delivery by Gov. Roy Barnes, Insurance Reform Press Conference, Feb. 19, 2002.
2. *Id.*
3. Interview with Cathey W. Steinberg, Consumers' Insurance Advocate, Governor's Office of the Consumers' Insurance Advocate (May 28, 2002) [hereinafter Steinberg Interview].
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*

health industries.[9] When the House Insurance Committee favorably reported SB 476 on the last day of the session, Representative Henrietta Turnquest of the 73d District introduced the bill on the House floor and explained that the Governor's Office of the Insurance Consumers' Advocate had worked closely with consumers and insurance providers throughout the session to build a consensus on the bill.[10] In opposition, Representative Jeff Brown of the 130th District suggested that as an alternative to SB 476, the Governor should convene a consensus coalition of all interested parties to discuss the issues SB 476 addressed.[11]

Introduction

Senators Steve Thompson, Connie Stokes, Charlie Tanksley, and Greg Hecht, of the 33rd, 43rd, 32nd, and 34th Districts, respectively, sponsored SB 476.[12] Senator Thompson introduced the bill on the Senate floor on February 20, 2002.[13] The Senate assigned the bill to its Insurance and Labor Committee, which favorably reported the bill as substituted on March 1, 2002.[14] The Senate adopted the Committee substitute and a floor amendment and passed the bill on March 8, 2002 by a vote of 53 to 1.[15]

The House assigned SB 476 to its Committee on Insurance, which created its own substitute and favorably reported the bill on April 9, 2002.[16] The House adopted the Committee substitute and passed the bill on April 10, 2002 by a vote of 107 to 34.[17] The bill returned to the Senate on April 12, 2002, and the Senate agreed to the House substitute on the same day.[18] The Senate then forwarded the bill to

9. Steinberg Interview, *supra* note 3.

10. Audio Recording of House Proceedings, Apr. 10, 2002 (remarks by Rep. Henrietta Turnquest), *at* http://state.ga.us/services/leg/audio/2002archive.html [hereinafter House Audio].

11. House Audio *supra* note 10 (remarks by Rep. Brown).

12. SB 476, as introduced, 2002 Ga. Gen. Assem.

13. State of Georgia Final Composite Status Sheet, SB 476, Apr. 12, 2002.

14. *Id.*

15. Georgia Senate Voting Record, SB 476 (Mar. 8, 2002); State of Georgia Final Composite Status Sheet, SB 476, Apr. 12, 2002.

16. State of Georgia Final Composite Status Sheet, SB 476, Apr. 12, 2002

17. Georgia House of Representatives Voting Record, SB 476 (Apr. 10, 2002); State of Georgia Final Composite Status Sheet, SB 476, Apr. 12, 2002.

18. Georgia Senate Voting Record, SB 476 (Apr. 12, 2002); State of Georgia Final Composite Status Sheet, SB 476, Apr. 12, 2002.

Governor Roy Barnes, who signed SB 476 into law on April 19, 2002.[19]

Consideration by the Senate Insurance and Labor Committee

After introduction, the Senate assigned the bill to its Insurance and Labor Committee, which favorably reported the bill, as substituted, on March 1, 2002.[20] As introduced, the bill amended Code section 33-6-5 by adding a new subsection providing that no insurer or managed care entity licensed by the Insurance Commissioner shall violate any provision of Chapter 20A of Title 33.[21] Additionally, as introduced, the bill struck Code section 33-20A-3 in its entirety and inserted a new section 33-20A-3 providing updated definitions for "facility," "health benefit plan," "precertification or preauthorization," and "verification of benefits."[22] The change to the "facility" definition was to eliminate confusion in the chapter between facilities and home health care services for clean-up purposes.[23] The "precertification or preauthorization" and "verification of benefits" definitions were added to provide a clear distinction for insurance consumers and others so they may easily differentiate the two terms by statute.[24]

The Committee substitute added a definition for "elective procedure" in response to the insurance industry's concern that individuals would attempt to use the 24-hour calling system for verification of benefits as opposed to precertification or preauthorization.[25] Accordingly, it was necessary to make an elective/non-elective distinction which would allow insurers to request individuals calling for verification of benefits to call back during regular business hours as further provided by an amendment to Code section 33-20A-7.1.[26]

19. 2002 Ga. Laws 441, § 11, at 453.

20. State of Georgia Final Composite Status Sheet, SB 476, Apr. 12, 2002.

21. SB 476, as introduced, 2002 Ga. Gen. Assem.

22. *Id.*

23. Interview with Jean O'Connor, Health Policy Analyst, JD, MPH, Governor's Office of the Consumers' Insurance Advocate (May 28, 2002) [hereinafter O'Connor Interview].

24. *Id.*

25. *Compare* SB 476, as introduced, 2002 Ga. Gen. Assem., *with* SB 476 (SCS), 2002 Ga. Gen. Assem.

26. O'Connor Interview, *supra* note 23.

As introduced, the bill also amended Code section 33-20A-7 by adding a new Code section 33-20A-7.1, which provided that a managed care plan must inform any enrollee, provider, or facility calling to request information regarding verification of benefits that such verification is not a guarantee of payment for those services.[27] Furthermore, if such services are covered benefits, then the bill required the managed care entity to inform the caller whether precertification was also required.[28] Additionally, the bill imposed liability at the reimbursement level, as provided by the health benefit plan or managed care plan, for any precertified services, albeit with some exceptions.[29] The bill also required that any managed care plan requiring precertification of services must have personnel available to provide precertification 24 hours a day, seven days a week.[30] Also, the bill prohibited managed care plans from imposing financial penalties against an enrollee for failure to obtain timely precertification.[31]

The Committee substitute added language clarifying that such requirements are imposed on the managed care plan for calls placed during regular business hours and that any caller must be given the immediate option of speaking to an employee or agent of the managed care plan.[32] Additionally, the Committee substitute provided that a managed care plan shall not be liable for services otherwise precertified if, at the time they were provided, evidence existed of fraud by the enrollee, facility, or provider of such services.[33]

The Committee substitute also amended Code Section 33-20A-5 by requiring a managed care entity to provide continuity in access to services to the insured in the event a physician's contract is terminated.[34] The amendment required a managed care entity to demonstrate that they allow such continuity in services for the statutorily designated time period in order to be licensed.[35]

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27. SB 476, as introduced, 2002 Ga. Gen. Assem.
28. *Id.*
29. *Id.*
30. *Id.*
31. *Id.*
32. *Compare* SB 476, as introduced, 2002 Ga. Gen. Assem., *with* SB 476 (SCS), 2002 Ga. Gen. Assem.
33. *Id.*
34. *Id.*
35. O'Connor Interview, *supra* note 23.

The Committee substitute also amended Article 3 of Chapter 20A, the "Patient Protection Act," by requiring, in a new section 33-20A-61, that insurance carriers provide continuity in services for 60 days for certain individuals should the insurance carrier terminate a physician's contract, or should a physician terminate his or her own contract.[36] The Committee substitute added a new Code section 33-20A-62 which placed some limitations on an insurance carrier's ability to conduct audits and impose retroactive denial of payment on submitted claims.[37] Such limitations were added in an effort to impose finality and efficiency into the claims process.[38] The Committee substitute also required that the carrier provide a claimant with written notice of its intent to conduct an audit or to impose a retroactive denial of payment no later than twelve months from the time the claim was submitted, and that any such audit or retroactive must be completed within eighteen months of the claim submission.[39] The Committee substitute also imposed similar limitations on doctors' offices and hospitals for submitting claims in order to balance the burden imposed on insurers.[40]

As introduced, the bill also amended Code section 33-24-47.1 by inserting a new section providing that the Code section shall also apply to Chapter 42 of Title 33.[41] In addition, the bill prohibited an insurer from refusing to renew a policy unless the insurer provided written notice of non-renewal to the insured.[42] The bill provided that such notice was not required if the insured was terminating the policy, but was required when a group blanket accident and sickness policy was canceled or not renewed by an insurer for nonpayment no less than 60 days prior to their policy termination date.[43]

As introduced, the bill also amended Code Section 33-24-59.5 by prohibiting an insurer from contesting, requesting payment, or

36. *Compare* SB 476, as introduced, 2002 Ga. Gen. Assem., *with* SB 476 (SCS), 2002 Ga. Gen. Assem. *See also* O'Connor Interview, *supra* note 23.

37. *Id.*

38. *Compare* SB 476, as introduced, 2002 Ga. Gen. Assem., *with* SB 476 (SCS), 2002 Ga. Gen. Assem.

39. *Id.*

40. *Id.*

41. SB 476, as introduced, 2002 Ga. Gen. Assem.

42. *Id.*

43. *Id.*

reopening a claim after a year has passed from the date the claim was submitted or the service was rendered.[44]

Consideration by the Senate and Floor Amendment

The Senate adopted the Committee substitute and passed SB 467 with a floor amendment on March 8, 2002.[45] The Senate floor amendment, offered by Senator Tom Price of the 56th District, required insurers to notify enrollees of plan provider limitations including the number, mix, and distributions of participating providers, and a summary of any agreements or contracts between the insurer and a health care provider or hospital.[46]

Consideration by the House Committee on Insurance

After introduction, the House assigned SB 476 to its Insurance Committee.[47] The Insurance Committee favorably reported SB 476, as substituted, on April 9, 2002.[48] The Insurance Committee adjusted the preamble to reflect the following changes.[49] The Insurance Committee added an amendment which provided that discrimination based on race, color, and national and ethnic origin, in connection with any kind of insurance, constituted a form of unfair discrimination and deceptive acts and practices.[50] The amendment further provided that a violation of such unfair discrimination gave rise to a civil cause of action for any damages.[51]

The Insurance Committee amended the definition of "elective procedure", provided in Code section 33-20A-3, by changing it to "non-urgent" procedure and adjusted the definition accordingly.[52] The Committee substitute also amended Code section 33-20A-7.1 by including language allowing insurers to precertify or verify benefits by either electronic or recorded means after regular business hours.[53]

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44. *Id.*
45. State of Georgia Final Composite Status Sheet, SB 476, Apr. 12, 2002.
46. *Compare* SB 467 (SCS), 2002 Ga. Gen. Assem., *with* SB 467 (SCSFA), 2002 Ga. Gen. Assem.
47. State of Georgia Final Composite Status Sheet, SB 476, Apr. 12, 2002.
48. *Id.*
49. *Compare* SB 476 (SCSFA), 2002 Ga. Gen. Assem., *with* SB 476 (HCS), 2002 Ga. Gen. Assem.
50. *Id.*
51. *Id.*
52. *Id.*
53. *Id.*

The Insurance Committee also clarified when and how information about precertification or pre-authorization must be provided to enrollees requesting verification of benefits.[54] Additionally, the Committee substitute removed the previously added section that limited insurers' ability to penalize enrollees who fail to timely obtain proper precertification of benefits.[55]

The Committee substitute changed the time in which insurers must notify enrollees of policy termination due to an employer's failure to pay premiums from five days prior to the end of the grace period to fourteen days after termination.[56] The Committee substitute also required insurers to include information about policy conversion with the notice of termination if such termination was due to the employer's failure to pay.[57]

The Committee substitute also extended the continuity of care provision from 60 days to the insured's entire pregnancy.[58] The Committee substitute extended limits imposed on insurers to conduct post-payment audits from 18 to 24 months after the date of service.[59] The Committee substitute further imposed a broader 24-month limit on the ability of providers and facilities to request additional payment from insurers.[60] The Committee substitute required providers and facilities to bill an enrollee for any balance within 45 days of notification of the results of a post-payment audit.[61]

The Committee substitute also amended Code section 33-24-21.1 by clarifying conversion rights available to enrollees to ensure that individuals and group policies cancelled due to the employer's non-payment are not construed as individuals who failed to pay their premiums.[62]

Lastly, the Committee substitute provided an effective date of October 1, 2002, with an exception for all currently disputed claims affected by the limitations imposed on post-payment audits and retroactive denial of benefits.[63]

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54. *Id.*
55. *Compare* SB 476 (SCSFA), 2002 Ga. Gen. Assem., *with* SB 476 (HCS), 2002 Ga. Gen. Assem.
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.*
61. *Compare* SB 476 (SCSFA), 2002 Ga. Gen. Assem., *with* SB 476 (HCS), 2002 Ga. Gen. Assem.
62. *Id.*
63. *Id.*

Consideration by the House

The House passed SB 476, as substituted, on April 10, 2002.[64] The Senate agreed to the House changes and passed SB 476 on April 12, 2002.[65] The Senate forwarded the bill to Governor Roy Barnes, who signed SB 476 into law on April 19, 2002.[66]

The Act

Code Section 33-6-4

The Act creates a new division, (b)(8)(A)(iv) of Code section 33-6-4, that prohibits "discrimination based on race, color, and national or ethnic origin."[67] This new division also provides that it is an unfair business practice to limit the type and scope of coverage available, or charge an individual a different rate because of an individual's race, color, or national or ethnic origin, or to refuse to insure or to continue to insure that individual.[68] The Act further provides that such a violation give rise to a civil cause of action for damages, including bad faith and attorneys fees.[69] Furthermore, the Act provides that if such discrimination is intentional, a court may award punitive damages.[70]

Code Section 33-6-5

The Act adds a new Code section 33-6-5(12.1) that requires compliance with Chapter 20A of Title 33 in its entirety for any licensed insurer or managed care entity.[71]

64. State of Georgia Final Composite Status Sheet, SB 476, Apr. 12, 2002.
65. *Id.*
66. *Id.*
67. O.C.G.A. § 33-6-4(b) (Supp. 2002).
68. *Id.*
69. *Id.*
70. *Id.*
71. O.C.G.A. § 33-6-5 (12.1) (Supp. 2002).

Code Section 33-20A-3

The Act amends Code section 33-20A-3 by adding definitions for "facility," "health benefit plan," "home health care provider," "non-urgent procedure," "precertification or preauthorization," and "verification of benefits."[72]

Code Section 33-20A-5

The Act adds a new subparagraph (C.1) to Code section 33-20A-5 which requires a managed care plan to obtain a signed acknowledgment that each enrollee received detailed information about participating plan providers including the "number, mix, and distribution of participating providers."[73] The Act also requires that managed care plans disclose the "existence of limitations . . . on choices of health care providers," and provide "[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."[74] The Act does not require that the summary include certain details of financial agreements between the managed care plan and doctors or hospitals.[75] However, the Act provides that the summary may disclose the "category or type of compensation . . . paid by the managed care plan to each class of health care provider or hospital under contract with the managed care plan."[76]

Code Section 33-20A -7.1

The Act adds a new Code section, 33-20A-7.1, which provides rules for managed care plans covering precertification of health care coverage.[77] The rules require that a caller must have the option of

72. *Compare* 1999 Ga. Laws 274, § 1 at 328 (formerly found at O.C.G.A. § 33-20A-3 (2001)) and 1996 Ga. Laws 751, § 1 at 486 (formerly found at O.C.G.A. § 33-20A-3 (Supp. 2001)), *with* O.C.G.A. § 33-20A-3 (Supp. 2002).

73. O.C.G.A. § 33-20A-5 (Supp. 2002).

74. *Id.*

75. *Id.*

76. *Id.*

77. O.C.G.A. § 33-20A-7.1 (Supp. 2002).

speaking to a live person during regular business hours.[78] The Act also requires managed care plans to have employees or agents available 24 hours a day, seven days a week, if they require precertification, except in the case of "non-urgent procedures."[79] The Act also provides that at the time an enrollee calls for precertification, the managed care plan must advise them of the acceptance or rejection of the requested coverage and provide reasons for any rejection.[80] The Act allows the acceptance, rejection, or explanation be given through an automated system as long as a real person is available to provide further information to the caller. [81]

Code Sections 33-20A-60, 33-20A–61, and 33-20A-62

The Act adds a new Article 3 to Chapter 20A of Title 33 relating to managed health care plans including, new definitions provided in Code section 33-20A-60.[82] The Act adds a new Code section, 33-20A-61, which requires every physician contract to include a provision indicating that if the insurer terminates the contract, an enrollee with a chronic or terminal illness, or an inpatient, may continue treatment with that doctor under the plan for 60 days after the termination date.[83] The Act requires continuity of care for pregnant enrollees, including to six weeks of post-delivery care.[84] However, the Act does not require such continuity of care if the physician's contract is terminated because the physician lost his or her license or poses a threat to the "health, safety, or welfare of enrollees."[85] The new Code section 33-20A-61 requires similar continuity of care requirements and limitations when the physician terminates the contract with the insurer.[86]

The Act also adds a new Code section, 33-20A-62, which places time limitations on post-payment audits and retroactive denial of benefits and associated notice requirements to enrollees.[87] The Act

78. *Id.*
79. *Id.*
80. *Id.*
81. O.C.G.A. § 33-20A-7.1 (Supp. 2002).
82. O.C.G.A. § 33-20A-60 (Supp. 2002).
83. O.C.G.A. § 33-20A-61 (Supp. 2002).
84. O.C.G.A. § 33-20A-61 (Supp. 2002).
85. O.C.G.A. § 33-20A-61 (Supp. 2002).
86. O.C.G.A. § 33-20A-61 (Supp. 2002).
87. O.C.G.A. § 33-20A-62 (Supp. 2002).

imposes a statute of limitations of 12 months on the ability of an insurer to engage in a post-payment audit or a retroactive denial.[88] Also, the Act imposes a prompt billing requirement on insurance providers and facilities requiring that they submit any bill to an enrollee within 45 days of the date the provider or facility knew "further payment was due as the result of a post-payment audit, retroactive denial, or rejected request to adjust a previously paid claim."[89] If a bill is not submitted to the enrollee within the requisite period, then they "shall be relieved of any and all legal obligations to respond to a request for additional payment."[90]

Code Section 33-24-21.1

The Act amends Code section 33-24-21.1(g) by extending eligibility for converted polices or contracts to qualifying individuals whose insurance company terminated a group policy because the employer failed to pay premiums to the insurer.[91]

Code Section 33-24-47.1

The Act amends Code section 33-24-47.1 by adding references of applicability to Chapter 42 of Title 33.[92] The Act adds a new subsection (d) that requires an insurer to provide notice to group members when a group policy is cancelled or not renewed due to nonpayment of a premium.[93] The new subsection (d) provides that the insurer must notify, at least by certified first class mail, each group member within 14 days of expiration of the grace period of their continuation or conversion rights under Code sections 33-24-21.1 or 33-24-21.2, or any other Code section that may apply.[94]

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88. *Id.*
89. *Id.*
90. *Id.*
91. *Compare* 1986 Ga. Laws 1455, § 1, at 689 (formerly found at O.C.G.A. § 33-24-21.1 (2001)), *with* O.C.G.A. § 33-24-21.1 (Supp. 2002).
92. *Compare* 1991 Ga. Laws 498, § 1, at 1359 (formerly found at O.C.G.A. § 33-24-47.1 (2001)), *with* O.C.G.A. § 33-24-47.1 (Supp. 2002).
93. *Id.*
94. *Id.*