

9-1-1999

## INSURANCE Managed Healthcare Plans: Require Managed Care Plans and Health Maintenance Organizations to Make Certain Disclosures; Provide a Consumer Choice Option for Access to Out-of-Network Providers and Hospitals; Prohibit Plans from Using Certain Financial Incentive and Disincentive Programs; Provide Timely Payment by Managed Care Plans; Prohibit Certain Penalties by Such Plans Against Healthcare Providers and Hospitals; Provide for Violations

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### Recommended Citation

Keri L. Patterson, *INSURANCE Managed Healthcare Plans: Require Managed Care Plans and Health Maintenance Organizations to Make Certain Disclosures; Provide a Consumer Choice Option for Access to Out-of-Network Providers and Hospitals; Prohibit Plans from Using Certain Financial Incentive and Disincentive Programs; Provide Timely Payment by Managed Care Plans; Prohibit Certain Penalties by Such Plans Against Healthcare Providers and Hospitals; Provide for Violations*, 16 GA. ST. U. L. REV. (1999).  
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## INSURANCE

*Managed Healthcare Plans: Require Managed Care Plans and Health Maintenance Organizations to Make Certain Disclosures; Provide a Consumer Choice Option for Access to Out-of-Network Providers and Hospitals; Prohibit Plans from Using Certain Financial Incentive and Disincentive Programs; Provide Timely Payment by Managed Care Plans; Prohibit Certain Penalties by Such Plans Against Healthcare Providers and Hospitals; Provide for Violations*

**CODE SECTIONS:** O.C.G.A. §§ 33-20A-5 to -7 (amended), -9.1 (new), 33-21-3, -13, -28 (amended)

**BILL NUMBER:** SB 210

**ACT NUMBER:** 280

**GEORGIA LAWS:** 1999 Ga. Laws 342

**SUMMARY:** The Act requires managed care plans and health maintenance organizations to disclose all pertinent information regarding healthcare services or benefits under the plan to consumers. Consumers are also entitled to information regarding limitations on services, potential liability for using out-of-network providers, and financial obligations of the enrollee. Enrollees in a plan will also be given a consumer choice option providing additional access to out-of-network providers. The Act prohibits plans and organizations from compensating a health provider for providing less than medically necessary treatment or punishing a provider for giving appropriate care; the Act also mandates that healthcare providers or hospitals shall fully and promptly be paid any payment or reimbursement. Healthcare providers cannot be penalized for discussing with their patients what medical care is actually

necessary. The Act provides for penalties in the event of noncompliance.

EFFECTIVE DATE: July 1, 1999

### *History*

Every day medical directors for Health Maintenance Organizations (HMOs) deny medical coverage to faceless patients who live thousands of miles away.<sup>1</sup> Many patients cannot even see their own doctor, but must be treated by a doctor chosen by their healthcare plan.<sup>2</sup> Moreover, HMOs sometimes restrict the type of treatment doctors can recommend to their patients.<sup>3</sup> The Act allows patients to choose their healthcare provider, requires disclosure of information between the provider and the plan, provides for prompt payment of claims, and encourages communication between doctor and patient.<sup>4</sup>

### *Introduction*

SB 210 resulted from the combined efforts of Governor Roy Barnes, consumer advocates, healthcare providers and hospitals, the insurance industry, and the business community.<sup>5</sup> After the Governor introduced SB 210, the bill's sponsors and the Governor met with members of the Georgia Chamber of Commerce, representatives of the managed care industry, representatives of medical providers, and other affected parties to examine the bill and make changes that would serve the interests of all constituencies involved.<sup>6</sup> These negotiations led to numerous amendments.

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1. See Georgia Governor Roy Barnes, *Georgia NOW, HMO Reform* (visited Apr. 3, 1999) <<http://www.state.ga.us/governor/sphmo.html>> [hereinafter Barnes Remarks].

2. See *id.*

3. See *id.*

4. See Record of Proceedings in the Health and Human Services Committee Hearing (Mar. 1, 1999) (remarks by Sen. Charles Walker) (available in Georgia State University College of Law Library).

5. See Telephone Interview with Renay Blumenthal, Policy Director for the Governor's Office (Apr. 16, 1999) [hereinafter Blumenthal Interview].

6. See *id.*; Telephone Interview with Amy Fincher, Assistant Vice President of Government Affairs, Georgia Chamber of Commerce (May 4, 1999) [hereinafter Fincher Interview]; Telephone Interview with Michael Wardrip, Director of Government Affairs, Georgia Association of Health Underwriters (May 4, 1999) [hereinafter Wardrip Interview].

*From Introduction in Senate to Senate Health and Human Services Committee*

*Amendments to Code Section 33-20A-5*

Governor Barnes introduced SB 210 in the Senate on February 23, 1999, and the bill was subsequently sent to the Senate Health and Human Services Committee (Committee).<sup>7</sup> The Committee made several amendments.<sup>8</sup> The first requires disclosure to enrollees and prospective enrollees, and the second requires access to services.<sup>9</sup>

One important change deleted what would have been a requirement in Code section 33-20A-5(1)(A)(xiii) that a managed care entity make available the full text of any agreements or contracts between the managed care plan and any healthcare provider or hospital.<sup>10</sup> However, the Committee softened the language to require only disclosure of a summary of agreements or contracts between the managed care plan and any healthcare provider or hospital.<sup>11</sup> The Senate Committee's language required managed care companies to disclose agreements or contracts pertaining to financial incentive or disincentive programs, to make timely payment and reimbursement to any healthcare provider or hospital, and to disclose rights of healthcare providers to discuss medically necessary or appropriate care with their patients.<sup>12</sup> The Committee's language ultimately became law.<sup>13</sup> In addition, the new Code section 33-20A-5(1)(A)(xiii) contains a list of items, which may be exempt from disclosure if the summary includes a disclosure of the type of compensation the managed care plan pays to contract providers or hospitals.<sup>14</sup> The Committee made these changes to forge a compromise between the insurance companies and consumers.<sup>15</sup> The insurance companies believed that disclosing the full text of any

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7. See State of Georgia Final Composite Status Sheet, May 3, 1999.

8. See *id.*

9. Compare 1996 Ga. Laws 485, § 1, at 488-91 (formerly found at O.C.G.A. § 33-20A-5 (Supp. 1998)), with O.C.G.A. § 33-20A-5 (Supp. 1999).

10. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem., and O.C.G.A. § 33-20A-5(1)(A)(xiii) (Supp. 1999).

11. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

12. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

13. See O.C.G.A. § 33-20A-5 (Supp. 1999).

14. See *id.*

15. See Blumenthal Interview, *supra* note 5.

agreement forced them to disclose too much proprietary information.<sup>16</sup> The original requirement in the bill went beyond mere pricing information to include information that could be damaging because it would be extremely detailed and likely to confuse the consumer.<sup>17</sup>

*Amendments to Code Sections 33-20A-6 and -7*

The Act amends Code sections 33-20A-6 to -7, relating to financial disincentive programs, timely payment and reimbursement to providers, and open communication between doctor and patient, by expounding on the language used in each Code section.<sup>18</sup> Lawmakers replaced the former Code sections to eliminate the ability of managed care plans to retaliate against providers or hospitals who tell their patients the truth about what kind of care or treatment they believed to be necessary.<sup>19</sup>

The Senate Committee deleted the provision in the bill's original version that would have added a requirement under Code section 33-20A-6(b) for managed care plans to make full payment or reimbursement pursuant to a contract or provision of the Code section within thirty days.<sup>20</sup> The Committee replaced that provision with the requirement that the managed care plan make full and timely payment to any healthcare provider or hospital in the same way payment is made for group accident and sickness insurance policies under paragraph (5) of Code section 33-30-6.<sup>21</sup> This change was a technical correction.<sup>22</sup> The original version of the bill was designed to insure that providers received timely reimbursements.<sup>23</sup> However, both providers and insurance companies pointed out that a Code section that spoke to the issue of reimbursement already existed, but it did not apply to managed care.<sup>24</sup> Code section 33-30-6 has a fifteen-day requirement for reimbursement rather than the thirty-day

16. *See id.*

17. *See* Wardrip Interview, *supra* note 6.

18. *Compare* O.C.G.A. §§ 33-20A-6 to -7 (Supp. 1999), *with* 1996 Ga. Laws 485, § 1, at 491 (formerly found at O.C.G.A. § 33-20A-6 to 33-20B-7 (Supp. 1998)).

19. *See* Telephone Interview with Sen. Charlie Tanksley, Senate District No. 32 (Apr. 14, 1999) [hereinafter Tanksley Interview].

20. *Compare* SB 210, as introduced, 1999 Ga. Gen. Assem., *with* SB 210 (SCS), 1999 Ga. Gen. Assem.

21. *Compare* SB 210, as introduced, 1999 Ga. Gen. Assem., *with* SB 210 (SCS), 1999 Ga. Gen. Assem.

22. *See* Blumenthal Interview, *supra* note 5.

23. *See id.*

24. *See id.*

requirement proposed by the bill as introduced.<sup>25</sup> This change merely applied the already-existing Code section to managed care.<sup>26</sup>

Next, the Senate Committee deleted the proposed language of Code section 33-20A-7(c), which would have penalized managed care plans by denying rate increase requests for a five-year period.<sup>27</sup> The Committee added a new penalty to Code section 33-20A-7, which provides that a violation of this Code section shall constitute an unfair trade practice punishable under Article 1, Chapter 6 of Title 33.<sup>28</sup> Although denying rate increases had been a major part of the bill, as introduced,<sup>29</sup> insurance companies called the standard for a violation “arbitrary and capricious.”<sup>30</sup> Insurance companies’ representatives said that freezing rates for five years could potentially be like “shutting the doors” of an insurance company, even if the violation was only a minor one.<sup>31</sup> All interested parties agreed to the change because it treated the HMO the same way a business would be treated.<sup>32</sup> The rationale behind the change was that the “punishment should fit the violation.”<sup>33</sup>

#### *O.C.G.A. § 33-20A-9.1*

The Act adds Code section 33-20A-9.1 to the Patient Protection Act, relating to costs and limits for using out-of-network providers.<sup>34</sup> The Senate Committee added a definition of “consumer choice option” to the proposed Code section 33-20A-9.1(b).<sup>35</sup> This change clarified the legislative intent, which was to provide consumers the unrestricted right to receive coverage services.<sup>36</sup>

25. See Wardrip Interview, *supra* note 6.

26. See Blumenthal Interview, *supra* note 5. Compare 1996 Ga. Laws 485, § 1, at 491 (formerly found at O.C.G.A. § 33-20A-6 (Supp. 1998)), with O.C.G.A. § 33-20A-6 (Supp. 1999); see also O.C.G.A. § 33-30-6 (1996).

27. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

28. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

29. See Barnes Remarks, *supra* note 1.

30. Blumenthal Interview, *supra* note 5.

31. Wardrip Interview, *supra* note 6.

32. See Blumenthal Interview, *supra* note 5.

33. Wardrip Interview, *supra* note 6.

34. See O.C.G.A. § 33-20A-9.1 (Supp. 1999).

35. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

36. See Blumenthal Interview, *supra* note 5.

Furthermore, the Committee deleted the phrase “with respect to cost sharing” from the proposed Code section 33-20A-9.1(c)(1)(B) as introduced and changed the provision to read: “Such health care provider or hospital agrees to accept reimbursement from both the plan and the enrollee at the rates and on the terms and conditions applicable to participating providers and hospitals and under any cost-sharing conditions provided in paragraph (3) of subsection (d) of this Code section.”<sup>37</sup> Because the purpose of the bill was to make it more affordable for consumers to go to out-of-network providers, the original version of the bill limited the increase in the amount insurance companies could charge for using out-of-network providers to no more than 7.5%.<sup>38</sup> But the insurance companies said that if the 7.5% cap remained, any excess cost to the insurance company would have to be spread out to all other consumers in the plan and not just the person choosing the option.<sup>39</sup> Insurance company representatives reasoned that the person using the choice option should be the one to pay for it, not everyone else in the plan.<sup>40</sup> This rationale, among others, motivated the change to the bill.<sup>41</sup> In addition, the change gave the Healthcare Plan a choice of whether to charge the consumer an increased premium or an increase in out-of-pocket expenses (co-pay).<sup>42</sup> If the Plan opts to increase the amount of co-pay, the reimbursement rates to the provider may be proportionately decreased so that an out-of-network doctor does not make additional profit.<sup>43</sup> However, the out-of-pocket expenditures of the consumer choice option is limited to a twenty-percent increase over the in-network charge.<sup>44</sup>

Technical changes to proposed Code section 33-20A-9.1(c)(1) replaced “a” nominated healthcare provider with “each” nominated healthcare provider.<sup>45</sup> Furthermore, lawmakers amended proposed Code section 33-20A-9.1(c), as introduced, by changing the phrase “[a]n enrollee who elects the consumer choice option” to Code section 33-

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37. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

38. See SB 210, as introduced, 1999 Ga. Gen. Assem.; Blumenthal Interview, *supra* note 5.

39. See Wardrip Interview, *supra* note 6.

40. See *id.*

41. See *id.*

42. See Tanksley Interview, *supra* note 19.

43. See *id.*

44. See *id.*

45. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

20A-9.1(d)(1) “[a]n enrollee who selects”<sup>46</sup> to ensure that the co-payment assessment would apply only if the consumer went out of network.<sup>47</sup> In the original version, the consumer could have taken advantage of the choice even if he or she did not ever use the option.<sup>48</sup> However, this change ensured that the consumer would pay only for using the privilege and not merely for having the privilege.<sup>49</sup>

Some of the most significant changes made to the bill involved the language of Code section 33-20A-9.1(d).<sup>50</sup> The Senate Committee changed the language of subsection 33-20A-9.1 (c) as proposed, which stated,

an enrollee who elects the consumer choice option shall be responsible for the payment of a premium over the amount of the premium for the coverage without such option, but any increase shall not exceed 7.5% of the premium without the option or the actuarial basis of the option taking into account actual administrative and other costs associated with the exercise of this option, whichever is less.<sup>51</sup>

The new language of Code section 33-20A-9.1(d)(1) provided that “an enrollee who selects the consumer choice option shall be responsible for any increases in premiums and cost sharing associated with the option.”<sup>52</sup> Accordingly, the Senate Committee added a requirement to Code section 33-20A-9.1(d)(1) that any difference in cost sharing for the consumer choice option could only apply when the enrollee used an out-of-network provider; thus, consumers would pay only for using the privilege and not just for having the privilege.<sup>53</sup>

The Senate Committee changed the language in Code section 33-20A-9.1(d)(2) to clarify that an HMO had a choice between the actuarial basis or a 17.5% increase in premium without the option or a 15% increase in premium without the option and with cost-sharing limits.<sup>54</sup>

46. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

47. See Tanksley Interview, *supra* note 19.

48. See *id.*

49. See *id.*

50. See Blumenthal Interview, *supra* note 5.

51. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

52. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

53. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

54. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.



For a Patient Provider Organization (PPO), the choice was the lesser of the actuarial basis and a 10% increase in premium only or a 7.5% increase in premium along with minimal cost sharing.<sup>55</sup> In subsection 33-20A-9.1(d)(2)(A), the Committee added specific limitations on any increases in premiums under the consumer choice option for health benefit plans offered by HMOs.<sup>56</sup> In Code section 33-20A-9.1(d)(2)(B), the Committee added specific limitations on any increases in premiums under the consumer choice option for all other managed care plans under the same chapter of the Code section.<sup>57</sup> Finally, in Code section 33-20A-9.1(d)(3), the Committee added specific limitations on cost sharing for the consumer choice option compared to in-network cost sharing.<sup>58</sup> The Senate Committee added each of these limitations because without them, “the sky would have been the limit” on how much a plan could charge for out-of-network providers.<sup>59</sup>

The Committee also added a provision to proposed Code section 33-20A-3(d)(4) allowing HMOs to have an independent actuarial evaluation of the consumer choice option after twelve months; the evaluation can compare actual costs of the consumer choice option with the costs associated with the standard plan.<sup>60</sup> After such evaluation, managed care entities can apply for a waiver of the cost provisions pertaining to managed care plans and health benefit plans under paragraphs (2) and (3) of the Code.<sup>61</sup> Lawmakers added this option as a concession to HMOs that believed they still could not afford the new consumer choice option.<sup>62</sup> The changes to the bill protected the insurance companies from “pric[ing] themselves into insolvency” in competitive situations.<sup>63</sup> If the HMO can prove to the Insurance Commissioner that it is losing money as a result of the option, the Commissioner may allow the insurance company to adjust its rates.<sup>64</sup>

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55. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

56. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

57. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

58. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

59. Blumenthal Interview, *supra* note 5.

60. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

61. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

62. See Blumenthal Interview, *supra* note 5; Wardrip Interview, *supra* note 6.

63. Tanksley Interview, *supra* note 19.

64. See *id.*

The Senate Committee changed proposed Code section 33-20A-9.1, as introduced, by adding a requirement that a managed care entity provide an enrollee who chooses the consumer choice option with a form for the healthcare provider or hospital to fill out.<sup>65</sup> The form would include the healthcare provider's agreement to the requirements as set out in the Code,<sup>66</sup> which ensures that the provider will agree to the quality-assurance requirements of the HMO.<sup>67</sup> Moreover, the Committee added language to the same subsection that required the managed care entity to provide any necessary information to the enrollee's chosen out-of-network provider that the managed care plan would provide to in-network healthcare providers and hospitals.<sup>68</sup> In addition, the language provided that a managed care plan could only refuse to approve reimbursement to a nominated healthcare provider or hospital if the plan could show by "clear and convincing" evidence that the healthcare provider or hospital did not meet the requirements outlined in the Code.<sup>69</sup> The form specifications prevent a plan from requiring a large quantity of forms from an enrollee or provider, and the "clear and convincing" evidence standard in the proposed Code section prevents a plan from refusing an enrollee-nominated provider for technical reasons.<sup>70</sup>

#### *Amendments to Title 33 Chapter 21*

The Act amends Code section 33-21-3 by adding paragraph (5), which mandates that HMOs comply with provisions in the new Code section 33-20A-9.1.<sup>71</sup> In addition, the Senate Committee amended Code section 33-21-13(K) by deleting the word "financial" from the bill's original version and adding a requirement for a summary of any agreements or contracts between HMOs and any provider subject to the same conditions as set out in Code section 30-20A-5(1)(A)(xiii).<sup>72</sup> This deletion modified the language of Code section 33-21-13 to make

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65. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

66. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

67. See Tanksley Interview, *supra* note 19.

68. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

69. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

70. Blumenthal Interview, *supra* note 5.

71. Compare 1979 Ga. Laws 1148, § 1, at 1153-55 (formerly found at O.C.G.A. § 33-21-3 (1992)), with O.C.G.A. § 33-21-3 (Supp. 1999).

72. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

it consistent with the language used in other code sections amended by the bill.<sup>73</sup>

The Act changes subsection (a) of Code section 33-21-28 to make all provisions of the title consistent with the chapter that applies to HMOs.<sup>74</sup>

*Amendment to Code Section 33-21-29*

The Committee also deleted the language that struck Code section 33-21-29, relating to point-of-service options.<sup>75</sup> Because the original version of the bill inadvertently struck the Code section, it was reinserted.<sup>76</sup> Lawmakers realized the importance of keeping the point-of-service option in the code because the consumer-choice option only allows the consumer to choose his or her doctor, the provider or hospital must be enrolled *prior to* the time that the consumer uses the option.<sup>77</sup> However, point-of-service allows the consumer to go to any out-of-network provider without prior approval, but the HMO can charge the consumer whatever it chooses under point-of-service.<sup>78</sup> Had lawmakers cut the point-of-service option, the bill would have failed to reach as many people as the drafters originally thought it would.<sup>79</sup>

*From Senate Committee on Health and Human Services to Senate*

On March 9, 1999, SB 210 returned to the Senate where lawmakers unanimously approved it.<sup>80</sup>

*From Senate to the House Floor*

On March 10, 1999, SB 210 went to the House floor for approval.<sup>81</sup> However, members of the House continued to change the text of the bill. Specifically, the House changed Code section 33-20A-9.1.

First, the House amendments added the phrase "similarly situated" before "participating providers" and hospitals to Code section 33-20A-9.1(c)(1)(B).<sup>82</sup> The House subsequently deleted the phrase "and under

73. See Blumenthal Interview, *supra* note 5.

74. Compare 1979 Ga. Laws 1148, § 1, at 1153-55 (formerly found at O.C.G.A. § 33-21-28(a) (1992)), with O.C.G.A. § 33-21-28 (Supp. 1999).

75. Compare SB 210, as introduced, 1999 Ga. Gen. Assem., with SB 210 (SCS), 1999 Ga. Gen. Assem.

76. See Tanksley Interview, *supra* note 19.

77. See *id.*

78. See *id.*

79. See Fincher Interview, *supra* note 6.

80. See Georgia Senate Voting Record, SB 210 (Mar. 9, 1999).

81. See State of Georgia Final Composite Status Sheet, May 3, 1999.

82. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(c)(1)(B)

any cost-sharing conditions provided in paragraph (3) of subsection (d) of this Code section,” replacing it with “[t]he reimbursement rates for the plan may be proportionally reduced from those paid to participating providers if the cost-sharing provisions in paragraph (3) of subsection (d) of this Code section are utilized in the consumer choice option.”<sup>83</sup> The Representatives added this provision so that a provider would have some standard by which to compare rates, terms, and conditions.<sup>84</sup> Lawmakers added the last sentence, “the reimbursement rates for the plan may be proportionally reduced” as a technical clarification that rates will be decreased according to earlier mentioned cost-sharing requirements because healthcare insurers said that allowing some cost-sharing would allow a change in the rates, terms, and conditions.<sup>85</sup>

The Senate Committee substitute’s proposed Code section 33-20A-9.1(d)(2)(A) originally read: “For health benefit plans offered by health maintenance organizations under Chapter 21 of this title, *the lesser of the following . . .*,” but lawmakers deleted the proposed language “the lesser of the following” and replaced it with “[t]he managed care entity may offer both of the following options, but must offer either.”<sup>86</sup> Proposed Code section 33-20A-9.1(d)(2)(A)(i) in the Senate Committee substitute originally read: “The actuarial basis of the option taking into account *actual* administrative and other costs associated with the exercise of this option. . . ,” but Representatives deleted the word “actual” from the provision.<sup>87</sup> In addition, the House added the phrase “a 17.5 percent increase in premium over the plan without the option, whichever is less, or . . .”<sup>88</sup> Representatives then amended the bill by adding to proposed Code section 33-20A-9.1(d)(2)(A)(ii) the language: “. . . or the actuarial basis of the option with cost sharing as provided under paragraph (3) of this subsection taking into account administrative and other costs associated with the exercise of this option or a 15 percent increase in premium over the plan without the option and with cost sharing as provided under paragraph (3) of this subsection, whichever is less.”<sup>89</sup>

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(Supp. 1999).

83. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(c)(1)(B) (Supp. 1999).

84. See Blumenthal Interview, *supra* note 5.

85. See *id.*

86. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(2)(A) (Supp. 1999) (emphasis added).

87. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(2)(A) (Supp. 1999).

88. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(2)(A) (Supp. 1999).

89. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-

Moreover, the Senate Committee substitute version of proposed Code section 33-20A-9.1(d)(2)(B) initially read: "For all other managed care plans under this chapter, the *lesser of the following . . .*," but House Members amended the provision by deleting the phrase "the lesser of the following" and adding the language "the managed care entity may offer both of the following options, but must offer either."<sup>90</sup> Likewise, changes to the bill deleted from proposed Code section 33-20A-9.1(d)(2)(B)(i) the word "actual" before administrative, combined the phrase "or a 10 percent increase in premium over the plan without the option," and added the language: "whichever is less; or. . ."<sup>91</sup> Lawmakers further changed the proposed Code section by adding the language "[t]he actuarial basis of the option with cost sharing as provided under paragraph (3) of this subsection taking into account administrative and other costs associated with the exercise of this option or a 7.5 percent increase in premium over the plan without the option and with cost sharing as provided under paragraph (3) of the subsection, whichever is less."<sup>92</sup>

The House Members amended Code section 33-20A-9.1(d)(2)(A) to (B) in response to suggestions from the Chamber of Commerce Committee that HMOs, managed care plans, and PPOs needed different options.<sup>93</sup> The insurance companies wanted to make it clear that the choice was not one of three, but only between two options—actuarial basis, *or* one of the other two (either a 17.5% increase in premium only or a 15% increase in premium along with minimal cost-sharing for HMOs and for PPOs, a 10% increase in premium only or a 7.5% increase in premium along with minimal cost-sharing).<sup>94</sup> The other two options were offered to give flexibility to the plans.<sup>95</sup>

House members added a subparagraph (C) to proposed subsection (d)(2), which stated "a health benefit plan may offer at no additional premiums or cost sharing a preferred provider organization [PPO] network plan under Article 2 of Chapter 30 of this title."<sup>96</sup>

9.1(d)(2)(A)(ii) (Supp. 1999).

90. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(2)(B) (Supp. 1999) (emphasis added).

91. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(2)(B)(i) (Supp. 1999).

92. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(2)(B) (Supp. 1999).

93. See Fincher Interview, *supra* note 6.

94. See Blumenthal Interview, *supra* note 5; see also SB 210-Pricing Overview of the Consumer Choice Option (1999) (available in Georgia State University College of Law Library).

95. See Blumenthal Interview, *supra* note 5.

96. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(2)(C)

Subparagraphs (i) and (ii) set out the requirements for the PPO network plan.<sup>97</sup> The new language in proposed Code section 33-20A-9.1(d)(2)(C), which ultimately became law, also added a provision that the subparagraph “shall not place capacity limits on the number or classes of providers authorized to be preferred providers except . . . .”<sup>98</sup>

The most controversial changes to proposed Code section 33-20A-9.1 stemmed from the requirement in the original bill that the plan accept “any willing provider.”<sup>99</sup> The problem arose because plans promise in-network doctors a number of patients, and those patients anticipate certain lower costs when they join the plan.<sup>100</sup> The “any willing provider” language would open up the plan to an endless number of doctors who would agree to the plan.<sup>101</sup> As a result, insurance plans could not promise in-network doctors more patients (known as steerage); therefore, the plans’ costs would have gone up, which ultimately would have passed to the consumer.<sup>102</sup>

The changes to Code section 33-20A-9.1(d)(2)(A)-(C) solved this problem.<sup>103</sup> Subsections (A) and (B) applied various rates to HMOs and other managed care plans and were designed to more closely reflect actual costs to the insurance company for the option.<sup>104</sup> Subsection (C) created a compromise—it retained the 7.5% cap, but by making the cap an option, the plan could “offer at no additional premiums or cost sharing a preferred provider organization network plan . . . .”<sup>105</sup> allowing the plan itself to accept the “any willing provider.”<sup>106</sup> The changes also resulted from PPOs with open panel networks (*i.e.*, they accept any willing provider into their plan) that believed the changes needed to be added for clarification.<sup>107</sup> As a result of the changes, PPOs that already have standards for bringing in out-of-network providers can now offer the consumer choice option at no additional premium or cost-sharing.<sup>108</sup>

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(Supp. 1999).

97. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(2)(C) (Supp. 1999).

98. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(2)(C) (Supp. 1999).

99. Fincher Interview, *supra* note 6; see also Wardrip Interview, *supra* note 6.

100. See Fincher Interview, *supra* note 6; Wardrip Interview, *supra* note 6.

101. Fincher Interview, *supra* note 6; see also Wardrip Interview, *supra* note 6.

102. See Wardrip Interview, *supra* note 6.

103. See *id.*

104. See *id.*

105. O.C.G.A. § 33-20A-9.1(d)(2)(C) (Supp. 1999).

106. Wardrip Interview, *supra* note 6.

107. See Blumenthal Interview, *supra* note 5.

108. See *id.*

Finally, the Representatives made technical changes to proposed Code section 33-20A-9.1(d)(3), which added the language “[e]xcept as provided in subparagraph (C) of paragraph (2) of this subsection for a consumer choice option without cost sharing, any increases in cost sharing for the consumer choice option, as compared to in network cost sharing.”<sup>109</sup>

Code section 33-20A-9.1(d)(3)(C) would have read “if coinsurance is used in network”; however, Representatives deleted that phrase and added “[i]n all cases” to the opening of the subparagraph<sup>110</sup> as a technical clarification.<sup>111</sup> Insurance companies believed that without this phrase, they would not be able to charge the extra ten percent they were allowed for out-of-network providers under the consumer choice option.<sup>112</sup>

*From House Floor Amendments to Senate*

On March 24, 1999, the Senate approved all House Floor Amendments.<sup>113</sup> The General Assembly sent the bill to the Governor on March 29 and he signed it into law on April 20, 1999.<sup>114</sup>

*Keri L. Patterson*

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109. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(3) (Supp. 1999).

110. Compare SB 210 (SCS), 1999 Ga. Gen. Assem., with O.C.G.A. § 33-20A-9.1(d)(3)(C) (Supp. 1999).

111. See Blumenthal Interview, *supra* note 5.

112. See *id.*

113. See State of Georgia Final Composite Status Sheet, May 3, 1999.

114. See *id.*