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INSURANCE

Essential Rural Health Care Provider Access Act: Prohibit Exclusion of Essential Rural Health Care Providers from Health Benefit Plans

CODE SECTIONS:	O.C.G.A. §§ 31-7-72 (amended), -75.3, 33-20B-1 to -6 (new)
BILL NUMBER:	SB 594
ACT NUMBER:	870
GEORGIA LAWS:	1998 Ga. Laws 900
SUMMARY:	The Act requires that health insurance plans of all types allow participation by qualified rural health care providers. The Act first provides that health plans must give rural providers the opportunity to apply to become a participating provider. The Act requires that if the rural providers' applications are denied or rejected, or if they are later terminated by the plan, the health plan must notify them of the specific reasons for the adverse action and provide an opportunity to cure the deficiency. Further, rural providers may appeal any adverse decision to the Insurance Commissioner; however, any confidential or proprietary information discussed at such a hearing is not subject to the State's open records requirements, and, thus, may not be accessed by the public. Finally, the Act clarifies a hospital authority provision relating to the method of filling vacancies in their governing bodies and includes additional language relating to home health care and certificates of need.
EFFECTIVE DATE:	April 14, 1998[1]

1. 1998 Ga. Laws 900, § 5, at 905. The Act became effective upon approval by the Governor. *See id.*

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History

Health care costs have become a primary concern for everyone who receives, provides, or pays for the care. Health Care Financing Administration statistics show total national health expenditures of $604.1 billion in 1989 and projected expenditures of over $1.6 trillion by the year 2000.[2] The cost of care spirals upward just as our ability to pay that cost falls.[3] In an effort to control rising costs, government and private third-party payers continually cut reimbursement to providers, forcing providers to give the same care for less money.[4] While large urban providers can frequently find a way to pay the increased costs or can diversify to increase their revenues, small rural providers have fewer options and less margin for error.[5] As a result, "Georgia's rural hospitals are in critical condition,"[6] and rural providers are falling by the wayside.[7] One rural hospital was forced to close in 1997, and a number of others face critical financial challenges that may close their doors.[8]

Although cuts in government reimbursement rates are a factor, a major cause of the financial crisis in rural health care is the shift to managed care.[9] In order to lower costs, managed care plans typically contract with large, full-service hospitals that handle a broader range of medical needs than do smaller, rural providers.[10] Although their reasons for doing so are understandable—it is more administratively

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2. *See* JONATHON S. RAKICH ET AL., MANAGING HEALTH SERVICES ORGANIZATIONS 69 (3d ed. 1992).

3. *See generally* INTRODUCTION TO HEALTH SERVICES (Stephen J. Williams & Paul R. Torrens eds., 3d ed. 1988) [hereinafter Williams, INTRODUCTION].

4. *See id.*

5. *See id.*; Kelly Greene, *Georgia's Rural Hospitals Struggle to Stay Alive*, WALL ST. J., SOUTHEAST J., July 2, 1997, at S1 [hereinafter Greene, *Rural Hospitals Struggle*].

6. Greene, *Rural Hospitals Struggle, supra* note 5.

7. *See generally* Williams, INTRODUCTION, *supra* note 3, at 480-88; Greene, *Rural Hospitals Struggle, supra* note 5.

8. *See* Greene, *Rural Hospitals Struggle, supra* note 5; Kelly Greene, *Small Georgia County Considers Tax Hike to Keep Hospital Open*, WALL ST. J., SOUTHEAST J., July 23, 1997, at S6 [hereinafter Greene, *Keep Hospital Open*] (noting that rural Georgia hospitals are facing federal Medicare cuts as well as reduced state Medicaid payments that cost them $65 million in 1995); Kelly Greene, *As Rural Hospitals Bleed, Georgia Looks for a Cure*, WALL ST. J., SOUTHEAST J., Sept. 17, 1997, at S1 [hereinafter Greene, *Rural Hospitals Bleed*].

9. *See* Greene, *Rural Hospitals Struggle, supra* note 5; Greene, *Keep Hospital Open, supra* note 8; Greene, *Rural Hospitals Bleed, supra* note 8 (noting that federal Medicare freeze is expected to cost state hospitals around $900 million over next five years, and three years of state Medicaid cuts have cost them an additional $80 million).

10. *See* Greene, *Rural Hospitals Struggle, supra* note 5.

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efficient to contract with one broad-based provider than with a number of individual providers[11]—the effect can be devastating: smaller hospitals, no longer able to make up the difference between shrinking reimbursement rates and the cost of providing care, are teetering.[12] And as smaller providers close, rural residents must travel to urban centers for their health care.[13]

To address the crisis, the Georgia General Assembly considered several bills that would grant various forms of relief to rural providers.[14] One of those bills, SB 594, specifically addressed the relationship between rural providers and managed care plans.[15] Although the General Assembly had considered a similar bill during its 1996 session, that legislation lacked broad-based support.[16] During the 1998 session, however, Senator Guy Middleton sponsored a new bill at the request of the GHA: An Association of Hospitals and Health Systems, and enlisted key health care industry support prior to introducing the bill.[17] As a result, HB 594 encountered less resistance and was successfully enacted.[18]

SB 594

Introduction

The "Essential Rural Health Care Provider Access Act"[19] requires that managed care plans give rural providers the opportunity to apply

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11. *See* Telephone Interview with Holly Bates Snow, Director of Government Relations, GHA: An Association of Hospitals and Health Systems (May 27, 1998) [hereinafter Snow Interview].

12. *See* Greene, *Rural Hospitals Struggle, supra* note 5.

13. *See Bill Would Widen Hospital Insurance*, ATLANTA J. & CONST., Feb. 17, 1998, at D5 [hereinafter *Hospital Insurance*].

14. *See* Andy Miller, *Prescriptions for Health Care*, ATLANTA J. & CONST., Jan. 13, 1998, at C3; *Hospital Insurance, supra* note 13.

15. *See* SB 594, as introduced, 1998 Ga. Gen. Assem.

16. *See* Snow Interview, *supra* note 11. SB 594 underwent a greater pre-introduction consensus-building process than did its 1996 predecessor, and so enjoyed more broad-based support from insurers, businesses, and health care providers. *See id.*

17. *See* Telephone Interview with Sen. Guy Middleton, Senate District No. 50 (May 29, 1998) [hereinafter Middleton Interview] (stating that prior to the bill's introduction, he met with Health Maintenance Organizations (HMOs), insurers, hospitals, physicians, and other health care groups to work out a viable bill for rural providers); *see also* Snow Interview, *supra* note 11 (stating that key players, including GHA: An Association of Hospitals and Health Systems, BlueCross and BlueShield of Georgia, and others, supported the legislation).

18. *See* Middleton Interview, *supra* note 17; Snow Interview, *supra*, note 11.

19. O.C.G.A. § 33-20B-1 (Supp. 1998).

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to become a participating provider in the plan and that the plans consider their applications just as they would those of nonrural providers.[20] Both the House and the Senate introduced versions of this bill.[21] HB 1798 was introduced to exempt certain rural providers from certificate of need (CON) requirements to provide home health services and was amended to contain the rural provider access provisions included in SB 594.[22] HB 1798 passed in the House and was sent to the Senate Health and Human Services Committee.[23] However, passage of SB 594 in both the Senate and the House made further consideration of HB 1798 unnecessary.[24]

SB 594 was introduced on February 6, 1998 and was sent to the Senate Health and Human Services Committee on that same day.[25] On Tuesday, February 10, 1998, the Committee voted "do pass by substitution,"[26] and the Senate unanimously passed the amended bill on February 16, 1998.[27] SB 594 proceeded to the House Insurance Committee, which recommended that it pass by substitute.[28] On

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20. *See* 1998 Ga. Laws 900.

21. *See* SB 594, as introduced, 1998 Ga. Gen. Assem.; HB 1798, as introduced, 1998 Ga. Gen. Assem.; Middleton Interview, *supra* note 17.

22. *See* HB 1798, as introduced, 1998 Ga. Gen. Assem.; Letter from Holly Bates Snow, Director of Government Relations, GHA: An Association of Hospitals and Health Systems (Jan. 23, 1999).

23. *See Lawmakers '98* (GPTV broadcast, Mar. 12, 1998) (available in Georgia State University College of Law Library).

24. *See* Middleton Interview, *supra* note 17. Senator Middleton met with Rep. Thomas Murphy, Speaker of the House, to discuss the similarities and differences between SB 594 and HB 1798. *See id.* It was agreed following the discussion that HB 1798, which was virtually identical to SB 594 in its rural provider access sections, would be substantially amended and submitted as the House substitute to SB 594. *See id.* The amended substitute bill omitted the certificate of need (CON) language and included a section addressing an additional rural hospital concern—the method of filling vacancies on hospital authorities. *See id.*; *see also* O.C.G.A. § 31-7-72(d) (Supp. 1998).

The CON process generates considerable political activity by health care interest groups, particularly those which represent home health care and nursing homes. *See* Telephone Interview with Sen. Jack Hill, Senate District No. 4 (June 20, 1998) [hereinafter Hill Interview]. Elected Senators and Representatives are sensitive to the political implications of the CON process, and they hesitate to append a CON provision to any legislation without extensive and exhaustive debate. *See id.* The needed debate could have significantly slowed, or even endangered, SB 594's enactment; therefore, the parties agreed to delete the CON language. *See id.*; Middleton Interview, *supra* note 17.

25. *See* State of Georgia Final Composite Status Sheet, Mar. 19, 1998.

26. *See* Georgia Senate Weekly Wrap-up Report (Feb. 9, 1998) <http://www.state.ga.us/homepages/senate/releases/weekly/weekfeb998.html>.

27. *See* State of Georgia Final Composite Status Sheet, Mar. 19, 1998; Georgia Senate Voting Record, SB 594 (Feb. 16, 1998).

28. *See* State of Georgia Final Composite Status Sheet, Mar. 19, 1998.

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March 12, 1998, the bill was amended on the House floor, passed the House, and then went to the Senate for concurrence.[29] On March 13, 1998, the Senate unanimously agreed to the House substitute,[30] and the bill was sent to Governor Zell Miller on March 24, 1998.[31] The Governor signed the bill on April 14, 1998.[32]

Primary Provisions

Intent of the General Assembly

Section 1 of the Act states that the General Assembly's intent is "to promote and preserve the provision of primary care to the residents of . . . rural areas."[33] The General Assembly recognizes that rural health care providers are frequently excluded from managed care plans and that their exclusion exacerbates the shortage of providers that already exists in rural areas.[34] Finally, the General Assembly concludes that specific steps must be taken to assure that health care services remain available to Georgia's rural citizens.[35]

Title

Code section 33-20B-1 provides that the Act may be cited as the "Essential Rural Health Care Provider Access Act."[36]

Definitions

Code section 33-20B-2 defines key terms used in this chapter.[37] Notably, an "[e]ssential rural health care provider" is "any hospital, federally qualified health center, or rural health clinic . . . which is located in a rural area and which complies with [later provisions of the Act]."[38] There are no geographic or affiliation requirements to the designation, such as a requirement that the provider be a given distance from a metropolitan area or that it affiliate with a larger

29. *See id.*; Georgia House of Representatives Voting Record, SB 594 (Mar. 12, 1998).
30. *See* Georgia Senate Voting Record, SB 594 (Mar. 13, 1998).
31. *See* State of Georgia Final Composite Status Sheet, Mar. 19, 1998.
32. *See* 1998 Ga. Laws 900, at 905.
33. *Id.* at 900.
34. *See id.*
35. *See id.*
36. O.C.G.A. § 33-20B-1 (Supp. 1998).
37. *See id.* § 33-20B-2.
38. *Id.* § 33-20B-2(1).

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center for certain types of care;[39] rather, any listed provider which qualifies under the later provisions is an essential rural health care provider.[40]

Also key is the definition of "hospital," which requires that the facility "operate no more than 100 beds"; that it provide 24-hour emergency care and a "range of health care services"; and that it "derive[] at least [forty] percent of its patient revenues from medicare, Medicaid, or any combination of [the two]."[41] The Code section states that a "rural area" is "any county [with] a population of less than 35,000,"[42] and that a "rural health clinic" is "any [clinic] located in a rural area and which meets the [federal] definition of [that term]."[43]

The definition of "physician" was the only definition subjected to amendment during the enactment process.[44] As introduced, the bill stated that a "physician" is any person licensed to practice medicine under state law "who practices as a family physician, general internist, pediatrician, general practitioner, general surgeon, or obstetrician/gynecologist."[45] Because the term "physician" is not limited to those specialties in other provisions of state law and its limitation here could cause confusion, the phrase "for purpose of this section only" was added to the definition.[46]

Application

Code section 33-20B-3 first provides that any essential rural health care provider "shall have the opportunity to become a participating

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39. Other states have addressed the rural health care crisis in various ways. *See, e.g.*, FLA. STAT. ch. 395.602 (1997); KAN. STAT. ANN. § 65-468 (1996); MICH. COMP. LAWS § 333.21568 (1997). One approach is to authorize formation of vertically integrated health networks, comprised of rural primary care hospitals which affiliate with larger "essential access community hospitals." FLA. STAT. ch. 395.602 (1997); KAN. STAT. ANN. § 65-468 (1996); MICH. COMP. LAWS § 333.21568 (1997). The smaller facilities typically must meet certain requirements, such as facility size or geographic proximity to a metropolitan area, and must form cooperative agreements with the larger facilities for referral and treatment services. *See* FLA. STAT. ch. 395.602 (1997); KAN. STAT. ANN. § 65-468 (1996); MICH. COMP. LAWS § 333.21568 (1997).

40. *See* O.C.G.A. § 33-20B-2(1) (Supp. 1998).

41. *Id.* § 33-20B-2(6).

42. *Id.* § 33-20B-2(8).

43. *Id.* § 33-20B-2(9).

44. *See* Middleton Interview, *supra* note 17.

45. SB 594, as introduced, 1998 Ga. Gen. Assem.

46. *Compare* SB 594, as introduced, 1998 Ga. Gen. Assem. (defining "physician" as comprised only of specific specialties), *with* O.C.G.A. § 33-20B-2(7) (Supp. 1998) (including phrase "for purpose of this section only").

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provider" in a health care plan if the provider meets certain conditions.[47] Specifically, the provider must (1) participate in Medicare and Medicaid;[48] (2) implement a policy to provide care to indigent and charity patients;[49] (3) be licensed where required and be qualified to render plan services;[50] (4) agree either to the same payment terms as other similar providers or to mutually agreed upon terms for payment;[51] and (5) meet "reasonable and nondiscriminatory" standards established by the plan.[52] While "reasonable" and "nondiscriminatory" are not defined, the section does state that the standards and qualifications may not discriminate "on the basis of geographic proximity to other participating providers or corporate status."[53]

After setting out the qualifying conditions, the Code section requires that *all* providers who meet those conditions "shall be given the opportunity to apply to become a participating provider in a plan."[54] The Code section then sets out the health plans' obligations: the plans must consider rural providers' applications just as they would the applications of other providers, and they must negotiate in good faith with rural providers to determine whether the providers meet their standards.[55] Next, health plans must include "sufficient and reasonable numbers of physicians located in rural areas,"[56] so that rural patrons are not forced to travel outside the rural area to receive care.[57]

Finally, this Code section exempts health maintenance organizations (HMOs) from compliance with the Act if their current service areas were approved by the Commissioner of Human

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47. O.C.G.A. § 33-20B-3(a) (Supp. 1998).
48. *See id.* § 33-20B-3(a)(1).
49. *See id.* § 33-20B-3(a)(2).
50. *See id.* § 33-20B-3(a)(3).
51. *See id.* § 33-20B-3(a)(4)(A)-(B).
52. *Id.* § 33-20B-3(a)(5).
53. *Id.*
54. *Id.* § 33-20B-3(b).
55. *See id.*
56. *Id.* § 33-20B-3(c).
57. *See* Middleton Interview, *supra* note 17. In the Senate's version of the bill, this section also required that local physicians hold medical staff privileges at the local hospital. *See* SB 594, as introduced, 1998 Ga. Gen. Assem. However, the requirement raised certain quality and administrative concerns with HMOs and other health plans, and was deleted as a compromise. *See* Middleton Interview, *supra* note 17. Moreover, the local privilege provision remains in the definition of "physician," so that its inclusion here was redundant. *See* O.C.G.A. § 33-20B-2(7) (Supp. 1998).

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Resources or if the Commissioner of Insurance deems that they have complied with standards established by the Commissioner of Human Resources.[58] The Code section does state, however, that the Commissioner of Human Resources will consider how an HMO treats rural providers when considering the HMO's request to originate or expand its service into a rural area.[59]

Denial, Rejection, or Termination

Code section 33-20B-4 provides that if a health plan wishes to deny, reject, or terminate an essential rural provider, the plan must inform the provider in writing of its reasons for the adverse action and must, "[w]here possible," give the provider an opportunity to cure the deficiency.[60] If the provider believes the adverse action was taken in violation of this chapter, the provider has the right, under Code section 33-20B-5, to appeal the decision before the Commissioner of Insurance or the Commissioner's designee.[61] If, during the hearing or appeal, any proprietary or otherwise confidential materials are presented, that information will be sealed by the Commissioner and not subject to discovery under Georgia's open meetings laws.[62]

Administration

Code section 33-20B-6 provides that administration of this chapter shall be through the Commissioner of Insurance.[63]

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58. *See* O.C.G.A. § 33-20B-3(d) (Supp. 1998). This exemption is provided because HMOs are subject to regulation under a separate Georgia statute, and their actions with regard to all providers, both urban and rural, are subject to review under that statute; therefore, regulation under this Code section is unnecessary. *See* Middleton Interview, *supra* note 17; Snow Interview, *supra* note 11.

59. *See* O.C.G.A. § 33-20B-3(d) (Supp. 1998). HMOs are not yet a major health care presence in rural areas. *See* Hill Interview, *supra* note 24. The exemption acknowledges the lack of presence, but requires that as HMOs become more rurally active, they must remain aware of rural residents' needs for locally provided health care services. *See id.*

60. O.C.G.A. § 33-20B-4 (Supp. 1998).

61. *See id.* § 33-20B-5.

62. *See id.* The House, responding to constituents' concerns about disclosure of their proprietary information in these hearings, added this provision in the House substitute to SB 594, which the Senate subsequently passed. *Compare* SB 594, as introduced, 1998 Ga. Gen. Assem., *with* O.C.G.A. § 33-20B-5 (Supp. 1998).

63. *See* O.C.G.A. § 33-20B-6 (Supp. 1998).

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Hospital Authorities

Governing Bodies

Section 3 of the Act amends Article 4 of Chapter 7 of Title 31 of the Code, relating to the construction and regulation of hospital authorities.[64] Code section 31-7-72 provides that when a hospital authority was created by joint action of two or more counties, municipalities, or a combination of counties and municipalities, and one of the creating bodies is a rural county, the method of filling vacancies on the hospital authority may be changed only by a local act of the General Assembly and, once changed, will be governed by the local act.[65]

Home Health

Section 4 of the Act amends Article 4 of Chapter 7 of Title 31 by adding Code section 31-7-75.3, which provides that a hospital authority that owns a hospital qualified to provide home health services under the exemption provided in Code section 31-6-47 "shall be authorized to exercise such powers under this article."[66] This language relates to a section of the Act that was dropped during floor debate in the House; that section would have created an exemption to the CON process for rural hospitals that wanted to provide home health services.[67] Because the exemption was not included in the final bill, this remnant language has no effect.[68]

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64. *See id.* § 31-7-72.

65. *See id.* § 31-7-72(d). Representative Thomas Murphy, Speaker of the House, added this Code section to address circumstances at the hospital authority in his legislative district. *See* Interview with Allison Keitt Luke, Esq., Regulatory/Legislative Counsel, GHA: An Association of Hospitals and Health Systems (June 15, 1998) [hereinafter Luke Interview]; Snow Interview, *supra* note 11. Because the Code section also relates to the protection of rural health care interests and does not adversely affect other provisions of the bill, it was retained in the final version. *See* Middleton Interview, *supra* note 17; Snow Interview, *supra* note 11.

66. O.C.G.A. § 31-7-75.3 (Supp. 1998).

67. *See* Middleton Interview, *supra* note 17.

68. *See id.*; Luke Interview, *supra* note 65; Snow Interview, *supra* note 11. The Senate realized that after the certificate of need language was deleted in the House, these provisions had no effect; however, rather than delete the provisions and send the bill back to the House, a process which could unduly delay further consideration of the bill, the Senate let the language stand. *See* Record of Proceedings in the Senate (Mar. 11, 1998) (remarks by Sen. Thomas Price, Senate District No. 56) (available in Georgia State University College of Law Library); Luke Interview, *supra* note 65.

Conclusion

The Essential Rural Health Care Provider Access Act protects the interests of rural providers, health care plans, and rural Georgia residents. The Act supports rural health care by requiring that health care plans allow qualified essential rural health care providers to participate in their plans.[69] It safeguards health care plans by assuring that standards for health care delivery and payment are met.[70] Moreover, the Act protects rural citizens by assuring that their health care will be available locally, rather than in a regional center far from home.[71] Because it addresses all these concerns at such a critical time for rural providers, SB 594 "may be the most important bill passed this year."[72]

Sandra K. Herron

69. *See* O.C.G.A. § 33-20B-3 (Supp. 1998).
70. *See id.* § 33-20B-3(a)(5).
71. *See id.* § 33-20B-3(c).
72. Middleton Interview, *supra* note 17.

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