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INSURANCE Health Care Plans: Provide for Certification of Managed Health Care Plans; Mandate Disclosure of Information to Enrollees; Mandate a Grievance Procedure for Enrollees Denied a Claim; Bar Plans from Paying Physicians Who Give Less Than Appropriate Care or Penalizing Physicians Who Advocate Appropriate Care for Their Patients

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INSURANCE

Health Care Plans: Provide for Certification of Managed Health Care Plans; Mandate Disclosure of Information to Enrollees; Mandate a Grievance Procedure for Enrollees Denied a Claim; Bar Plans from Paying Physicians Who Give Less Than Appropriate Care or Penalizing Physicians Who Advocate Appropriate Care for Their Patients

CODE SECTIONS:	O.C.G.A. §§ 33-20A-1 to -10 (new), 33-21-1, -13 (amended), -18.1 (new)
BILL NUMBER:	HB 1338
ACT NUMBER:	751
GEORGIA LAWS:	1996 Ga. Laws 485
SUMMARY:	This Act is known as the Patient Protection Act of 1996. The Act encourages physicians to advocate appropriate care for their patients. Under the Act, a managed care plan must obtain a certificate from the Commissioner of Insurance before offering coverage to State residents, and the Commissioner may terminate the certificate for violations. Mandatory standards for certification include disclosure to enrollees and applicants of the precise nature of services and benefits available under the plan, copayments, any reviews of care that could result in denial of coverage, the names of physicians who accept the coverage, a grievance procedure for denied claims and a summary of the outcomes of grievance procedures, the availability of emergency services, whether the plan restricts the availability of prescription drugs (referred to as a formulary restriction), and access to additional information about the plan. The plan must provide reasonably prompt care twenty-four hours a day, must pay for emergency services and out-of-area services, and must establish a quality assurance (QA) program. The QA program must, among other things, stress health outcomes, have written protocols, provide review by physicians, and detect underutilization and overutilization. The plan may not use financial incentives that

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compensate a physician for providing less than appropriate care. Furthermore, a plan may not penalize a physician who discusses appropriate care with or on behalf of his patient. The plan must have procedures to safeguard patient privacy. The plan must provide, without prior authorization, for emergency services to stabilize a patient; the patient may not be transferred to another facility unless the treating physician certifies that the patient is stable.

EFFECTIVE DATE: July 1, 1996

History

Managed care is a health insurance scheme that operates according to an entirely different paradigm from traditional indemnity health insurance.[1] Indemnity insurance, or fee-for-service insurance, allows an insured to choose essentially any doctor or hospital and pays usual, customary, and reasonable claims.[2] Managed care provides for both payment and delivery of health services through contracts with selected doctors and hospitals (the panel), and attempts to lower fees charged by the panel.[3] The panel typically gives discounts to ensure a source of patients.[4]

Although managed care was prompted as a way to capture savings through reduced premiums for the insured, whether and to what extent cost savings have been achieved is still unclear.[5] Some studies have

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1. The Act defines 'managed care plan' as follows:

> [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:
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> (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.

O.C.G.A. § 33-20A-3(7) (Supp. 1996).

2. Sana Loue, *An Epidemiological Framework for the Formulation of Health Insurance*, 14 J. LEGAL MED. 523, 527 (1993).

3. The definition of "managed care plan" for purposes of the Act expressly includes cost savings. *See supra* note 1.

4. Michael A. Hiltzik & David R. Olmos, *A Mixed Diagnosis for HMOs. They Strongly Deny Rationing Care, But Times Study Finds They Withhold Some Services From Sicker Patients Solely Because of High Costs*, L.A. TIMES, Aug. 27, 1995, at 1.

5. Greg Scandlen, *Has Managed Care 'Won'?*, INVESTOR'S BUS. DAILY, July 26,

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shown that after an initial savings in premiums when the insured switches to managed care, the rise in premiums will often be equal to or greater than the rise in the premiums of comparable indemnity insurance.[6] Some of the problems for managed care companies have been caused by administrative costs.[7] Furthermore, the salary structure in managed care plans is allegedly unusually top heavy compared to other industries.[8] Some commentators have accused managed care plans of rationing medical care to achieve profits.[9]

Public concern over the possibility that managed care plans may be denying medically necessary care has been reflected in a few high-profile lawsuits. Recently in Georgia, for example, a court awarded a plaintiff $45 million from Kaiser Permanente.[10] In that case, a child sustained severe injuries because of a delay after Kaiser instructed the mother to take him to a panel hospital forty-two miles away rather than to the nearest hospital.[11] Similarly, a California court awarded a plaintiff with breast cancer $89 million ($12 million compensatory, $77 million punitive) from Health Net because of bad faith refusal to pay for a necessary bone-marrow transplant.[12] Another transplant denial case in California described in Time magazine, in which Health Net discouraged plan doctors from discussing a needed bone-marrow transplant with the patient,[13] so impassioned one Georgia legislator[14] that he brought in copies of the article and distributed them to fellow

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1995, at A2.

6. *Id.*

7. John Merline, *Pay or Pay: Managed Care Will Not Save Medicare, But A Dose of Reality Might*, NAT'L REV., May 29, 1995, at 45.

8. Martin Dyckman, *Comeuppance for HMOs Series*, ST. PETERSBURG TIMES, Jan. 2, 1996, at 13A.

9. Hiltzik & Olmos, *supra* note 4; *see also Statelines New York: Public Advocate's Report Blasts HMOs*, AM. POL. NETWORK, Jan. 5, 1996, at 5 (espousing even more negative indictment of New York HMOs).

10. Mark Silk, *$45 Million Malpractice Verdict Fulton County Jury Award Against HMO Largest Ever in State*, ATLANTA J. & CONST., Feb. 4, 1995, at C10.

11. *Id.*

12. *Punitive Damages Ordered in Case Against Health Net*, WALL ST. J., Dec. 30, 1993, at B5.

13. Erik Larson, *The Soul of an HMO: Managed Care is Certainly Bringing Down America's Medical Costs, But It is Also Raising the Question of Whether Patients, Especially Those With Severe Illnesses, Can Still Trust Their Doctors*, TIME, Jan. 22, 1996, at 44.

14. Telephone Interview with Rep. Bart Ladd, House District No. 59 (Apr. 8, 1996) [hereinafter Ladd Interview]. Representative Ladd introduced HB 1183, which became moot because its only two provisions—a physician anti-gag rule and a point-of-service option provision—became incorporated into HB 1338 and HB 1404, respectively. *Id.* He retained a keen interest in these bills during the session and stated that David Cook, Lobbyist, Medical Association of Georgia, "knew everything about HB 1338." *Id.*

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committee members.[15] Representative Ehrhart, a co-sponsor of HB 1338, considered physician gagging highly objectionable.[16]

Concern over these and other potential abuses of managed care have led several states to consider legislation to protect patients enrolled in managed care plans.[17] Some believe the Georgia Patient Protection Act of 1996 is the most extensive of any of these efforts.[18]

HB 1338

Before passage of the Act, the Commissioner of Insurance had regulatory powers over managed care plans.[19] The Act greatly expands the scope of this power.[20] Previously, the Commissioner could issue a certificate of authority[21] to a health care plan, allowing it to sell an insurance product, but the Commissioner was not empowered to withhold certificates for reasons that directly involved patient care.[22] For example, the Commissioner could authorize a certificate as long as the insurer would not create an "unnecessary duplication of similar services,"[23] the methods of solicitation appeared fair and reasonable,[24] and the method of establishing rates was fair.[25] The Commissioner could revoke a certificate if an insurer's financial condition was

15. *A Cure for Gagged Physicians*, ATLANTA J. & CONST., Jan. 25, 1996, at A12.

16. Telephone Interview with Rep. Earl Ehrhart, House District No. 36 (June 25, 1996) [hereinafter Ehrhart Interview].

17. Telephone Interview with David Cook, Lobbyist, Medical Association of Georgia (Apr. 8, 1996) [hereinafter Cook Interview I]. Mr. Cook was the principal author of HB 1338. *Id.* New Jersey, Oregon, and Texas are also considering patient-protection legislation and the American Medical Association has proposed model legislation. *Id.; see* ARK. CODE ANN. § 23-99-201 (Michie 1987 & Supp. 1995). *See generally* Milton Friedman, *A Way Out of Soviet-Style Health Care*, WALL ST. J., Apr. 17, 1996, at A20. Friedman quotes the description in Alexander Solzhenitsyn's, *The Cancer Ward*, of the elderly Russian physician who had worked both in private practice before 1918 and subsequently in the Soviet system. *Id.* The physician explained how under the "free" Soviet health system physicians were reduced to catching malingerers and frauds; the system made "doctor and patient as enemies." *Id.* Friedman points out that modern "health maintenance organizations and other forms of managed care" create a similar atmosphere of "depersonalized" care with "doctor and patient as enemies." *Id.*

18. Cook Interview I, *supra* note 17. Cook believes, for example, that none of the bills being considered by other states address formulary restrictions. *Id.*

19. 1976 Ga. Laws 1461, § 1, at 1476 (codified at O.C.G.A. § 33-20-9(a) (1992)).

20. *See* O.C.G.A. §§ 33-20A-1 to -10 (Supp. 1996).

21. *See* 1976 Ga. Laws 1461, § 1, at 1476-78 (codified at O.C.G.A. § 33-20-9(a) (1992)).

22. *See id.*

23. *Id.*

24. *Id.* (codified at O.C.G.A. § 33-20-9(a)(4) (1992)).

25. *Id.* (codified at O.C.G.A. § 33-20-9(a)(5) (1992)).

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unsound[26] or if an insurer compelled a claimant to accept less than the amount due.[27]

In contrast, the Act establishes detailed standards, many directly affecting patient care, that a managed care plan must meet and continue to meet, before the Commissioner issues a certificate or re-certifies the plan.[28] Beyond the certificate requirements, managed care plans "may not use a financial incentive program that directly compensates a health care provider for ordering . . . less than medically . . . appropriate care . . .";[29] may not prevent or discourage a physician from discussing medically appropriate care;[30] must pay for all emergency care until the patient is stabilized;[31] and must pay for medically necessary, non-formulary drugs.[32] Importantly, the Act mandates that the Commissioner apply sanctions, including termination of the certificate, for any violation.[33]

Physician Anti-Gag Rule

As introduced, HB 1338 contained an "anti-gag" rule.[34] The Senate Insurance and Labor Committee replaced this rule with very general language: "[n]o health care provider may be penalized for discussing medically necessary or appropriate health care with or on behalf of his or her patient."[35] The Committee settled on this language because, as the Committee revised the anti-gag rule as introduced, the rule became so convoluted that eventually no one could understand it.[36] Consequently, the Committee simplified and shortened the rule so that its meaning would be unmistakable.[37] Additionally, the preamble to the Act states that "it is the public policy of the State of Georgia that

26. *Id.* at 1479 (codified at O.C.G.A. § 33-20-11(3) (1992)).
27. *Id.* at 1480 (codified at O.C.G.A. § 33-20-11(4) (1992)).
28. O.C.G.A. §§ 33-20A-4, -5 (Supp. 1996)
29. *Id.* § 33-20A-6.
30. *Id.* § 33-20A-7.
31. *Id.* § 33-20A-9(1).
32. *Id.* § 33-20A-9(2).
33. *Id.* § 33-20A-4(c).
34. HB 1338, as introduced, 1996 Ga. Gen. Assem. The original version protected a physician who advocated for medically appropriate health care for his or her patient from being terminated from the plan; also, the plan could not "otherwise penalize" the physician. *Id.*
35. HB 1338 (SCS), 1996 Ga. Gen. Assem. Although Rep. Ehrhart would have preferred the "anti-gag" rule to specify exactly what a managed care plan could or could not do and exactly what a physician could or could not say, he is satisfied that the language of the Act solves the problem. *See* Ehrhart Interview, *supra* note 16.
36. Telephone Interview with David Cook, Lobbyist, Medical Association of Georgia (June 6, 1996) [hereinafter Cook Interview II]. Eventually, the rule grew to an entire legal size page. *Id.*
37. *Id.*

physicians and health care providers be encouraged to advocate for medically appropriate health care for their patients."[38] The broad language of the anti-gag rule and the preamble protects not only the physician who suggests an appropriate procedure to his or her own patient, for example, an oncologist who suggests a bone-marrow transplant to a patient with breast cancer, but also the physician who testifies as an expert on behalf of a patient who sues a managed care plan, for example, for failure to cover the cost of a recommended bone-marrow transplant.[39]

Some legislators believe the Act implies a private right of action for a physician who is penalized by a managed care plan for advocating on behalf of a patient.[40] The Act's language that "[n]othing in this Code section shall be construed as precluding other remedies at law,"[41] which appears in the section giving the Commissioner the power to terminate a managed care plan's certificate for violations of the Act, may be persuasive on this issue.[42]

Emergency Services

As introduced, HB 1338 merely defined emergency services[43] and mandated that a managed care plan provide for reimbursement for medically necessary emergency services not reasonably available through the plan.[44] The Senate Insurance and Labor Committee further refined the definition of emergency services[45] and restricted

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38. O.C.G.A. § 33-20A-2 (Supp. 1996).

39. *See* Cook Interview I, *supra* note 17. A physician whose very livelihood may depend upon maintaining an economic relationship with a managed care plan would have a strong disincentive to testify against the plan. *See* Friedman, *supra* note 17.

40. Representative Ladd believes that the Act implies a private right of action. *See* Ladd Interview, *supra* note 14. Representative Ehrhart said that though he did not deliberately seek to include a private right of action in the Act, he believes that the language of the Act probably does provide this right. Ehrhart Interview, *supra* note 16. Mr. Cook said that he purposely used this language to imply a private right of action. Cook Interview II, *supra* note 36.

Case law in Georgia is unsettled with respect to tests a court should use to imply a private right of action. In Adams v. City of Atlanta, 253 Ga. 581, 322 S.E.2d 730 (1984), the Georgia Supreme Court permitted a private right of action under a Georgia statute by following the four-part test announced in Cort v. Ash, 422 U.S. 66 (1975). When the Georgia Supreme Court revisited this issue, however, it cited neither *Adams* nor *Cort*. Davis v. Findley, 262 Ga. 612, 422 S.E.2d 859 (1992). The United States Supreme Court has itself questioned, though not overruled, *Cort*. *See* Thompson v. Thompson, 484 U.S. 174 (1988).

41. O.C.G.A. § 33-20A-4(c) (Supp. 1996).

42. *See id.*

43. HB 1338, as introduced, 1996 Ga. Gen. Assem.

44. *Id.*

45. HB 1338 (SCS), 1996 Ga. Gen. Assem.

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the ability of a managed care plan to have an emergency patient transferred from a non-plan hospital to a plan hospital.[46]

The definition of emergency services in HB 1338, as introduced, was similar to the language in the Act,[47] but limited emergency services to those performed in a hospital emergency room.[48] The broader language of the Act should include ambulance and other emergency transportation as well as emergency services rendered by a physician outside of an emergency room, such as in an urgent care facility or even a doctor's office.[49]

The Act addresses a concern that plans were encouraging premature transfers of emergency patients from non-plan hospitals to plan hospitals before the patients were medically transferable[50] The Act resolves this concern by requiring a managed care plan to reimburse for emergency services[51] and to disclose to enrollees "what constitutes an emergency situation and what constitutes emergency services."[52] Further, the Act requires managed care plans to include provisions allowing examination, emergency treatment, stabilization, and transfer of patients without prospective authorization from the plans.[53]

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46. *Id.*

47. O.C.G.A. § 33-20A-3(2) (Supp. 1996). The Act defines "emergency services" or "emergency care" as

> [T]hose 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.

Id.

48. *Compare* O.C.G.A. § 33-20A-3(2) (Supp. 1996) *with* HB 1338, as introduced, 1996 Ga. Gen. Assem.

49. *See* Cook Interview II, *supra* note 36. In drafting this section, Mr. Cook relied on emergency-room physicians to identify problems that patients enrolled in managed care plans encountered when seeking emergency services. *Id.*

50. Cook Interview I, *supra* note 17.

51. O.C.G.A. § 33-20A-5(2)(C) (Supp. 1996)

52. *Id.* § 33-20A-5(1)(A)(vii).

53. *See id.* § 33-20A-9(1). The Act states:

> 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. 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

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A related concern was that some HMOs were refusing to pay for emergency care rendered for conditions that retrospectively proved to be benign.[54] The Act addresses this concern by changing the standard for defining any emergency to that of the "prudent layperson."[55]

Formulary Restrictions

A standard approach to cost savings by managed care companies is the use of restricted drug formularies.[56] This approach involves limiting the physician's prescription medication choices to the cheapest effective agents within a drug class.[57] Though presumably designed to extract savings for the plan, restrictive formularies have subtle costs,[58] as well as the possibility for abuse.[59]

The Act takes a two-pronged approach to prevent abuse: (1) it forces disclosure of a restrictive formulary[60] and (2) it forces a procedure by

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> 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.

Id.

54. Telephone Interview with David Cook, Lobbyist, Medical Association of Georgia (Nov. 8, 1996). Suppose, for example, that a man develops chest pain, fears he is having a heart attack, and goes to an emergency room. Suppose further that after a medical evaluation, his chest pain proves to be the result of indigestion rather than a heart attack. Before the Act, a reviewer for a managed care plan could deem the emergency-room visit to be unnecessary and controvert the claim. *Id.* Under the Act, so long as "a prudent layperson, possessing an average knowledge of medicine and health," believes that his or her condition requires emergency care, the condition will meet the definition of "emergency." O.C.G.A. § 33-20A-3(2) (Supp. 1996).

55. O.C.G.A. § 33-20A-3(2) (Supp. 1996); *see supra* note 47.

56. R. Taniguchi, *Pharmacy Benefit Management Companies*, 52 AM. J. HEALTH SYS. PHARM. 1915 (1995).

57. Kevin J. Dunne & Ciara R. Ryan, *How Management of Medical Costs is Revolutionizing the Drug Industry: Managed Pharmaceutical Care and Verticle Integration of Drug Makers and PBMs Promise Benefits, But Also Harbor Lurking Liability*, 62 DEF. COUNS. J. 177, 178 (1995).

58. Ron Winslow, *Limiting Drugs a Doctor Orders May Cost More*, WALL ST. J., Mar. 20, 1996, at B1. Winslow reviewed a recent study of six HMOs that concluded that

> in the HMO with the strictest formulary, patients got more prescriptions, had more visits to the doctor, more emergency-room care and higher hospital use than patients in the HMO that didn't use a formulary.
>
> Similarly, use of generic drugs was linked with higher overall use of prescriptions, as well as more office visits for patients being treated for high blood pressure, ear infections and arthritis. High generic-drug use among ulcer patients was associated with more hospital admissions.

Id.

59. *AMA House Scrutinizes Managed Care Prescription Policies, Decries Payments to Pharmacists for Switches*, 52 AM. J. HEALTH SYS. PHARM. 1967 (1995).

60. O.C.G.A. § 33-20A-5(1)(A)(ix) (Supp. 1996). Representative Ehrhart strongly supported the mandatory disclosure provisions of the Act. *See* Ehrhart Interview

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which a patient can obtain a necessary, non-formulary drug.[61] The disclosure prong mandates not only disclosure of the existence of the formulary, but also that enrollees and even prospective enrollees of the plan must be provided "a description of specific drug and therapeutic class restrictions."[62] The procedure prong is uncomplicated.[63] The language does not specify that the physician must certify the ineffectiveness of the formulary drug or the adverse reaction; presumably the patient need only make the certification in good faith.[64]

Quality Assurance Program

The Act requires a managed care plan to have a Quality Assurance (QA) program in place and disclose the program to all enrollees and prospective enrollees.[65] The QA program must contain specific requirements designed to ensure quality care to patients and must review utilization in a way that "stresses health outcomes,"[66] provides

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supra, note 16. "What does an HMO have to hide?" *Id.* Representative Ehrhart wanted to guarantee that anyone purchasing a managed care plan would know exactly what he or she was getting. *Id.*

61. O.C.G.A. § 33-20A-9(2) (Supp. 1996).

62. *Id.* § 33-20A-5(1)(A)(ix).

63. O.C.G.A. § 33-20A-9(2) outlines the procedure for obtaining non-formulary drugs:

> 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.

Id. § 33-20A-9(2).

64. *See* Cook Interview II, *supra* note 36. Cook learned from other lobbyists of the study that showed that restricted formularies have unintended consequences. *See* Winslow, *supra* note 56. Additionally, a Senator told Cook of personal problems the Senator experienced when dealing with a restricted formulary. *See* Cook Interview II, *supra* note 36. Cook, therefore, included these provisions in the Act as a further effort to protect patients from the known problems of restricted formularies. *Id.*

65. O.C.G.A. § 33-20A-5(1)(A)(vi), (3) (Supp. 1996); *see* Cook Interview II, *supra* note 36. The Medical Association of Georgia received many complaints from physicians about managed care plans preventing physicians from delivering necessary care to patients. Cook Interview II, *supra* note 36. The quality assurance program, and in particular, the provision to detect underutilization, was designed to collect information about this problem. *Id.; see also* Ehrhart Interview, *supra* note 16. Representative Ehrhart received many similar constituent complaints. *Id.* Ehrhart pointed out that the American Medical Association's model act contained a quality assurance program. *Id.*

66. O.C.G.A. § 33-20A-5(3)(B)(i)(I) (Supp. 1996).

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review by physicians,[67] and "has mechanisms to detect both underutilization and overutilization of services."[68]

The QA program must also establish and disclose a grievance procedure that "provides the enrollee with a prompt and meaningful hearing on the issue of denial, in whole or in part, of a health care treatment or service or claim therefor."[69] The grievance procedure must meet detailed due process requirements.[70] Furthermore, the plan must disclose the outcome of all grievances filed in the previous three years.[71]

Disclosure Provisions

In addition to the disclosure provisions already mentioned, managed care plans face substantial disclosure requirements to enrollees and prospective enrollees in order to obtain a certificate from the Commissioner.[72] The disclosure requirements extend to individuals who request information and not merely to the individual's employer who may be paying the premiums.[73]

The Act requires disclosure of services offered and limitations on services,[74] "copayments [and] prior authorization . . . that could result in the patient's being denied coverage,"[75] and potential liability for medical services obtained outside of the managed care plan.[76] Additionally, the plan must, upon request, provide a list of physicians and hospitals participating in the plan and disclose any limitation on available choices.[77] The Act requires disclosure of limited utilization incentive plans[78] and "[a] statement as to where and in what manner additional information is available."[79]

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67. *Id.* § 33-20A-5(3)(B)(i)(III).
68. *Id.* § 33-20A-5(3)(B)(i)(VI).
69. *Id.* § 33-20A-5(3)(B)(ii).
70. *Id.*
71. *Id.* § 33-20A-5(1)(A)(xii); *see* Cook Interview II, *supra* note 36. Cook said that grievance procedures were common in the various state patient-protection acts that he examined. Cook Interview II, *supra* note 36. He borrowed some of the best provisions from each of these acts in drafting HB 1338. *Id.*
72. O.C.G.A. § 33-20A-5 (Supp. 1996).
73. *Id.* § 33-20A-5(1); *see* Ehrhart Interview, *supra* note 16. The disclosure provisions are in the Act as another protection for patients enrolled in managed care. *See also* Cook Interview II, *supra* note 36 (agreeing with Ehrhart).
74. O.C.G.A. § 33-20A-5(1)(A)(i) (Supp. 1996).
75. *Id.* § 33-20A-5(1)(A)(ii).
76. *Id.* § 33-20A-5(1)(A)(iii)-(iv).
77. *Id.* § 33-20A-5(1)(A)(v), (x).
78. *Id.* § 33-20A-5(1)(A)(viii).
79. *Id.* § 33-20A-5(1)(A)(xi).

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Physician Incentives

A managed care plan may not use financial incentives to induce a physician to provide less than appropriate care.[80] This is another provision designed to counteract the allegedly core problem of managed care: the denial of coverage or treatment for medically necessary care.[81] This provision addresses concerns over the doctors', rather than the plans', incentives to underutilize services.[82] However, the Act does not prohibit capitation schemes.[83]

Miscellaneous Provisions

The Act requires a managed care plan to safeguard the privacy of patient information.[84] Each managed care plan must also maintain accurate and timely records for its patients.[85]

Glenn L. Goodhart

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80. O.C.G.A. § 33-20A-6 (Supp. 1996); *see* Cook Interview II, *supra* note 36. Cook was concerned that patients were unaware that managed care plans have given physicians financial incentives to reduce care given to patients. Cook Interview II, *supra* note 36.

81. *See* Cook Interview II, *supra* note 36.

82. *See* O.C.G.A. § 33-20A-6 (Supp. 1996).

83. *Id.; see* Cook Interview II, *supra* note 36; *see also* Douglas G. Cave, *Capitated Chronic Disease Management Programs: A New Market for Pharmaceutical Companies*, 11 BENEFITS Q. 6 (1995). A "capitation scheme" is one in which a physician is periodically reimbursed a flat fee per patient regardless of the amount and cost of care given to the patient. Cave, *supra* at 6-7. Any particular capitation scheme may cap some or all of these costs with the level of reimbursement varying per patient. *Id.*

84. O.C.G.A. § 33-20A-8 (Supp. 1996); *see* Cook Interview II, *supra* note 36. Cook was alert to increasing public concern about privacy in general and privacy of medical records specifically. Cook Interview II, *supra* note 36. He believed that this provision would resonate with managed care plans and physicians. *Id.*

85. O.C.G.A. § 30-20A-8 (Supp. 1996).

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