Senate Bill 277

By: Senator Williams of the 27th

A BILL TO BE ENTITLED

AN ACT

1 To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to
2 establish standards for carriers and health care providers with regard to payment under a
3 managed care plan in the provision of emergency medical care; to provide for applicability;
4 to provide for definitions; to provide for requirements regarding the provision of emergency
5 medical care for covered persons under a managed care plan; to provide for requirements for
6 managed care plan contracts between carriers and covered persons; to provide for payments
7 to providers; to provide for penalties for violations; to provide for a short title; to provide for
8 related matters; to repeal conflicting laws; and for other purposes.

9 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

10 **SECTION 1.**

11 This Act shall be known and may be referred to as the "Consumer Coverage for Emergency
12 Medical Care Act."

13 **SECTION 2.**

14 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
15 adding a new chapter to read as follows:

16 "CHAPTER 20E

17 33-20E-1.

18 This chapter shall apply to all carriers providing a managed care plan that pays for the
19 provision of emergency medical care to covered persons. This chapter shall only apply to
20 emergency medical care.

21 33-20E-2.

22 As used in this chapter, the term:

23 (1) 'Balance bill' means the amount that a nonparticipating provider may charge a
24 covered person. Such amount charged shall equal the difference between the amount
25 paid by the carrier and the amount of the nonparticipating provider's bill charge but shall
26 not include any amount for coinsurance, copayment, or deductibles due from the covered
27 person.
28 (2) 'Carrier' means an accident and sickness insurer, fraternal benefit society, hospital
29 service corporation, medical service corporation, health care corporation, health
30 maintenance organization, provider sponsored health care corporation, or any similar
31 entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of
32 the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001,
33 et seq., which entity provides for the financing or delivery of emergency medical care
34 through an emergency medical services system or through a health benefit plan, or the
35 plan administrator of any health benefit plan established pursuant to Article 1 of Chapter
36 18 of Title 45.
37 (3) 'Covered person' means an individual who is covered under a managed care plan.
38 (4) 'Emergency condition' means any medical condition of a recent onset and severity,
39 including but not limited to severe pain that would lead a prudent layperson, possessing
40 an average knowledge of medicine and health, to believe that his or her condition,
41 sickness, or injury is of such a nature that failure to obtain immediate medical care could
42 result in:
43 (A) Placing the patient's health in serious jeopardy;
44 (B) Serious impairment to bodily functions; or
45 (C) Serious dysfunction of any bodily organ or part.
46 (5) 'Emergency medical care' means emergency services provided after the onset of a
47 medical or traumatic condition manifesting itself by acute symptoms of sufficient
48 severity, including severe pain, such that the absence of immediate medical or surgical
49 attention could reasonably be expected to result in placing the patient's health in serious
50 jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily
51 organ or part and for services for the first 24 hours after the covered person's emergency
52 condition has stabilized, whether or not the emergency services and services after
53 stabilization occur in an emergency department.
54 (6) 'Emergency medical provider' means any physician licensed by the Georgia
55 Composite Medical Board who provides emergency medical care and any other health
56 care provider licensed in this state who renders emergency medical care.
57 (7) 'First dollar coverage' means payment by a carrier directly to a health care provider
58 for services of the entire allowed amount for such services pursuant to Code Section

59 33-20E-3 without any reduction in payment for the managed care plan's required
60 deductibles, coinsurances, copays, or other patient financial responsibility.
61 (8) 'Health care provider' means any physician or other person who is licensed or
62 otherwise authorized in this state to furnish emergency medical care.
63 (9) 'Managed care plan' means a major medical, hospitalization, or dental plan that
64 provides for the financing and delivery of health care services to persons enrolled in such
65 plan through:
66 (A) Arrangements with selected providers to furnish health care services;
67 (B) Explicit standards for the selection of participating providers; and
68 (C) Cost savings for persons enrolled in the plan to use the participating providers and
69 procedures provided for by the plan;
70 The term 'managed care plan' shall not apply to Chapter 9 of Title 34, relating to workers'
71 compensation.
72 (10) 'Nonparticipating provider' means a health care provider who has not entered into
73 a direct contract with a carrier for the delivery of emergency medical care to covered
74 persons under a managed care plan.
75 (11) 'Participating provider' means a health care provider who has entered into a direct
76 contract with a carrier for the delivery of emergency medical care to covered persons
77 under a managed care plan.
78 (12) 'Stabilized' means the effect of providing medical or surgical treatment of an
79 emergency condition as may be necessary to assure, within reasonable medical
80 probability, that no material deterioration of the condition is likely to result from or occur
81 during the transfer of the individual from a facility, or that with respect to a pregnant
82 woman who is having contractions, the woman has delivered the child and the placenta.

83 33-20E-3.
84 (a) Notwithstanding any provision of law to the contrary, a carrier that provides any
85 benefits to covered persons with respect to emergency medical care shall pay for such
86 emergency medical care:
87 (1) Without the need for any prior authorization determination;
88 (2) Regardless of whether the health care provider furnishing such emergency medical
89 care is a participating provider with respect to emergency medical care; and
90 (3) Furnished by a nonparticipating provider.
91 (b) In the event a covered person receives emergency medical care by a nonparticipating
92 provider, the nonparticipating provider may bill the carrier directly and the carrier shall
93 directly pay the nonparticipating provider as coded, with first dollar coverage, for the

94 emergency medical care rendered to the covered person at the lesser of the following
95 amounts:
96 (1) The nonparticipating provider's actual charges; or
97 (2) The eightieth percentile of all charges for the same particular emergency medical
98 care, in similar facilities, in the same geographic location, as reported by an independent
99 benchmarking data base of actual charges not affiliated with any carrier or health care
100 provider. The charges shall be tied to 2016 charges and may be adjusted for inflation
101 according to the Consumer Price Index or another indicator, as determined by the
102 department.
103 The carrier may collect any required deductibles, coinsurances, copays, or other patient
104 financial responsibility directly from the covered person pursuant to the provisions of the
105 managed care plan contract.
106 (c) A managed care plan shall not deny benefits for emergency medical care previously
107 rendered, based upon a covered person's failure to provide subsequent notification in
108 accordance with plan provisions, where the covered person's medical condition prevented
109 timely notification.
110 (d) In the event a covered person receives emergency medical care by a nonparticipating
111 provider, once such covered person is stabilized, as required by the federal Emergency
112 Medical Treatment and Active Labor Act, the carrier shall arrange transfer of the covered
113 person to a participating provider at the carrier's cost. If the carrier fails to transfer such
114 covered person within 24 hours after the covered person is stabilized, the carrier shall pay
115 the entirety of the nonparticipating provider's charges for the care of the covered person
116 thereafter in accordance with the payment criteria in subsection (b) of this Code section.

117 33-20E-4.
118 No managed care plan shall deny or restrict in-network covered benefits to a covered
119 person solely because the covered person obtained treatment outside the network. Notice
120 of such protection shall be provided in writing to the covered person by the carrier.

121 33-20E-5.
122 (a)(1) A managed care plan contract issued, amended, or renewed on or after July 1,
123 2017, shall provide that if a covered person receives emergency medical care from a
124 nonparticipating provider at an in-network facility, such covered person shall not be
125 required to pay more to the carrier than the same cost sharing that the covered person
126 would have to pay to the carrier for the same emergency medical care received from a
127 participating provider. Such amount shall be referred to as the 'in-network cost-sharing
128 amount.'

129 (2) A nonparticipating provider shall not balance bill or collect any amount from a
130 covered person for emergency medical care subject to paragraph (1) of this subsection.
131 (b)(1) A managed care plan contract issued, amended, or renewed on or after July 1,
132 2017, which provides coverage for out-of-network services shall provide that, if a
133 covered person receives emergency medical care at an out-of-network facility by a
134 nonparticipating provider, such covered person shall pay no more than the same cost
135 sharing that the covered person would have to pay for the out-of-network benefits under
136 the managed care plan. Such amount shall be referred to as the 'out-of-network
137 cost-sharing amount.'
138 (2) A nonparticipating provider shall not balance bill or collect any amount from a
139 covered person for emergency medical care subject to paragraph (1) of this subsection.
140 (c) A managed care plan contract issued, amended, or renewed on or after July 1, 2017,
141 shall provide that, if a covered person receives emergency medical care from a
142 nonparticipating provider, any cost-sharing amount attributable to an out-of-network
143 deductible shall be applied to such covered person's in-network deductible.

144 33-20E-6.
145 (a) A violation of this chapter by a carrier shall be considered an unfair trade practice
146 under Article 1 of Chapter 6 of this title and shall be subject to penalties as determined by
147 the department.
148 (b) This Code section shall not apply to any health care provider or emergency medical
149 provider.″

150 **SECTION 3.**

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