The Senate Committee on Insurance and Labor offered the following substitute to SB 56:

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 insurers and health care providers with regard to payment under a
3 health benefit plan in the provision of emergency medical services; to provide for
4 applicability; to provide for definitions; to provide for certain patient or prospective patient
5 disclosures; to provide for insurer disclosures; to provide for requirements regarding the
6 provision of emergency medical services for covered persons under a health benefit plan; to
7 provide for requirements for health benefit plan contracts between insurers and covered
8 persons; to provide for payments to providers; to provide for penalties for violations; to
9 provide for mediation; to provide for related matters; to provide for a short title; to repeal
10 conflicting laws; and for other purposes.

11 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

12 **SECTION 1.**

13 This Act shall be known and may be cited as the "Consumer Coverage and Protection for
14 Out-of-Network Medical Care Act."

15 **SECTION 2.**

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

18 "CHAPTER 20E

19 33-20E-1.

20 This chapter shall apply to all insurers providing a health benefit plan that pays for the
21 provision of medical services to covered persons.

22 33-20E-2.
23 As used in this chapter, the term:
24 (1) 'Balance bill' means the amount that a nonparticipating provider may charge a
25 covered person. Such amount charged shall equal the difference between the amount
26 paid by the insurer and the amount of the nonparticipating provider's bill charge but shall
27 not include any amount for coinsurance, copayments, or deductibles due from the covered
28 person.
29 (2) 'Covered person' means an individual who is covered under a health benefit plan.
30 (3) 'Emergency medical provider' means any physician licensed by the Georgia
31 Composite Medical Board who provides emergency medical services and any other
32 health care provider licensed in this state who renders emergency medical services.
33 (4) 'Emergency medical services' means medical services after the recent onset of a
34 medical or traumatic condition manifesting itself by acute symptoms of sufficient
35 severity, including, but not limited to, severe pain, that would lead a prudent layperson
36 possessing an average knowledge of medicine and health to believe that his or her
37 condition, sickness, or injury is of such a nature that failure to obtain immediate medical
38 care could result in placing the patient's health in serious jeopardy, serious impairment
39 to bodily functions, or serious dysfunction of any bodily organ or part, and services for
40 the first 24 hours after the covered person's emergency condition has stabilized, as
41 determined by the treating health care provider, whether or not the emergency services
42 and services after stabilization occur in an emergency department. Such term shall
43 include care for an emergency condition that continues once a patient is admitted to the
44 hospital from the hospital emergency department and could include other specialists and
45 providers.
46 (5) 'First dollar coverage' means payment by an insurer directly to a health care provider
47 for services of the entire allowed amount for such services pursuant to Code
48 Section 33-20E-3 without any reduction in payment for the health benefit plan's required
49 coinsurance, copayments, deductibles, or other patient financial responsibility. The
50 insurer shall be responsible for collecting these amounts directly from the covered person.
51 (6) 'Gould Factors' means the following factors:
52 (A) The provider's training, qualifications, and length of time in practice;
53 (B) The nature of the services provided;
54 (C) The fees usually charged by the provider;
55 (D) Prevailing provider rates charged in the general geographic area in which the
56 services were rendered;
57 (E) Other aspects of the economics of the medical provider's practice that are relevant;
58 and

59 (F) Any unusual circumstances in the case.
60 (7) 'Health benefit plan' means a policy, contract, certificate, or agreement entered into,
61 offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse
62 any of the costs of health care services, but shall not apply to Chapter 9 of Title 34,
63 relating to workers' compensation.
64 (8) 'Health care provider' or 'provider' means any physician or other individual who is
65 licensed or otherwise authorized in this state to furnish emergency medical services.
66 (9) 'Insurer' means an entity subject to the insurance laws and regulations of this state,
67 or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or
68 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the
69 costs of health care services, including an accident and sickness insurance company, a
70 health maintenance organization, a health care plan, managed care plan, or any other
71 entity providing a health insurance plan, a health benefit plan, or health care services.
72 (10) 'Medical services' means the examination or treatment of persons for the prevention
73 of illness or the correction or treatment of any physical or mental condition resulting from
74 illness, injury, or other human physical problem and includes, but is not limited to:
75 (A) Hospital services which include the general and usual care, services, supplies, and
76 equipment furnished by hospitals;
77 (B) Medical services which include the general and usual care and services rendered
78 and administered by doctors of medicine, doctors of dental surgery, and doctors of
79 podiatry; and
80 (C) Other medical services which include appliances and supplies, nursing care by a
81 registered nurse; institutional services, including the general and usual care, services,
82 supplies, and equipment furnished by health care institutions and agencies or entities
83 other than hospitals; physiotherapy; ambulance services; drugs and medications;
84 therapeutic services and equipment, including oxygen and the rental of oxygen
85 equipment; hospital beds; iron lungs; orthopedic services and appliances, including
86 wheelchairs, trusses, braces, crutches, and prosthetic devices, including artificial limbs
87 and eyes, and any other appliance, supply, or service related to health care.
88 (11) 'Minimum benefit standard' or 'MBS' means the usual and customary rate defined
89 as the 95th percentile of allowable benefits and the 80th percentile of charges averaged
90 together for a particular medical service performed by a health care provider in the same
91 or similar specialty and provided in the same geographic area. Both percentile of
92 allowable benefits and the percentile of charges shall be reported in a benchmarking data
93 base maintained by a nonprofit organization specified by the commissioner. The rate
94 shall be tied to 2018 rates and may be adjusted for inflation according to the Consumer
95 Price Index for medical care or another indicator as determined by the department

96 pursuant to rules and regulations promulgated by the Commissioner. The nonprofit
97 organization shall not be affiliated with or receive funding from a health insurance
98 company and shall be accessible to providers without charge.
99 (12) 'Nonparticipating provider' means a health care provider who has not entered into
100 a direct contract with a health benefit plan for the delivery of medical services.
101 (13) 'Participating provider' means a health care provider who has entered into a direct
102 contract with an insurer for the delivery of medical services to covered persons under a
103 health benefit plan.
104 (14) 'Stabilized' means the effect of providing medical or surgical treatment for an
105 emergency condition as may be necessary to assure, within reasonable medical
106 probability, that no material deterioration of the condition is likely to result from or occur
107 during the transfer of the patient from a facility, or that with respect to a pregnant woman
108 who is having contractions, the woman has delivered the child and the placenta.
109 (15) 'Surprise bill' means a bill to a patient after medical services, not including
110 emergency medical services, where an unanticipated event results in the provision of
111 services by a nonparticipating provider.
112 (16) 'Usual and customary cost' means the charges routinely billed by the provider for
113 his or her professional services regardless of the payor involved and before any discounts
114 are applied pursuant to charity or financial assistance policies or insurer contracting
115 discounts.

116 33-20E-3.
117 (a) A health care provider who is a physician shall provide a patient or prospective patient
118 with the name or practice name, mailing address, and telephone number of any health care
119 provider that the office or surgery center utilizes for the provision of anesthesiology,
120 laboratory, pathology, radiology, or assistant surgeon services in connection with care to
121 be provided in the physician's office or an ambulatory surgery center owned by the
122 physician for the patient at least 48 hours prior to the provision of services where possible.
123 Such information may be provided by publication on the provider's website.
124 (b) Where an unanticipated event causes a change in the providers of radiology,
125 anesthesiology, pathology, or other services, the physician shall be held harmless for any
126 resulting bills from such provider or providers.
127 (c) A hospital shall establish, update, and make public through posting on the hospital's
128 website, to the extent required by federal guidelines, a list of the hospital's standard charges
129 for items and services provided by the hospital, including for diagnosis related groups
130 established under Section 1886(d)(4) of the federal Social Security Act.
131 (d) A hospital shall post on the hospital's website:

132 (1) The health benefit plans with which the hospital has an executed provider agreement;
133 (2) A statement that physician services provided in the hospital may not be included in
134 the hospital's charges, that physicians who provide services in the hospital may or may
135 not participate with the same health benefit plans as the hospital, and that the prospective
136 patient should check with the physician arranging for the hospital services to determine
137 the health benefit plans in which the physician participates; and
138 (3) As applicable, the name, mailing address, and telephone number of the physician
139 groups with which the hospital has contracted to provide services, including
140 anesthesiology, pathology, and radiology, and instructions on how to contact these groups
141 to determine the health benefit plan participation of the physicians in such groups.
142 (e) In registration or admission materials provided in advance of medical services, not
143 including emergency medical services, a hospital shall:
144 (1) Advise the patient or prospective patient to check with the physician arranging the
145 hospital services to determine:
146 (A) The name or practice name, mailing address, and telephone number of any other
147 physician whose services will be arranged for by the physician; and
148 (B) Whether the services of physicians who are employed or contracted by the hospital
149 to provide services, including anesthesiology, pathology, and radiology, are reasonably
150 anticipated to be provided to the patient; and
151 (2) Provide patients or prospective patients with information on how to timely determine
152 the health benefit plans in which the physicians participate who are reasonably
153 anticipated to provide services to the patient at the hospital, as determined by the
154 physician arranging the patient's hospital services, and who are employees of the hospital
155 or contracted by the hospital to provide services, including anesthesiology, pathology,
156 and radiology.
157 (f) Unknown or unanticipated services are not subject to the requirements of this Code
158 section.

159 33-20E-4.
160 (a) An insurer shall provide to a covered person:
161 (1) Information that a covered person may obtain a referral to a health care provider
162 outside of the insurer's network or panel when the insurer does not have a health care
163 provider who is geographically accessible to the covered person and who has appropriate
164 training and experience in the network or panel to meet the particular health care needs
165 of the covered person and the procedure by which the covered person can obtain such
166 referral;

167 (2) Notice that the covered person shall have direct access to primary and preventive
168 obstetric and gynecologic services, including annual examinations, care resulting from
169 such annual examinations, and treatment of acute gynecologic conditions, or for any care
170 related to a pregnancy, from a qualified provider of such services of her choice from
171 within the plan;
172 (3) All appropriate mailing addresses and telephone numbers to be utilized by covered
173 persons seeking information or authorization;
174 (4) An accurate provider directory as required by Chapter 20C of this title;
175 (5) Where applicable, a description of the method by which a covered person may submit
176 a claim for health care services;
177 (6) With respect to out-of-network coverage:
178 (A) A clear description of the methodology used by the insurer to determine
179 reimbursement for out-of-network health care services;
180 (B) The amount that the insurer will reimburse under the methodology for
181 out-of-network health care services set forth as a percentage of the usual and customary
182 cost for out-of-network health care services;
183 (C) Examples of anticipated out-of-pocket costs for frequently billed out-of-network
184 health care services; and
185 (D) Notice that the patient may be responsible for the balance of the nonparticipating
186 provider's fee if the rate paid by the plan is below the provider's usual and customary
187 amount;
188 (7) Information in writing and through an Internet website that reasonably permits a
189 covered person or prospective covered person to estimate the anticipated out-of-pocket
190 costs for out-of-network health care services in a geographical area or ZIP Code based
191 upon the difference between the amount that the insurer will reimburse for
192 out-of-network health care services, the patient's MBS, and the usual and customary cost
193 for out-of-network health care services;
194 (8) The written application procedures and minimum qualification requirements for
195 health care providers to be considered by the insurer; and
196 (9) Other information as required by the Commissioner.
197 (b) An insurer shall furnish an explanation of benefits to a nonparticipating provider within
198 30 days of receiving a bill from the covered person or directly from the nonparticipating
199 provider. The explanation of benefits shall conspicuously indicate whether the health
200 benefit plan coverage for the patient is subject to the requirements of this chapter, or
201 otherwise preempted under 29 U.S.C. Section 1144(a) as a self-funded employee welfare
202 plan regulated under the federal Employee Retirement Income Security Act of 1974, 29
203 U.S.C. Section 1002(1).

204 (c) An insurer shall disclose whether a health care provider scheduled to provide a health
205 care service is a participating provider and, with respect to coverage of nonparticipating
206 provider services, disclose the approximate dollar amount that the insurer will pay for a
207 specific health care service from a nonparticipating provider. Insurers shall also inform a
208 covered person through such disclosure that such approximation shall not be binding on
209 the insurer and that the approximate dollar amount that the insurer shall pay for a specific
210 health care service from a nonparticipating provider may change.
211 (d) Where services have been precertified or preauthorized by an insurer, the insurer shall
212 guarantee coverage of such services at the rates payed to a participating provider regardless
213 of any changes of network status following the precertification or preauthorization.
214 (e) Where an insurer fails to adequately and correctly keep its directory pursuant to Code
215 Section 33-20C-2 and such failure results in the unanticipated provision of out-of-network
216 services, the insurer shall compensate the provider at the provider's usual and customary
217 cost or MBS, whichever is less.
218 (f) Where a delay in the credentialing of a provider causes the service to be deemed
219 out-of-network, the insurer shall compensate the provider at the provider's full rate at no
220 expense to the patient.

221 33-20E-5.
222 (a) Notwithstanding any provision of law to the contrary, an insurer that provides any
223 benefits to covered persons with respect to emergency medical services shall pay for such
224 emergency medical services:
225 (1) Without the need for any prior authorization determination and without any
226 retrospective payment denial for services rendered; and
227 (2) Regardless of whether the health care provider furnishing emergency medical
228 services is a participating provider with respect to emergency medical services.
229 (b) In the event a covered person receives emergency medical services by a
230 nonparticipating provider or hospital, the nonparticipating provider or hospital shall bill the
231 insurer directly and the insurer shall directly pay, within 15 days for electronic claims and
232 30 days for paper claims, the nonparticipating provider or hospital as coded, with first
233 dollar coverage, for the emergency medical services rendered to the covered person by the
234 lesser of:
235 (1) The nonparticipating provider or hospital's actual billed charges; or
236 (2) In the case of a health care provider, the minimum benefit standard.
237 Payment shall be made without retrospective denials and without deductions for the
238 covered person's coinsurance, copayments, and deductibles. The insurer shall collect any
239 required coinsurance, copayments, deductibles, or other patient financial responsibilities

240 directly from the covered person pursuant to the provisions of the health benefit plan
241 contract. Patient responsibility is limited to the in-network payment as required under the
242 managed care plan contract.
243 (c) A health benefit plan shall not deny benefits for emergency medical services previously
244 rendered, based upon a covered person's failure to provide subsequent notification in
245 accordance with plan provisions, where the covered person's medical condition prevented
246 timely notification.
247 (d) In the event a covered person receives emergency medical services by a
248 nonparticipating provider, once such covered person is stabilized, as determined by the
249 attending physician, the insurer may arrange for transfer of the covered person to a
250 participating provider at the insurer's cost. If the insurer fails to transfer such covered
251 person within 24 hours after the insurer receives notice that the covered person is
252 stabilized, the insurer shall pay the entirety of the nonparticipating provider's charges for
253 the care of the covered person thereafter in accordance with the payment criteria provided
254 in subsection (b) of this Code section.
255 (e) Insurers shall not communicate or include in written form false, misleading, or
256 confusing information in their explanation of benefits to patients or guarantors regarding
257 usual and customary costs, balance billing, or mediation disputes between physicians and
258 insurers.
259 (f) For purposes of the covered person's financial responsibilities, the health benefit plan
260 shall treat the health care services the covered person receives from a nonparticipating
261 provider pursuant to this Code section as if the services were provided by a participating
262 provider, including counting the covered person's cost sharing for such services toward the
263 covered person's deductible and maximum out-of-pocket limit applicable to services
264 obtained from participating providers under the health benefit plan.

265 33-20E-6.
266 No health benefit plan shall deny or restrict covered benefits from a participating provider
267 to a covered person solely because the covered person obtained treatment from a
268 nonparticipating provider. Notice of such protection shall be provided in writing to the
269 covered person by the insurer.

270 33-20E-7.
271 (a)(1) A health benefit plan contract issued, amended, or renewed on or after July 1,
272 2019, shall provide that if a covered person receives emergency medical services from
273 a nonparticipating provider, such covered person shall not be required to pay more to the
274 insurer than the same amount that the covered person would have to pay to the insurer for

275 the same emergency medical services received from a similar participating provider at
276 a similar in-network facility. Such amount shall be referred to as the 'in-network
277 cost-sharing amount.'
278 (2) Neither a nonparticipating provider nor a participating provider shall bill or collect
279 any amount from the covered person for emergency medical services subject to
280 paragraph (1) of this subsection. Coinsurance, copayments, and deductibles shall be
281 collected by the insurer, and first dollar coverage shall be paid by the insurer directly to
282 the provider in a timely manner, as coded and billed, and without retrospective denials.
283 (b) A health benefit plan contract issued, amended, or renewed on or after July 1, 2019,
284 shall provide that, if a covered person receives emergency medical services from a
285 nonparticipating provider, any cost-sharing amount attributable to an out-of-network
286 deductible shall be applied to such covered person's in-network deductible.

287 33-20E-8.
288 (a) A violation of this chapter by an insurer shall be considered an unfair trade practice
289 under Article 1 of Chapter 6 of this title and shall be subject to penalties as determined by
290 the department.
291 (b) This Code section shall not apply to any health care provider, hospital, or emergency
292 medical provider.

293 33-20E-9.
294 (a) Where a patient obtains medical services, not including emergency medical services,
295 and an unexpected event arises resulting in a surprise bill to a patient, mediation shall be
296 available from the department where the resulting bill to the patient is greater than
297 $1,000.00, provided that:
298 (1) Participants in such a mediation shall include the patient or the patient's authorized
299 representative, the insurer, and the provider of the care resulting in the bill to the patient;
300 (2) Patients shall submit accurate and complete health insurance information prior to
301 initiating mediation;
302 (3) Where possible, mediation shall occur by teleconference;
303 (4) In determining appropriate payment, the Gould Standard shall be taken into account
304 by the parties involved; and
305 (5) Costs not specific to any one party shall be shared evenly among all parties to the
306 mediation.
307 (b) The department shall develop rules in accordance with the requirements of this Code
308 section.″

309 **SECTION 3.**

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