Senate Bill 56

By: Senators Hufstetler of the 52nd, Watson of the 1st, Burke of the 11th, Parent of the 42nd, Jackson of the 2nd and others

AS PASSED SENATE

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to establish standards for insurers and health care providers with regard to payment under a health benefit plan in the provision of emergency medical services; to provide for applicability; to provide for definitions; to provide for certain patient or prospective patient disclosures; to provide for insurer disclosures; to provide for requirements regarding the provision of emergency medical services for covered persons under a health benefit plan; to provide for requirements for health benefit plan contracts between insurers and covered persons; to provide for payments to providers; to provide for penalties for violations; to provide for mediation; to provide for related matters; to provide for a short title; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

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

SECTION 2.

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

"CHAPTER 20E

33-20E-1.

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

33-20E-2.

As used in this chapter, the term:

(1) 'Balance bill' means the amount that a nonparticipating provider may charge a covered person. Such amount charged shall equal the difference between the amount paid by the insurer and the amount of the nonparticipating provider's bill charge but shall not include any amount for coinsurance, copayments, or deductibles due from the covered person.

(2) 'Covered person' means an individual who is covered under a health benefit plan.

(3) 'Emergency medical provider' means any physician licensed by the Georgia Composite Medical Board who provides emergency medical services and any other health care provider licensed in this state who renders emergency medical services.

(4) 'Emergency medical services' means those 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.

(5) Reserved.

(6) 'Gould Factors' means the following factors:

(A) The provider's training, qualifications, and length of time in practice;

(B) The nature of the services provided;

(C) The fees usually charged by the provider;

(D) Prevailing provider rates charged in the general geographic area in which the services were rendered;

(E) Other aspects of the economics of the medical provider's practice that are relevant; and

(F) Any unusual circumstances in the case.

(7) 'Health benefit plan' means a policy, contract, certificate, or agreement entered into, offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, but shall not apply to Chapter 9 of Title 34, relating to workers' compensation.

(8) 'Health care provider' or 'provider' means any physician or other individual who is licensed or otherwise authorized in this state to furnish emergency medical services.

(9) 'Insurer' means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or

enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an accident and sickness insurance company, a health maintenance organization, a health care plan, managed care plan, or any other entity providing a health insurance plan, a health benefit plan, or health care services.

(10) 'Medical services' means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from illness, injury, or other human physical problem and includes, but is not limited to:

(A) Hospital services which include the general and usual care, services, supplies, and equipment furnished by hospitals;

(B) Medical services which include the general and usual care and services rendered and administered by doctors of medicine, doctors of dental surgery, and doctors of podiatry; and

(C) Other medical services which include appliances and supplies, nursing care by a registered nurse; institutional services, including the general and usual care, services, supplies, and equipment furnished by health care institutions and agencies or entities other than hospitals; physiotherapy; ambulance services; drugs and medications; therapeutic services and equipment, including oxygen and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and appliances, including wheelchairs, trusses, braces, crutches, and prosthetic devices, including artificial limbs and eyes, and any other appliance, supply, or service related to health care.

(11) 'Minimum benefit standard' or 'MBS' means the usual and customary rate defined as the 95th percentile of allowable benefits and the 80th percentile of charges averaged together for a particular medical service performed by a health care provider in the same or similar specialty and provided in the same geographic area. Both percentile of allowable benefits and the percentile of charges shall be reported in a benchmarking data base maintained by a nonprofit organization specified by the commissioner. The rate shall be tied to 2018 rates and may be adjusted for inflation according to the Consumer Price Index for medical care or another indicator as determined by the department pursuant to rules and regulations promulgated by the Commissioner. The nonprofit organization shall not be affiliated with or receive funding from a health insurance company and shall be accessible to providers without charge.

(12) 'Nonparticipating provider' means a health care provider who has not entered into a direct contract with a health benefit plan for the delivery of medical services.

(13) 'Participating provider' means a health care provider who has entered into a direct contract with an insurer for the delivery of medical services to covered persons under a health benefit plan.

(14) 'Stabilized' means the effect of providing medical or surgical treatment for an emergency condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility, or that with respect to a pregnant woman who is having contractions, the woman has delivered the child and the placenta.

(15) 'Surprise bill' means a bill to a patient after medical services, not including emergency medical services, where an unanticipated event results in the provision of services by a nonparticipating provider.

(16) 'Usual and customary cost' means the charges routinely billed by the provider for his or her professional services regardless of the payor involved and before any discounts are applied pursuant to charity or financial assistance policies or insurer contracting discounts.

33-20E-3.

(a) A health care provider who is a physician shall provide a patient or prospective patient with the name or practice name, mailing address, and telephone number of any health care provider that the office or surgery center utilizes for the provision of anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office or an ambulatory surgery center owned by the physician for the patient at least 48 hours prior to the provision of services where possible. Such information may be provided by publication on the provider's website.

(b) Where an unanticipated event causes a change in the providers of radiology, anesthesiology, pathology, or other services, the physician shall be held harmless for any resulting bills from such provider or providers.

(c) A hospital shall establish, update, and make public through posting on the hospital's website, to the extent required by federal guidelines, a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis related groups established under Section 1886(d)(4) of the federal Social Security Act.

(d) A hospital shall post on the hospital's website:

(1) The health benefit plans with which the hospital has an executed provider agreement;

(2) A statement that physician services provided in the hospital may not be included in the hospital's charges, that physicians who provide services in the hospital may or may not participate with the same health benefit plans as the hospital, and that the prospective patient should check with the physician arranging for the hospital services to determine the health benefit plans in which the physician participates; and

(3) As applicable, the name, mailing address, and telephone number of the physician groups with which the hospital has contracted to provide services, including

anesthesiology, pathology, and radiology, and instructions on how to contact these groups to determine the health benefit plan participation of the physicians in such groups.

(e) In registration or admission materials provided in advance of medical services, not including emergency medical services, a hospital shall:

(1) Advise the patient or prospective patient to check with the physician arranging the hospital services to determine:

(A) The name or practice name, mailing address, and telephone number of any other physician whose services will be arranged for by the physician; and

(B) Whether the services of physicians who are employed or contracted by the hospital to provide services, including anesthesiology, pathology, and radiology, are reasonably anticipated to be provided to the patient; and

(2) Provide patients or prospective patients with information on how to timely determine the health benefit plans in which the physicians participate who are reasonably anticipated to provide services to the patient at the hospital, as determined by the physician arranging the patient's hospital services, and who are employees of the hospital or contracted by the hospital to provide services, including anesthesiology, pathology, and radiology.

(f) Unknown or unanticipated services are not subject to the requirements of this Code section.

33-20E-4.

(a) An insurer shall provide to a covered person:

(1) Information that a covered person may obtain a referral to a health care provider outside of the insurer's network or panel when the insurer does not have a health care provider who is geographically accessible to the covered person and who has appropriate training and experience in the network or panel to meet the particular health care needs of the covered person and the procedure by which the covered person can obtain such referral;

(2) Notice that the covered person shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, or for any care related to a pregnancy, from a qualified provider of such services of her choice from within the plan;

(3) All appropriate mailing addresses and telephone numbers to be utilized by covered persons seeking information or authorization;

(4) An accurate provider directory as required by Chapter 20C of this title;

(5) Where applicable, a description of the method by which a covered person may submit a claim for health care services;

(6) With respect to out-of-network coverage:

(A) A clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services;

(B) The amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services;

(C) Examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; and

(D) Notice that the patient may be responsible for the balance of the nonparticipating provider's fee if the rate paid by the plan is below the provider's usual and customary amount;

(7) Information in writing and through an Internet website that reasonably permits a covered person or prospective covered person to estimate the anticipated out-of-pocket costs for out-of-network health care services in a geographical area or ZIP Code based upon the difference between the amount that the insurer will reimburse for out-of-network health care services, the patient's MBS, and the usual and customary cost for out-of-network health care services;

(8) The written application procedures and minimum qualification requirements for health care providers to be considered by the insurer; and

(9) Other information as required by the Commissioner.

(b) An insurer shall furnish an explanation of benefits to a nonparticipating provider within 30 days of receiving a bill from the covered person or directly from the nonparticipating provider. The explanation of benefits shall conspicuously indicate whether the health benefit plan coverage for the patient is subject to the requirements of this chapter, or otherwise preempted under 29 U.S.C. Section 1144(a) as a self-funded employee welfare plan regulated under the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1002(1).

(c) An insurer shall disclose whether a health care provider scheduled to provide a health care service is a participating provider and, with respect to coverage of nonparticipating provider services, disclose the approximate dollar amount that the insurer will pay for a specific health care service from a nonparticipating provider. Insurers shall also inform a covered person through such disclosure that such approximation shall not be binding on the insurer and that the approximate dollar amount that the insurer shall pay for a specific health care service from a nonparticipating provider may change.

(d) Where services have been precertified or preauthorized by an insurer, the insurer shall guarantee coverage of such services at the rates payed to a participating provider regardless of any changes of network status following the precertification or preauthorization.

(e) Where an insurer fails to adequately and correctly keep its directory pursuant to Code Section 33-20C-2 and such failure results in the unanticipated provision of out-of-network services, the insurer shall compensate the provider at the provider's usual and customary cost or MBS, whichever is less.

(f) Where a delay in the credentialing of a provider causes the service to be deemed out-of-network, the insurer shall compensate the provider at the provider's full rate at no expense to the patient.

33-20E-5.

(a) Notwithstanding any provision of law to the contrary, an insurer that provides any benefits to covered persons with respect to emergency medical services shall pay for such emergency medical services:

(1) Without the need for any prior authorization determination and without any retrospective payment denial for services rendered; and

(2) Regardless of whether the health care provider furnishing emergency medical services is a participating provider with respect to emergency medical services.

(b) In the event a covered person receives emergency medical services by a nonparticipating provider or hospital, the nonparticipating provider or hospital shall bill the insurer directly and the insurer shall directly pay the nonparticipating provider or hospital as coded for the emergency medical services rendered to the covered person in accordance with Code Section 33-24-59.14 the lesser of:

(1) The nonparticipating provider or hospital's actual billed charges; or

(2) In the case of a health care provider, the minimum benefit standard.

(c) A health benefit plan shall not deny benefits for emergency medical services previously rendered, based upon a covered person's failure to provide subsequent notification in accordance with plan provisions, where the covered person's medical condition prevented timely notification.

(d) Insurers shall not communicate or include in written form false, misleading, or confusing information in their explanation of benefits to patients or guarantors regarding usual and customary costs, balance billing, or mediation disputes between physicians and insurers.

(e) For purposes of the covered person's financial responsibilities, the health benefit plan shall treat the health care services the covered person receives from a nonparticipating provider pursuant to this Code section as if the services were provided by a participating

provider, including counting the covered person's cost sharing for such services toward the covered person's deductible and maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

33-20E-6.

No health benefit plan shall deny or restrict covered benefits from a participating provider to a covered person solely because the covered person obtained treatment from a nonparticipating provider. Notice of such protection shall be provided in writing to the covered person by the insurer.

33-20E-7.

(a) A health benefit plan contract issued, amended, or renewed on or after July 1, 2020, shall provide that if a covered person receives emergency medical services from a nonparticipating provider, such covered person shall not be required to pay more than the same amount that the covered person would have to pay for the same emergency medical services received from a similar participating provider at a similar in-network facility. Such amount shall be referred to as the 'in-network cost-sharing amount.'

(b) Neither a nonparticipating provider nor a participating provider shall bill or collect any amount from the covered person for emergency medical services subject to subsection (a) of this Code section other than the patient's coinsurance, copayments, and deductibles, which is limited to the in-network cost-sharing amount.

33-20E-8.

(a) A violation of this chapter by an insurer shall be subject to penalties as determined by the Commissioner.

(b) A violation of this chapter by a health care provider shall be subject to penalties as determined by the applicable licensing board regulating such health care provider.

(c) A violation of this chapter by a hospital shall be subject to penalties as determined by the Department of Community Health pursuant to its enforcement powers in Title 31.

33-20E-9.

(a) Where a patient obtains medical services, not including emergency medical services, and an unexpected event arises resulting in a surprise bill to a patient, mediation shall be available from the department where the resulting bill to the patient is greater than $1,000.00, provided that:

(1) Participants in such a mediation shall include the patient or the patient's authorized representative, the insurer, and the provider of the care resulting in the bill to the patient;

(2) Patients shall submit accurate and complete health insurance information prior to initiating mediation;

(3) Where possible, mediation shall occur by teleconference;

(4) In determining appropriate payment, the Gould Standard shall be taken into account by the parties involved; and

(5) Costs not specific to any one party shall be shared evenly among all parties to the mediation.

(b) The department shall develop rules in accordance with the requirements of this Code section."

SECTION 3.

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