

Senate Bill 359

By: Senators Hufstetler of the 52nd, Burke of the 11th, Watson of the 1st, Kirkpatrick of the 32nd, Henson of the 41st and others

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 certain patient or prospective patient disclosures;
5 to provide for insurer disclosures; to provide for requirements regarding the provision of
6 emergency medical care for covered persons under a managed care plan; to provide for
7 requirements for managed care plan contracts between carriers and covered persons; to
8 provide for payments to providers; to provide for penalties for violations; to provide for
9 mediation; to provide for related matters; to provide for a short title; to repeal conflicting
10 laws; and for other purposes.

11 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

12 style="text-align:center">**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 style="text-align:center">**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 style="text-align:center">"CHAPTER 20E

19 33-20E-1.

20 This chapter shall apply to all carriers providing a managed care plan that pays for the
21 provision of medical care 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 carrier 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) 'Carrier' means an accident and sickness insurer, fraternal benefit society, hospital
30 service corporation, medical service corporation, health care corporation, health
31 maintenance organization, provider sponsored health care corporation, or any similar
32 entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of
33 the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001,
34 et seq., which entity provides for the financing or delivery of emergency medical care or
35 through an emergency medical services system or through a health benefit plan, or the
36 plan administrator of any health benefit plan established pursuant to Article 1 of Chapter
37 18 of Title 45.

38 (3) 'Covered person' means an individual who is covered under a managed care plan.

39 (4) 'Elective medical care' means medical services not defined as 'emergency medical
40 care' under this chapter.

41 (5) 'Emergency condition' means any medical condition of a recent onset and severity,
42 including but not limited to severe pain that would lead a prudent layperson, possessing
43 an average knowledge of medicine and health, to believe that his or her condition,
44 sickness, or injury is of such a nature that failure to obtain immediate medical care could
45 result in:

46 (A) Placing the patient's health in serious jeopardy;

47 (B) Serious impairment to bodily functions; or

48 (C) Serious dysfunction of any bodily organ or part.

49 (6) 'Emergency medical care' means emergency services which originate in a hospital
50 emergency department after the onset of a medical or traumatic condition manifesting
51 itself by acute symptoms of sufficient severity, including severe pain, such that the
52 absence of immediate medical or surgical attention could reasonably be expected to result
53 in placing the patient's health in serious jeopardy, serious impairment to bodily functions,
54 or serious dysfunction of any bodily organ or part, and services for the first 24 hours after
55 the covered person's emergency condition has stabilized, whether or not the emergency
56 services and services after stabilization occur in an emergency department. Such term
57 shall include care for an emergency condition that continues once a patient is admitted

58 to the hospital from the hospital emergency department and could include other
 59 specialists and providers.

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

63 (8) 'First dollar coverage' means payment by a carrier directly to a health care provider
 64 for services of the entire allowed amount for such services pursuant to Code
 65 Section 33-20E-3 without any reduction in payment for the managed care plan's required
 66 coinsurance, copayments, deductibles, or other patient financial responsibility. The
 67 carrier shall be responsible for collecting these amounts directly from the covered person.

68 (9) 'Health care provider' means any physician or other person who is licensed or
 69 otherwise authorized in this state to furnish emergency medical care.

70 (10) 'Managed care plan' means a major medical, hospitalization, or dental plan that
 71 provides for the financing and delivery of health care services to persons enrolled in such
 72 plan through:

73 (A) Arrangements with selected providers to furnish health care services;

74 (B) Explicit standards for the selection of participating providers; and

75 (C) Cost savings for persons enrolled in the plan to use the participating providers and
 76 procedures provided for by the plan;

77 The term 'managed care plan' shall not apply to Chapter 9 of Title 34, relating to workers'
 78 compensation.

79 (11) 'Minimum benefit standard' or 'MBS' means the eightieth percentile of all charges
 80 for the particular health care service performed by a health care provider in the same or
 81 similar specialty and provided in the same geographical area as reported in a
 82 benchmarking data base maintained by a nonprofit organization specified by the
 83 Commissioner. The nonprofit organization shall not be affiliated, financially supported,
 84 or otherwise supported by a health insurance company.

85 (12) 'Nonparticipating provider' means a health care provider who has not entered into
 86 a direct contract with a carrier for the delivery of emergency medical care to covered
 87 persons under a managed care plan.

88 (13) 'Participating provider' means a health care provider who has entered into a direct
 89 contract with a carrier for the delivery of emergency medical care to covered persons
 90 under a managed care plan.

91 (14) 'Stabilized' means the effect of providing medical or surgical treatment for an
 92 emergency condition as may be necessary to assure, within reasonable medical
 93 probability, that no material deterioration of the condition is likely to result from or occur

94 during the transfer of the patient from a facility, or that with respect to a pregnant woman
 95 who is having contractions, the woman has delivered the child and the placenta.
 96 (15) 'Surprise bill' means a bill to a patient after elective medical care where an
 97 unanticipated event results in the provision of services by an out-of-network provider.
 98 (16) 'Usual and customary cost' means the charges routinely billed by the provider for
 99 its professional services regardless of the payor involved and before any discounts that
 100 are applied pursuant to charity or indigent patient charge policies or insurance carrier
 101 contracting discounts.

102 33-20E-3.

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

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

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

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

118 (1) The health benefit plans in which the hospital is a participating provider;

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

124 (3) As applicable, the name, mailing address, and telephone number of the physician
 125 groups with which the hospital has contracted to provide services, including
 126 anesthesiology, pathology, and radiology, and instructions on how to contact these groups
 127 to determine the health benefit plan participation of the physicians in such groups.

128 (e) In registration or admission materials provided in advance of nonemergency hospital
 129 services, a hospital shall:

- 130 (1) Advise the patient or prospective patient to check with the physician arranging the
131 hospital services to determine:
- 132 (A) The name or practice name, mailing address, and telephone number of any other
133 physician whose services will be arranged for by the physician; and
- 134 (B) Whether the services of physicians who are employed or contracted by the hospital
135 to provide services, including anesthesiology, pathology, and radiology, are reasonably
136 anticipated to be provided to the patient; and
- 137 (2) Provide patients or prospective patients with information on how to timely determine
138 the health benefit plans in which the physicians participate who are reasonably
139 anticipated to provide services to the patient at the hospital, as determined by the
140 physician arranging the patient's hospital services, and who are employees of the hospital
141 or contracted by the hospital to provide services, including anesthesiology, pathology,
142 and radiology.
- 143 (f) Unknown or unanticipated services are not subject to the requirements of this Code
144 section.

145 33-20E-4.

- 146 (a) An insurer shall provide to an enrollee:
- 147 (1) Information that an enrollee may obtain a referral to a health care provider outside
148 of the insurer's network or panel when the insurer does not have a health care provider
149 who is geographically accessible to the enrollee and who has appropriate training and
150 experience in the network or panel to meet the particular health care needs of the enrollee
151 and the procedure by which the enrollee can obtain such referral;
- 152 (2) Notice that the enrollee shall have direct access to primary and preventive obstetric
153 and gynecologic services, including annual examinations, care resulting from such annual
154 examinations, and treatment of acute gynecologic conditions, or for any care related to
155 a pregnancy, from a qualified provider of such services of her choice from within the
156 plan;
- 157 (3) All appropriate mailing addresses and telephone numbers to be utilized by enrollees
158 seeking information or authorization;
- 159 (4) A monthly updated listing by specialty, which may be in a separate document, of the
160 name, address, and telephone number of all participating providers, including facilities,
161 and in the case of physicians, the board certification, languages spoken, and any
162 affiliations with participating hospitals. The listing shall also be posted on the insurer's
163 website, and the insurer shall update the website within 15 days of the addition or
164 termination of a provider from the insurer's network or a change in a physician's hospital
165 affiliation;

166 (5) Where applicable, a description of the method by which an enrollee may submit a
167 claim for health care services;

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

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

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

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

176 (D) Notice that the patient may be responsible for the balance of the out-of-network
177 provider's fee if the rate paid by the plan is below the provider's billed amount;

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

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

186 (9) Other information as required by the Commissioner.

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

194 (c) An insurer shall disclose whether a health care provider scheduled to provide a health
195 care service is an in-network provider and, with respect to out-of-network coverage,
196 disclose the approximate dollar amount that the insurer will pay for a specific
197 out-of-network health care service. Insurers shall also inform an enrollee through such
198 disclosure that such approximation shall not be binding on the insurer and that the
199 approximate dollar amount that the insurer shall pay for a specific out-of-network health
200 care service may change.

201 (d) Where services have been precertified or preauthorized by an insurer, the insurer shall
 202 guarantee coverage of such services at the usual and customary cost regardless of any
 203 changes of network status following the precertification or preauthorization.

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

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

211 33-20E-5.

212 (a) Notwithstanding any provision of law to the contrary, a carrier that provides any
 213 benefits to covered persons with respect to emergency medical care shall pay for such
 214 emergency medical care:

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

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

219 (b) In the event a covered person receives emergency medical care by a nonparticipating
 220 provider, the nonparticipating provider shall bill the carrier directly and the carrier shall
 221 directly pay, within 15 days for electronic claims and 30 days for paper claims, the
 222 nonparticipating provider as coded, with first dollar coverage, for the emergency medical
 223 care rendered to the covered person by the lesser of:

224 (1) The usual and customary rate; or

225 (2) The minimum benefit standard. The charges shall be tied to 2017 charges and may
 226 be adjusted for inflation according to the Consumer Price Index for medical care or
 227 another indicator as determined by the department. Such data base shall be accessible to
 228 providers without charge.

229 Payment shall be made without retrospective denials and without deductions for the plan's
 230 coinsurance, copayments, and deductibles. The carrier shall collect any required
 231 coinsurance, copayments, deductibles, or other patient financial responsibilities directly
 232 from the covered person pursuant to the provisions of the managed care plan contract.
 233 Patient responsibility is limited to the in-network payment as required under the managed
 234 care plan contract.

235 (c) A managed care plan shall not deny benefits for emergency medical care previously
 236 rendered, based upon a covered person's failure to provide subsequent notification in

237 accordance with plan provisions, where the covered person's medical condition prevented
 238 timely notification.

239 (d) In the event a covered person receives emergency medical care by a nonparticipating
 240 provider, once such covered person is stabilized, as required by the federal Emergency
 241 Medical Treatment and Active Labor Act, the carrier shall arrange for transfer of the
 242 covered person to a participating provider at the carrier's cost. If the carrier fails to transfer
 243 such covered person within 24 hours after the covered person is stabilized, the carrier shall
 244 pay the entirety of the nonparticipating provider's charges for the care of the covered
 245 person thereafter in accordance with the payment criteria provided in subsection (b) of this
 246 Code section.

247 (e) Carriers shall not communicate or include in written form false, misleading, or
 248 confusing information in their explanation of benefits to patients or guarantors regarding
 249 usual and customary costs, balance billing, or mediation disputes between physicians and
 250 carriers.

251 (f) For purposes of an enrollee's financial responsibilities, the health care plan shall treat
 252 the health care services the enrollee receives from an out-of-network provider pursuant to
 253 this Code section as if the services were provided by an in-network provider, including
 254 counting the enrollee's cost sharing for such services toward the enrollee's deductible and
 255 maximum out-of-pocket limit applicable to services obtained from in-network providers
 256 under the health care plan.

257 33-20E-6.

258 No managed care plan shall deny or restrict in-network covered benefits to a covered
 259 person solely because the covered person obtained treatment outside the network. Notice
 260 of such protection shall be provided in writing to the covered person by the carrier.

261 33-20E-7.

262 (a)(1) A managed care plan contract issued, amended, or renewed on or after
 263 July 1, 2018, shall provide that if a covered person receives emergency medical care from
 264 a nonparticipating provider at either an in-network facility or an out-of-network facility,
 265 such covered person shall not be required to pay more to the carrier than the same amount
 266 that the covered person would have to pay to the carrier for the same emergency medical
 267 care received from a similar participating provider at a similar in-network facility. Such
 268 amount shall be referred to as the 'in-network cost-sharing amount.'

269 (2) Neither a nonparticipating provider nor a participating provider shall bill or collect
 270 any amount from the covered person for emergency medical care subject to paragraph (1)
 271 of this subsection. Coinsurance, copayments, and deductibles shall be collected by the

272 carrier, and first dollar coverage shall be paid by the carrier directly to the provider in a
 273 timely manner, as coded and billed, and without retrospective denials.

274 (b) A managed care plan contract issued, amended, or renewed on or after July 1, 2018,
 275 shall provide that, if a covered person receives emergency medical care from a
 276 nonparticipating provider, any cost-sharing amount attributable to an out-of-network
 277 deductible shall be applied to such covered person's in-network deductible.

278 33-20E-8.

279 (a) A violation of this chapter by a carrier shall be considered an unfair trade practice
 280 under Article 1 of Chapter 6 of this title and shall be subject to penalties as determined by
 281 the department.

282 (b) This Code section shall not apply to any health care provider or emergency medical
 283 provider.

284 33-20E-9.

285 (a) Where a patient obtains elective medical care and an unexpected event arises resulting
 286 in a surprise bill to a patient, mediation shall be available from the department where the
 287 resulting bill to the patient is greater than \$1,000.00. Surprise bills under such threshold
 288 shall not qualify for mediation under this subsection, provided that:

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

291 (2) Patients shall submit accurate and complete health insurance information prior to
 292 receiving services;

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

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

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

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

300 **SECTION 3.**

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