

House Bill 677

By: Representatives Silcox of the 52nd, Newton of the 123rd, Rhodes of the 120th, Beverly of the 143rd, Cooper of the 43rd, 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 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 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 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 those health care services that are provided for
34 a condition of recent onset and sufficient severity, including, but not limited to, severe
35 pain, that would lead a prudent layperson possessing an average knowledge of medicine
36 and health to believe that his or her condition, sickness, or injury is of such a nature that
37 failure to obtain immediate medical care could result in:

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

39 (B) Serious impairment to bodily functions; or

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

41 (5) Reserved.

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

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

44 (B) The nature of the services provided;

45 (C) The fees usually charged by the provider;

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

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

50 (F) Any unusual circumstances in the case.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

107 33-20E-3.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

150 33-20E-4.

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

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

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

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

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

166 (5) Where applicable, a description of the method by which a covered person may submit
167 a 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 nonparticipating
177 provider's fee if the rate paid by the plan is below the provider's usual and customary
178 amount;

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

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

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

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

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

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

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

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

212 33-20E-5.

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

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

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

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

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

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

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

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

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

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

241 33-20E-6.

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

246 33-20E-7.

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

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

257 33-20E-8.

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

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

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

264 33-20E-9.

265 (a) Where a patient obtains medical services, not including emergency medical services,
 266 and an unexpected event arises resulting in a surprise bill to a patient, mediation shall be
 267 available from the department where the resulting bill to the patient is greater than
 268 \$1,000.00, provided that:

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

- 271 (2) Patients shall submit accurate and complete health insurance information prior to
272 initiating mediation;
- 273 (3) Where possible, mediation shall occur by teleconference;
- 274 (4) In determining appropriate payment, the Gould Standard shall be taken into account
275 by the parties involved; and
- 276 (5) Costs not specific to any one party shall be shared evenly among all parties to the
277 mediation.
- 278 (b) The department shall develop rules in accordance with the requirements of this Code
279 section."

280 **SECTION 3.**

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