The House Committee on Insurance offers the following substitute to HB 678:

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 provide for consumer protections regarding health insurance; to provide for definitions; to
3 provide for disclosure requirements of providers, hospitals, and insurers; to provide for
4 billing, reimbursement, and arbitration of certain services; to provide for related matters; to
5 provide an effective date; to repeal conflicting laws; and for other purposes.

6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

7 **SECTION 1.**

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

10 "CHAPTER 20E

11 33-20E-1.
12 As used in this chapter, the term:
13 (1) 'Covered person' means an individual who is covered under a health care plan.
14 (2) 'Emergency services' means those health care services that are provided for a
15 condition of recent onset and sufficient severity, including, but not limited to, severe pain,
16 that would lead a prudent layperson possessing an average knowledge of medicine and
17 health to believe that his or her condition, sickness, or injury is of such a nature that
18 failure to obtain immediate medical care could result in:
19 (A) Placing the patient's health in serious jeopardy;
20 (B) Serious impairment to bodily functions; or
21 (C) Serious dysfunction of any bodily organ or part.
22 (3) 'Enrollee' means a policyholder, subscriber, covered person, or other individual
23 participating in a health care plan.

24 (4) 'Health care plan' means any hospital or medical insurance policy or certificate,
25 health care plan contract or certificate, qualified higher deductible health plan, health
26 maintenance organization subscriber contract, or any health insurance plan established
27 pursuant to Article 1 of Chapter 18 of Title 45; but a health care plan shall not include
28 certain limited benefit insurance policies or plans listed under paragraph (1.1) of Code
29 Section 33-1-2 or policies issued in accordance with Chapter 21A or 31 of this title or
30 Chapter 9 of Title 34, relating to workers' compensation.
31 (5) 'Health care provider' or 'provider' means any physician, dentist, podiatrist,
32 pharmacist, optometrist, psychologist, clinical social worker, advanced practice registered
33 nurse, registered optician, licensed professional counselor, physical therapist, marriage
34 and family therapist, chiropractor, athletic trainer qualified pursuant to Code
35 Section 43-5-8, occupational therapist, speech-language pathologist, audiologist, dietitian,
36 or physician assistant.
37 (6) 'Health care services' means the examination or treatment of persons for the
38 prevention of illness or the correction or treatment of any physical or mental condition
39 resulting from illness, injury, or other human physical problem and includes, but is not
40 limited to:
41 (A) Hospital services which include the general and usual care, services, supplies, and
42 equipment furnished by hospitals;
43 (B) Medical services which include the general and usual care and services rendered
44 and administered by doctors of medicine, doctors of dental surgery, and doctors of
45 podiatry; and
46 (C) Other health care services which include appliances and supplies; nursing care by
47 a registered nurse or a licensed practical nurse; institutional services, including the
48 general and usual care, services, supplies, and equipment furnished by health care
49 institutions and agencies or entities other than hospitals; physiotherapy; ambulance
50 services; drugs and medications; therapeutic services and equipment, including oxygen
51 and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and
52 appliances, including wheelchairs, trusses, braces, crutches, and prosthetic devices,
53 including artificial limbs and eyes; and any other appliance, supply, or service related
54 to health care.
55 (7) 'Health center' means an entity that serves a population that is medically underserved
56 or a special medically underserved population composed of migratory and seasonal
57 agricultural workers, the homeless, and residents of public housing by providing, either
58 through the staff and supporting resources of the center or through contracts or
59 cooperative arrangements for required primary health care services and as may be
60 appropriate for particular centers, additional health care services necessary for the

61 adequate support of the primary health care services for all residents of the area served
62 by the health center.
63 (8) 'Insurer' means any person engaged as indemnitor, surety, or contractor that issues
64 insurance, annuity or endowment contracts, subscriber certificates, or other contracts of
65 insurance by whatever name called. Health care plans under Chapter 20A of this title and
66 health maintenance organizations are insurers within the meaning of this chapter.
67 (9) 'Medically underserved population' means the population of an urban or rural area
68 designated by the United States Secretary of Health and Human Services as an area with
69 a shortage of personal health care services or a population group designated by the
70 Secretary in consultation with the state as having a shortage of such services.
71 (10) 'Out-of-network' refers to health care items or services provided to an enrollee by
72 providers who do not belong to the provider network in the health care plan.
73 (11) 'Required primary health care services' means health care services related to family
74 medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by
75 physicians and, when appropriate, physician assistants, nurse practitioners, and nurse
76 midwives; diagnostic laboratory and radiologic services; preventive health care services,
77 including prenatal and perinatal services; appropriate cancer screenings; well child
78 services; immunizations against vaccine-preventable diseases; screenings for elevated
79 blood lead levels, communicable diseases, or cholesterol; pediatric eye, ear, and dental
80 screenings to determine the need for vision and hearing correction and dental care; family
81 planning services; and preventive dental services.

82 33-20E-2.
83 (a) Upon request by a patient or prospective patient, a health care provider, group practice
84 of health care providers, diagnostic and treatment center, or health center on behalf of
85 health care providers rendering services at a group practice, diagnostic and treatment
86 center, or health center shall disclose to patients or prospective patients in writing or
87 through a website the health care plans with which the health care provider, group practice,
88 diagnostic and treatment center, or health center has an executed participation agreement
89 and the hospitals with which the health care provider is affiliated prior to the provision of
90 nonemergency services and, upon request, verbally at the time an appointment is scheduled
91 or confirm coverage prior to service being provided.
92 (b) If a health care provider, group practice of health care providers, diagnostic and
93 treatment center, or health center on behalf of health care providers rendering services at
94 a group practice, diagnostic and treatment center, or health center does not have an
95 executed participation agreement with a patient's or prospective patient's health care plan,

96 the health care provider, group practice, diagnostic and treatment center, or health center
97 shall:
98 (1) Prior to the provision of nonemergency services, inform such patient or prospective
99 patient in writing that the estimated amount the health care provider, group practice,
100 diagnostic and treatment center, or health center will bill the patient or prospective patient
101 for health care services is available to such patient or prospective patient upon the request
102 of such patient or prospective patient; and
103 (2) Upon receipt of a request from a patient or prospective patient, disclose to the patient
104 or prospective patient in writing the amount, the estimated amount, or a schedule of fees
105 that the health care provider, group practice, diagnostic and treatment center, or health
106 center will bill the patient or prospective patient for health care services provided or
107 anticipated to be provided to the patient or prospective patient absent unforeseen medical
108 circumstances that may arise when the health care services are provided. Estimates shall
109 not be binding on the provider or patient.
110 (c) A health care provider who is a physician shall upon request provide a patient or
111 prospective patient with the name, practice name, mailing address, and telephone number
112 of any health care provider scheduled by such physician or physician's office to perform
113 anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in
114 connection with care to be provided in the physician's office for the patient.
115 (d) A health care provider who is a physician shall, for a patient's scheduled inpatient or
116 outpatient hospital admission, provide such patient and hospital with the name, practice
117 name, mailing address, and telephone number of any other physician or group of physicians
118 whose services will be arranged for by the treating physician and are scheduled at the time
119 of the preadmission testing, registration, or admission at the time nonemergency services
120 are scheduled and information on how to determine the health care plans in which the
121 treating physician participates.
122 (e) To the extent required by federal guidelines, a hospital shall establish, update at least
123 annually, and make public through posting on the hospital's website a list of the hospital's
124 standard charges for items and services provided in the hospital, including for diagnosis
125 related groups established under Section 1886(d)(4) of the federal Social Security Act.
126 (f) A hospital shall post prominently on the hospital's website:
127 (1) The names and hyperlinks for direct access to websites of all health care plans or
128 insurers for which the hospital contracts as a network provider or participating provider;
129 (2) A statement that physician services provided in the hospital may not be included in
130 the hospital's charges, that physicians who provide services in the hospital may or may
131 not participate with the same health care plans as the hospital, and that the prospective

132 patient should check with the physician arranging for the hospital services to determine
133 the health care plans in which the physician participates; and
134 (3) As applicable, the name, mailing address, and telephone number of the physician
135 groups with which the hospital has contracted or that the hospital has employed to
136 provide hospital based services, including anesthesiology, pathology, or radiology, and
137 instructions on how to contact such groups to determine the health care plan participation
138 of the physicians in such groups.
139 (g) In registration or admission materials provided in advance of nonemergency hospital
140 services, a hospital shall:
141 (1) Advise the patient or prospective patient to check with the physician arranging the
142 hospital services regarding:
143 (A) The name, practice name, mailing address, and telephone number of any other
144 physician who the treating physician has arranged to render service to the patient or
145 prospective patient at the hospital; and
146 (B) Whether the services of hospital based physicians, including anesthesiology,
147 pathology, and radiology, are reasonably anticipated to be provided to the patient; and
148 (2) Provide patients or prospective patients upon request with information on how to
149 timely determine the health care plans participated in by physicians who are reasonably
150 anticipated to provide hospital based physician services to such patient or prospective
151 patient at the hospital.

152 33-20E-3.
153 (a) An insurer or a health care plan that provides out-of-network coverage shall upon
154 request provide to an enrollee:
155 (1) Information that an enrollee may make requests under this Code section and may
156 obtain a referral to a health care provider outside of the health care plan's network or
157 panel when the health care plan does not have a health care provider who is
158 geographically accessible to the enrollee and who has appropriate training and experience
159 in the network or panel to meet the particular health care needs of the enrollee and the
160 procedure by which the enrollee can obtain such referral;
161 (2) Notice that the enrollee shall have direct access to primary and preventive obstetric
162 and gynecologic services, including annual examinations, care resulting from such annual
163 examinations, and treatment of acute gynecologic conditions, or for any care related to
164 a pregnancy, from a qualified provider of such services of her choice from within the
165 plan;
166 (3) All appropriate mailing addresses and telephone numbers to be utilized by enrollees
167 seeking information or authorization;

168 (4) Where applicable, a description of the method by which an enrollee may submit a
169 claim for health care services;
170 (5) With respect to an insurer or a health care plan that provides out-of-network
171 coverage:
172 (A) A description of how such insurer determines reimbursement for out-of-network
173 health care services;
174 (B) The amount that the insurer will reimburse for out-of-network health care services;
175 and
176 (C) Examples of anticipated out-of-pocket costs for frequently billed out-of-network
177 health care services;
178 (6) Information in writing or through a website that reasonably permits an enrollee or
179 prospective enrollee to estimate the anticipated out-of-pocket costs for out-of-network
180 health care services in a geographical area or ZIP Code;
181 (7) The written application procedures and minimum qualification requirements for
182 health care providers to be considered by the insurer; and
183 (8) Other similar information as required by the Commissioner.
184 (b) An insurer shall disclose whether a health care provider scheduled to provide a health
185 care service is an in-network provider and, with respect to an insurer or a health care plan
186 that provides out-of-network coverage, shall disclose the approximate dollar amount that
187 the insurer will pay for a specific out-of-network health care service. The insurer shall also
188 inform an enrollee through such disclosure that such approximation is not binding on the
189 insurer and that the approximate dollar amount that the insurer will pay for a specific
190 out-of-network health care service may change.

191 33-20E-4.
192 An out-of-network referral denial means a denial of a request for an authorization or
193 referral to an out-of-network provider on the basis that the health care plan has a health
194 care provider in the network benefits portion of its network with appropriate training and
195 experience to meet the particular health care needs of an enrollee and who is able to
196 provide the requested health care service. The notice of an out-of-network referral denial
197 provided to an enrollee shall have information explaining what information the enrollee
198 must submit in order to appeal the out-of-network referral denial. An out-of-network
199 denial shall not constitute an adverse determination.

200 33-20E-5.
201 (a) An initial provider billing for health care goods or services shall be sent in compliance
202 with paragraph (14) of subsection (b) of Code Section 10-1-393, and for providers not

203 subject to such provision, not later than 90 days from the date of discharge of the patient
204 or the last instance of furnishing goods or services or after final adjudication, whichever
205 is later. The person responsible for payment shall have 90 days thereafter to secure
206 payment, negotiate amounts, initiate arbitration, or otherwise act upon the billing. Only
207 after the passage of 90 days shall the provider or hospital be authorized to commence
208 extraordinary collection action as defined by Section 501(r) of the Internal Revenue Code
209 or any implementing regulations.
210 (b) Arbitration may be initiated by the patient or person responsible for payment within
211 the 90 day period by filing an application with the Commissioner. The Commissioner shall
212 provide rules and procedures for handling the arbitration process. Each party to the
213 arbitration shall be responsible for one-half of the costs of proceedings.
214 (c) A decision in the arbitration under this Code section shall be final."

215 **SECTION 2.**

216 This Act shall become effective on January 1, 2019.

217 **SECTION 3.**

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