

The House Committee on Insurance offers the following substitute to HB 71:

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 network composition; to provide for billing and reimbursement of in-network and  
5 out-of-network services; to provide for payment of emergency services; to provide for related  
6 matters; to provide an effective date; to repeal conflicting laws; and for other purposes.

7 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

8 **SECTION 1.**

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

11 "CHAPTER 20E

12 33-20E-1.

13 As used in this chapter, the term:

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

15 (2) 'Emergency services' means those health care services that are provided for a  
16 condition of recent onset and sufficient severity, including, but not limited to, severe pain,  
17 that would lead a prudent layperson possessing an average knowledge of medicine and  
18 health to believe that his or her condition, sickness, or injury is of such a nature that  
19 failure to obtain immediate medical care could result in:

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

21 (B) Serious impairment to bodily functions; or

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

23 (3) 'Enrollee' means a policyholder, subscriber, covered person, or other individual  
24 participating in a health benefit plan.

25 (4) 'Health benefit plan' means any hospital or medical insurance policy or certificate,  
 26 health benefit plan contract or certificate, qualified higher deductible health plan, health  
 27 maintenance organization subscriber contract, any health benefit plan established  
 28 pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy;  
 29 but health benefit plan shall not include policies issued in accordance with Chapter 31 of  
 30 this title, relating to credit life insurance and credit accident and sickness insurance,  
 31 Chapter 9 of Title 34, relating to workers' compensation, Chapter 20A of this title,  
 32 relating to managed health care plans, or disability income policies.

33 (5) 'Health care provider' or 'provider' means any physician, dentist, podiatrist,  
 34 pharmacist, optometrist, psychologist, clinical social worker, advanced practice registered  
 35 nurse, registered optician, licensed professional counselor, physical therapist, marriage  
 36 and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section  
 37 43-5-8, occupational therapist, speech-language pathologist, audiologist, dietitian, or  
 38 physician assistant.

39 (6) 'Health care services' means the examination or treatment of persons for the  
 40 prevention of illness or the correction or treatment of any physical or mental condition  
 41 resulting from illness, injury, or other human physical problem and includes, but is not  
 42 limited to:

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

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

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

57 (7) 'Health center' means an entity that serves a population that is medically underserved,  
 58 or a special medically underserved population comprised of migratory and seasonal  
 59 agricultural workers, the homeless, and residents of public housing, by providing, either  
 60 through the staff and supporting resources of the center or through contracts or  
 61 cooperative arrangements for required primary health services and as may be appropriate

62 for particular centers, additional health services necessary for the adequate support of the  
63 primary health services for all residents of the area served by the health center.

64 (8) 'Insurer' means any person engaged as indemnitor, surety, or contractor who issues  
65 insurance, annuity or endowment contracts, subscriber certificates, or other contracts of  
66 insurance by whatever name called. Health care plans and health maintenance  
67 organizations are included as insurers within the meaning of this chapter.

68 (9) 'Medically underserved population' means the population of an urban or rural area  
69 designated by the United States Secretary of Health and Human Services as an area with  
70 a shortage of personal health services or a population group designated by the Secretary  
71 in consultation with the state as having a shortage of such services.

72 (10) 'Out-of-network' refers to health care items or services provided to an enrollee by  
73 providers who do not belong to the provider network in the health benefit plan.

74 (11) 'Patient' means a person who seeks or receives health care services under a health  
75 benefit plan.

76 (12) 'Precertification' means any written or oral determination made at any time by an  
77 insurer or any agent of such insurer that an enrollee's receipt of health care services is a  
78 covered benefit under the applicable plan and that any requirement of medical necessity  
79 or other requirements imposed by such plan as prerequisites for payment for such  
80 services have been satisfied. 'Agent' as used in this paragraph shall not include an agent  
81 or agency as defined in Code Section 33-23-1.

82 (13) 'Required primary health services' means health services related to family medicine,  
83 internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians  
84 and when appropriate, physician assistants, nurse practitioners, and nurse midwives;  
85 diagnostic laboratory and radiologic services; preventive health care services including  
86 prenatal and perinatal services; appropriate cancer screening; well child services;  
87 immunizations against vaccine-preventable diseases; screenings for elevated blood lead  
88 levels, communicable diseases, or cholesterol; pediatric eye, ear, and dental screenings  
89 to determine the need for vision and hearing correction and dental care; family planning  
90 services; and preventive dental services.

91 (14) 'Surprise bill' means a bill for health care services, other than emergency services,  
92 received by:

93 (A) An insured for services rendered by a nonparticipating physician at a participating  
94 hospital or ambulatory surgical center when a participating physician is unavailable or  
95 a nonparticipating physician renders services without the insured's knowledge or when  
96 unforeseen medical services arise at the time the health care services are rendered;  
97 provided, however, that a surprise bill shall not mean a bill received for health care

98 services when a participating physician is available and the insured has elected to obtain  
 99 services from a nonparticipating physician;

100 (B) An insured for services rendered by a nonparticipating provider when the services  
 101 were referred by a participating physician to a nonparticipating provider without the  
 102 explicit written consent of the insured acknowledging that the participating physician  
 103 is referring the insured to a nonparticipating provider and that the referral may result  
 104 in costs not covered by the health benefit plan; or

105 (C) A patient who is not an insured for services rendered by a physician at a hospital  
 106 or ambulatory surgical center when the patient has not timely received all of the  
 107 disclosures required by Code Section 33-20E-2.

108 (15) 'Usual and customary cost' means the eightieth percentile of all charges for the  
 109 particular health care service performed by a provider in the same or similar specialty and  
 110 provided in the same geographical area reported in a benchmarking data base maintained  
 111 by the department.

112 33-20E-2.

113 (a) A health care provider, group practice of health care providers, diagnostic and  
 114 treatment center, or health center on behalf of health care providers rendering services at  
 115 a group practice, diagnostic and treatment center, or health center shall disclose to patients  
 116 or prospective patients in writing or through an Internet website the health benefit plans in  
 117 which the health care provider, group practice, diagnostic and treatment center, or health  
 118 center is a participating provider and the hospitals with which the health care provider is  
 119 affiliated prior to the provision of nonemergency services and verbally at the time an  
 120 appointment is scheduled.

121 (b) If a health care provider, group practice of health care providers, diagnostic and  
 122 treatment center, or health center on behalf of health care providers rendering services at  
 123 a group practice, diagnostic and treatment center, or health center does not participate in  
 124 the network of a patient's or prospective patient's health benefit plan, the health care  
 125 provider, group practice, diagnostic and treatment center, or health center shall:

126 (1) Prior to the provision of nonemergency services, inform a patient or prospective  
 127 patient that the estimated amount the health care provider will bill the patient for health  
 128 care services is available upon request; and

129 (2) Upon receipt of a request from a patient or prospective patient, disclose to the patient  
 130 or prospective patient in writing the amount or estimated amount or, with respect to a  
 131 health center, a schedule of fees that the health care provider, group practice, diagnostic  
 132 and treatment center, or health center will bill the patient or prospective patient for health  
 133 care services provided or anticipated to be provided to the patient or prospective patient

134 absent unforeseen medical circumstances that may arise when the health care services are  
135 provided.

136 (c) A health care provider who is a physician shall provide a patient or prospective patient  
137 with the name, practice name, mailing address, and telephone number of any health care  
138 provider scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant  
139 surgeon services in connection with care to be provided in the physician's office for the  
140 patient or coordinated or referred by the physician for the patient at the time of referral to  
141 or coordination of services with such provider.

142 (d) A health care provider who is a physician shall, for a patient's scheduled hospital  
143 admission or scheduled outpatient hospital services, provide a patient and the hospital with  
144 the name, practice name, mailing address, and telephone number of any other physician  
145 whose services will be arranged for by the physician and are scheduled at the time of the  
146 preadmission testing, registration, or admission at the time nonemergency services are  
147 scheduled; and information as to how to determine the health benefit plans in which the  
148 physician participates.

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

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

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

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

160 (3) As applicable, the name, mailing address, and telephone number of the physician  
161 groups that the hospital has contracted with to provide services, including anesthesiology,  
162 pathology, or radiology, and instructions on how to contact these groups to determine the  
163 health benefit plan participation of the physicians in these groups; and

164 (4) As applicable, the name, mailing address, and telephone number of physicians  
165 employed by the hospital and whose services may be provided at the hospital with the  
166 health benefit plans in which they participate.

167 (g) In registration or admission materials provided in advance of nonemergency hospital  
168 services, a hospital shall:

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

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

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

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

182 (h) On and after January 1, 2018, a hospital shall make network participation in the health  
 183 benefit plans insurers contracted by such hospital a credentialing requirement for any  
 184 health care provider in order to receive credentials for providing care or receiving  
 185 admission privileges. As a part of the credentialing agreement, a hospital shall receive the  
 186 power to contract for the network participation of its providers with health benefit plans of  
 187 such insurers, provided that such health care providers shall be responsible for negotiating  
 188 all other terms, conditions, and prices with the health benefit plans insurers. Insurers shall  
 189 conduct all such negotiations in good faith, which obligation shall be enforceable by the  
 190 Commissioner.

191 (i) As a part of a network participation agreement between a health benefit plan insurer  
 192 and a hospital, the plan insurer shall agree to the participation of health care providers  
 193 credentialed by the hospital, unless withholding of such agreement for a particular health  
 194 care provider is based upon cause.

195 (j) Network participation agreements executed by a hospital shall include all appropriate  
 196 units of the hospital operations.

197 (k) Hospital and provider obligations under this Code section shall be enforceable by the  
 198 Department of Community Health.

199 33-20E-3.

200 (a) An insurer shall provide to an enrollee:

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

- 206 (2) Notice that the enrollee shall have direct access to primary and preventive obstetric  
207 and gynecologic services, including annual examinations, care resulting from such annual  
208 examinations, and treatment of acute gynecologic conditions, or for any care related to  
209 a pregnancy, from a qualified provider of such services of her choice from within the  
210 plan;
- 211 (3) All appropriate mailing addresses and telephone numbers to be utilized by enrollees  
212 seeking information or authorization;
- 213 (4) An annually updated listing by specialty, which may be in a separate document, of  
214 the name, address, and telephone number of all participating providers, including  
215 facilities, and in the case of physicians, the board certification, languages spoken, and any  
216 affiliations with participating hospitals. The listing shall also be posted on the insurer's  
217 website and the insurer shall update the website within 15 days of the addition or  
218 termination of a provider from the insurer's network or a change in a physician's hospital  
219 affiliation;
- 220 (5) Where applicable, a description of the method by which an enrollee may submit a  
221 claim for health care services;
- 222 (6) With respect to out-of-network coverage:
- 223 (A) A clear description of the methodology used by the insurer to determine  
224 reimbursement for out-of-network health care services;
- 225 (B) The amount that the insurer will reimburse under the methodology for  
226 out-of-network health care services set forth as a percentage of the usual and customary  
227 cost for out-of-network health care services; and
- 228 (C) Examples of anticipated out-of-pocket costs for frequently billed out-of-network  
229 health care services;
- 230 (7) Information in writing and through an Internet website that reasonably permits an  
231 enrollee or prospective enrollee to estimate the anticipated out-of-pocket cost for  
232 out-of-network health care services in a geographical area or ZIP code based upon the  
233 difference between what the insurer will reimburse for out-of-network health care  
234 services and the usual and customary cost for out-of-network health care services;
- 235 (8) The written application procedures and minimum qualification requirements for  
236 health care providers to be considered by the insurer; and
- 237 (9) Other information as required by the Commissioner.
- 238 (b) An insurer shall disclose whether a health care provider scheduled to provide a health  
239 care service is an in-network provider and, with respect to out-of-network coverage,  
240 disclose the approximate dollar amount that the insurer will pay for a specific  
241 out-of-network health care service. Insurers shall also inform an enrollee through such  
242 disclosure that such approximation is not binding on the insurer and that the approximate

243 dollar amount that the insurer will pay for a specific out-of-network health care service  
244 may change.

245 33-20E-4.

246 An out-of-network referral denial means a denial of a request for an authorization or  
247 referral to an out-of-network provider on the basis that the health benefit plan has a health  
248 care provider in the network benefits portion of its network with appropriate training and  
249 experience to meet the particular health care needs of an enrollee and who is able to  
250 provide the requested health service. The notice of an out-of-network referral denial  
251 provided to an enrollee shall have information explaining what information the enrollee  
252 must submit in order to appeal the out-of-network referral denial. An out-of-network  
253 denial shall not constitute an adverse determination.

254 33-20E-5.

255 (a) An insurer shall provide a description of the method by which an enrollee may submit  
256 a claim for health care services.

257 (b) An insurer shall provide a clear description of the methodology used by such insurer  
258 to determine reimbursement for out-of-network health care services and the amount that  
259 the insurer will reimburse under the methodology for out-of-network health care services  
260 set forth as a percentage of the usual and customary cost for out-of-network health care  
261 services.

262 (c) An insurer shall provide examples of anticipated out-of-pocket costs for frequently  
263 billed out-of-network health care services and information in writing and through an  
264 Internet website that reasonably permits an enrollee or prospective enrollee to estimate the  
265 anticipated out-of-pocket cost for out-of-network health care services in a geographical  
266 area or ZIP code based upon the difference between what the insurer will reimburse for  
267 out-of-network health care services and the usual and customary cost for out-of-network  
268 health care services.

269 (d) An insurer shall disclose whether a health care provider scheduled to provide a health  
270 care service is an in-network provider and, with respect to out-of-network coverage,  
271 disclose the approximate dollar amount that the insurer will pay for a specific  
272 out-of-network health care service. The insurer shall also inform an enrollee through such  
273 disclosure that such approximation is not binding on the insurer and that the approximate  
274 dollar amount that the insurer will pay for a specific out-of-network health care service  
275 may change."



276 **SECTION 2.**

277 This Act shall become effective on January 1, 2018.

278 **SECTION 3.**

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