The House Committee on Insurance offers the following substitute to HB 84:

A BILL TO BE ENTITLED
AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide for consumer protections regarding health insurance; to provide for definitions; to provide for disclosure requirements of providers, hospitals, and insurers; to provide for billing, reimbursement, and arbitration or mediation of certain services; to provide for related matters; to provide an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

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.

As used in this chapter, the term:

(1) 'Alternative dispute resolution' or 'ADR' refers to arbitration or mediation.

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

(3) 'Emergency 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.

(4) 'Enrollee' means a policyholder, subscriber, covered person, or other individual participating in a health care plan.

(5) 'Health care plan' means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, or any health insurance plan established pursuant to Article 1 of Chapter 18 of Title 45; but a health care plan shall not include certain limited benefit insurance policies or plans listed under paragraph (1.1) of Code Section 33-1-2, policies or plans listed under paragraph (3) of subsection (a) of Code Section 33-24-59.15, or policies issued in accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating to workers' compensation.

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

(7) 'Health care 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 health care services which include appliances and supplies; nursing care by a registered nurse or a licensed practical 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.

(8) 'Insurer' means any person engaged as indemnitor, surety, or contractor that issues insurance, annuity or endowment contracts, subscriber certificates, or other contracts of insurance by whatever name called. Health care plans under Chapter 20A of this title and health maintenance organizations are insurers within the meaning of this chapter.

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

33-20E-2.

(a) Upon request by a patient or prospective patient, a health care provider, group practice of health care providers, diagnostic and treatment center, or health center on behalf of health care providers rendering services at a group practice, diagnostic and treatment center, or health center shall disclose to patients or prospective patients in writing or through a website the health care plans with which the health care provider, group practice, diagnostic and treatment center, or health center has an executed participation agreement and the hospitals with which the health care provider is affiliated prior to the provision of nonemergency services and, upon request, verbally at the time an appointment is scheduled or confirm coverage prior to service being provided.

(b) If a health care provider, group practice of health care providers, diagnostic and treatment center, or health center on behalf of health care providers rendering services at a group practice, diagnostic and treatment center, or health center does not have an executed participation agreement with a patient's or prospective patient's health care plan, the health care provider, group practice, diagnostic and treatment center, or health center shall:

(1) Prior to the provision of nonemergency services, inform such patient or prospective patient in writing that the estimated amount the health care provider, group practice, diagnostic and treatment center, or health center will bill the patient or prospective patient for health care services is available to such patient or prospective patient upon the request of such patient or prospective patient; and

(2) Upon receipt of a request from a patient or prospective patient, disclose to the patient or prospective patient in writing the amount, the estimated amount, or a schedule of fees that the health care provider, group practice, diagnostic and treatment center, or health center will bill the patient or prospective patient for health care services provided or anticipated to be provided to the patient or prospective patient absent unforeseen medical circumstances that may arise when the health care services are provided. Estimates shall not be binding on the provider or patient.

(c) A health care provider who is a physician shall upon request provide a patient or prospective patient with the name, practice name, mailing address, and telephone number of any health care provider scheduled by such physician or physician's office to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office for the patient.

(d) A health care provider who is a physician shall, for a patient's scheduled inpatient or outpatient hospital admission, provide such patient and hospital with the name, practice name, mailing address, and telephone number of any other physician or group of physicians whose services will be arranged for by the treating physician and are scheduled at the time of the preadmission testing, registration, or admission at the time nonemergency services are scheduled and information on how to determine the health care plans in which the treating physician participates.

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

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

(1) The names and hyperlinks for direct access to websites of all health care plans or insurers for which the hospital contracts as a network provider or participating provider;

(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 care plans as the hospital, and that the prospective patient should check with the physician arranging for the hospital services to determine the health care 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 or that the hospital has employed to provide hospital based services, including anesthesiology, pathology, or radiology, and instructions on how to contact such groups to determine the health care plan participation of the physicians in such groups.

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

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

(A) The name, practice name, mailing address, and telephone number of any other physician who the treating physician has arranged to render service to the patient or prospective patient at the hospital; and

(B) Whether the services of hospital based physicians, including anesthesiology, pathology, and radiology, are reasonably anticipated to be provided to the patient; and

(2) Provide patients or prospective patients upon request with information on how to timely determine the health care plans participated in by physicians who are reasonably anticipated to provide hospital based physician services to such patient or prospective patient at the hospital.

33-20E-3.

(a) An insurer or a health care plan that provides out-of-network coverage shall upon request provide to an enrollee:

(1) Information that an enrollee may make requests under this Code section and may obtain a referral to a health care provider outside of the health care plan's network or panel when the health care plan does not have a health care provider who is geographically accessible to the enrollee and who has appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee can obtain such referral;

(2) Notice that the enrollee 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 enrollees seeking information or authorization;

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

(5) With respect to an insurer or a health care plan that provides out-of-network coverage:

(A) A description of how such insurer determines reimbursement for out-of-network health care services;

(B) The amount that the insurer will reimburse for out-of-network health care services; and

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

(6) Information in writing or through a website that reasonably permits an enrollee or prospective enrollee to estimate the anticipated out-of-pocket costs for out-of-network health care services in a geographical area or ZIP Code;

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

(8) Other similar information as required by the Commissioner.

(b) An insurer shall disclose whether a health care provider scheduled to provide a health care service is an in-network provider and, with respect to an insurer or a health care plan that provides out-of-network coverage, shall disclose the approximate dollar amount that the insurer will pay for a specific out-of-network health care service. The insurer shall also inform an enrollee through such disclosure that such approximation is not binding on the

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

33-20E-4.

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

33-20E-5.

(a) An initial provider billing for health care services shall be sent to a patient within 90 days of the date on which all health care plans, insurers, and other responsible third-party payors have notified the provider of the amount for which the patient is responsible for payment and all appeals of such determination have been exhausted.

(b) The patient or his or her legal representative shall be required to secure payment, negotiate amounts, or otherwise act upon the billing within 90 days. Only after the passage of 90 days shall the applicable provider be authorized to commence any extraordinary collection action as defined by Section 501(r) of the Internal Revenue Code and any implementation regulations. Nothing in this subsection shall preempt the provisions for timely payment of benefits by a health benefit plan or insurer under Code Sections 33-24-59.5 and 33-24-59.14.

(c) Alternative dispute resolution may be initiated by the patient, person responsible for payment, or his or her legal representative within 90 days of receipt of a bill for emergency services from a health care provider by filing an application with the Commissioner. The Commissioner shall provide rules and procedures for handling the alternative dispute resolution process, including, but not limited to, a minimum amount owed to qualify for alternative dispute resolution, and shall require the participation of the patient's health care plan or insurer. Each party to the alternative dispute resolution shall be responsible for an equal portion of the cost of the proceedings.

(d) A decision in the alternative dispute resolution process under this Code section shall be final.″

SECTION 2.

This Act shall become effective on January 1, 2020.

SECTION 3.

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