

The House Committee on Insurance offers the following substitute to SB 8:

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 payment of emergency services; to provide for related matters; to repeal conflicting laws; and
5 for other purposes.

6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

7 **SECTION 1.**

8 This Act shall be known and may be referred to as the "Surprise Billing and Consumer
9 Protection Act."

10 **SECTION 2.**

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

13 "CHAPTER 20E

14 33-20E-1.

15 As used in this chapter, the term:

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

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

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

23 (B) Serious impairment to bodily functions; or

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

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

27 (4) 'Health care plan' means any hospital or medical insurance policy or certificate,
 28 health care plan contract or certificate, qualified higher deductible health plan, health
 29 maintenance organization subscriber contract, any health insurance plan established
 30 pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy;
 31 but a health care plan shall not include certain limited benefit insurance policies or plans
 32 listed under paragraph (1.1) of Code Section 33-1-2, except for dental or vision plans,
 33 policies issued in accordance with Chapter 31 of this title, relating to credit life insurance
 34 and credit accident and sickness insurance, Chapter 9 of Title 34, relating to workers'
 35 compensation, or Chapter 21A of this title, relating to Medicaid care management
 36 organizations.

37 (5) 'Health care provider' or 'provider' means any physician, dentist, podiatrist,
 38 pharmacist, optometrist, psychologist, clinical social worker, advanced practice registered
 39 nurse, registered optician, licensed professional counselor, physical therapist, marriage
 40 and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section
 41 43-5-8, occupational therapist, speech-language pathologist, audiologist, dietitian, or
 42 physician assistant.

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

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

49 (B) Medical services which include the general and usual care and services rendered
 50 and administered by doctors of medicine, doctors of dental surgery, and doctors of
 51 podiatry; and

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

61 (7) 'Health center' means an entity that serves a population that is medically underserved
62 or a special medically underserved population composed of migratory and seasonal
63 agricultural workers, the homeless, and residents of public housing, by providing, either
64 through the staff and supporting resources of the center or through contracts or
65 cooperative arrangements for required primary health services and as may be appropriate
66 for particular centers, additional health services necessary for the adequate support of the
67 primary health services for all residents of the area served by the health center.

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

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

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

78 (11) 'Patient' means a person who seeks or receives health care services under a health
79 care plan.

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

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

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

97 (A) A covered person for services rendered by a nonparticipating physician at a
 98 participating hospital or ambulatory surgical center when a participating physician is
 99 unavailable or a nonparticipating physician renders services without the covered
 100 person's knowledge or when unforeseen medical services arise at the time the health
 101 care services are rendered; provided, however, that a surprise bill shall not mean a bill
 102 received for health care services when a participating physician is available and the
 103 covered person has elected to obtain services from a nonparticipating physician;
 104 (B) A covered person for services rendered by a nonparticipating provider when the
 105 services were arranged by a participating physician to a nonparticipating provider
 106 without the explicit written consent of the covered person acknowledging that the
 107 participating physician is referring the covered person to a nonparticipating provider
 108 and that the referral may result in costs not covered by the health care plan; or
 109 (C) A patient who is not a covered person for services rendered by a physician at a
 110 hospital or ambulatory surgical center when the patient has not timely received all of
 111 the disclosures required by Code Section 33-20E-2.

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 a website the health care plans with which the
 117 health care provider, group practice, diagnostic and treatment center, or health center has
 118 an executed participation agreement and the hospitals with which the health care provider,
 119 group practice, diagnostic and treatment center, or health center is affiliated prior to the
 120 provision of nonemergency services and verbally at the time an 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 care plan, the health care provider,
 125 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, group practice, diagnostic and
 128 treatment center, or health center will bill the patient for health care services is available
 129 upon request; and

130 (2) Upon receipt of a request from a patient or prospective patient, disclose to the patient
 131 or prospective patient in writing the amount or estimated amount or, with respect to a
 132 health center, a schedule of fees that the health care provider, group practice, diagnostic

133 and treatment center, or health center will bill the patient or prospective patient for health
134 care services provided or anticipated to be provided to the patient or prospective patient
135 absent unforeseen medical circumstances that may arise when the health care services are
136 provided.

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

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

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

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

156 (1) The health care plans with which the hospital has an executed participation
157 agreement;

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

163 (3) As applicable, the name, mailing address, and telephone number of the physician
164 groups that the hospital has contracted with or employed to provide hospital based
165 services, including anesthesiology, pathology, or radiology, and instructions on how to
166 contact these groups to determine the health care plan participation of the physicians in
167 these groups; and

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

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

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

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

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

179 (2) Provide patients or prospective patients with information as to how to timely
180 determine the health care plans participated in by physicians who are reasonably
181 anticipated to provide hospital based physician services to the patient at the hospital, as
182 determined by the physician arranging the patient's hospital services.

183 33-20E-3.

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

185 (1) Information that an enrollee may obtain a referral to a health care provider outside
186 of the health care plan's network or panel when the health care plan does not have a
187 health care provider who is geographically accessible to the enrollee and who has
188 appropriate training and experience in the network or panel to meet the particular health
189 care needs of the enrollee and the procedure by which the enrollee can obtain such
190 referral;

191 (2) Notice that the enrollee shall have direct access to primary and preventive obstetric
192 and gynecologic services, including annual examinations, care resulting from such annual
193 examinations, and treatment of acute gynecologic conditions, or for any care related to
194 a pregnancy, from a qualified provider of such services of her choice from within the
195 plan;

196 (3) All appropriate mailing addresses and telephone numbers to be utilized by enrollees
197 seeking information or authorization;

198 (4) An annually updated listing by specialty, which may be in a separate document, of
199 the name, address, and telephone number of all participating providers, including
200 facilities, and in the case of physicians, the board certification, languages spoken, and any
201 affiliations with participating hospitals. The listing shall also be posted on the insurer's
202 website and the insurer shall update the website within 15 days of the addition or

203 termination of a provider from the insurer's network or a change in a physician's hospital
 204 affiliation;

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

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

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

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

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

215 (7) Information in writing and through a website that reasonably permits an enrollee or
 216 prospective enrollee to estimate the anticipated out-of-pocket cost for out-of-network
 217 health care services in a geographical area or ZIP code based upon the difference between
 218 what the insurer will reimburse for out-of-network health care services and the usual and
 219 customary cost for out-of-network health care services;

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

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

223 (b) An insurer shall disclose whether a health care provider scheduled to provide a health
 224 care service is an in-network provider and, with respect to out-of-network coverage,
 225 disclose the approximate dollar amount that the insurer will pay for a specific
 226 out-of-network health care service. Insurers shall also inform an enrollee through such
 227 disclosure that such approximation is not binding on the insurer and that the approximate
 228 dollar amount that the insurer will pay for a specific out-of-network health care service
 229 may change.

230 33-20E-4.

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

239 33-20E-5.

240 For situations in which emergency services are rendered to a health care plan enrollee by
241 an out-of-network physician, such physician shall not balance bill the enrollee, provided
242 that the reimbursement allowed by the health care plan to the out-of-network physician is
243 the greatest of:

244 (1) The median network rate paid by the health care plan;

245 (2) The rate of the health care plan in its standard formula for out-of-network
246 reimbursement; or

247 (3) The medicare fee for service reimbursement;

248 all as calculated for the same or similar services rendered in the general geographic region
249 and provided by federal law and regulations."

250

SECTION 3.

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