House Bill 678

By: Representatives Smith of the 134th, Meadows of the 5th, Hawkins of the 27th, Newton of the 123rd, Burns of the 159th, and others

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

(2) '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.

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

(4) '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 or policies issued in accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating to workers' compensation.

(5) '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.

(6) '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.

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

adequate support of the primary health care services for all residents of the area served by the health center.

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

(10) '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.

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

33-20E-2.

(a) 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.

(c) A health care provider who is a physician shall provide a patient or prospective patient with the name, practice name, mailing address, and telephone number of any health care provider scheduled by the 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 or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such provider.

(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) A hospital shall establish, update, and make public through posting on the hospital's website, to the extent required by federal guidelines, 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 on the hospital's website:

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

(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 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 shall provide to an enrollee:

(1) Information that an enrollee 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 out-of-network coverage:

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

(B) The amount that the insurer will reimburse under the methodology 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 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 out-of-network coverage, 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 billing for health care goods or services shall be sent in compliance with paragraph (14) of subsection (b) of Code Section 10-1-393, and for providers not subject to such provision, not later than 90 days from the date of discharge of the patient or the last instance of furnishing goods or services. The person responsible for payment shall have 90 days thereafter to secure payment, negotiate amounts, initiate arbitration, or otherwise

act upon the billing. Only after the passage of 90 days shall the provider or hospital be authorized to commence formal collection efforts.

(b) Arbitration may be initiated by the patient or person responsible for payment within the 90 day period by filing an application with the Commissioner. The Commissioner shall provide rules and procedures for handling the arbitration process. Each party to the arbitration shall be responsible for one-half of the costs of proceedings.

(c) A decision in the arbitration under this Code section shall be final."

**SECTION 2.**

This Act shall become effective on January 1, 2019.

**SECTION 3.**

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