House Bill 71

By: Representatives Smith of the 134th, Powell of the 171st, Caldwell of the 131st, England of the 116th, and Ballinger of the 23rd

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 network composition; to provide for billing and reimbursement of in-network and out-of-network services; to provide for payment of emergency 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 benefit 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 benefit plan.

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

(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 services and care 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 or air 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 comprised 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 services and as may be appropriate

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

(8) 'Insurer' means any person engaged as indemnitor, surety, or contractor who issues insurance, annuity or endowment contracts, subscriber certificates, or other contracts of insurance by whatever name called. Health care plans and health maintenance organizations are included as 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 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 benefit plan.

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

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

(13) 'Required primary health services' means health 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 screening; 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.

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

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

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

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

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

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

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 an Internet website the health benefit plans in which the health care provider, group practice, diagnostic and treatment center, or health center is a participating provider and the hospitals with which the health care provider is affiliated prior to the provision of nonemergency services and verbally at the time an appointment is scheduled.

(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 participate in the network of a patient's or prospective patient's health benefit plan, the health care provider, group practice, diagnostic and treatment center, or health center shall:

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

(2) Upon receipt of a request from a patient or prospective patient, disclose to the patient or prospective patient in writing the amount or estimated amount or, with respect to a health center, 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 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 hospital admission or scheduled outpatient hospital services, provide a patient and the hospital with the name, practice name, mailing address, and telephone number of any other physician whose services will be arranged for by the physician and are scheduled at the time of the preadmission testing, registration, or admission at the time nonemergency services are scheduled; and information as to how to determine the health benefit plans in which the 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 by 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 benefit plans in which the hospital is a participating provider;

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

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

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

(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 to determine:

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

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

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

(h) On and after January 1, 2018, a hospital shall make network participation in the health benefit plans insurers contracted by such hospital a credentialing requirement for any health care provider in order to receive credentials for providing care or receiving admission privileges. As a part of the credentialing agreement, a hospital shall receive the power to contract for the network participation of its providers with health benefit plans of such insurers.

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

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

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 insurer's network or panel when the insurer 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) An annually updated listing by specialty, which may be in a separate document, of the name, address, and telephone number of all participating providers, including facilities, and in the case of physicians, the board certification, languages spoken, and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within 15 days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

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

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

(A) A clear description of the methodology used by the 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 set forth as a percentage of the usual and customary cost 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;

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

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

(9) 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. Insurers 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 benefit 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 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 insurer shall provide a description of the method by which an enrollee may submit a claim for health care services.

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

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

(d) 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.″

SECTION 2.

This Act shall become effective on January 1, 2018.

SECTION 3.

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