Senate Bill 359

By: Senators Hufstetler of the 52nd, Burke of the 11th, Watson of the 1st, Kirkpatrick of the 32nd, Henson of the 41st and others

AS PASSED SENATE

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to establish standards for carriers and health care providers with regard to payment under a managed care plan in the provision of emergency medical care; to provide for applicability; to provide for definitions; to provide for certain patient or prospective patient disclosures; to provide for insurer disclosures; to provide for requirements regarding the provision of emergency medical care for covered persons under a managed care plan; to provide for requirements for managed care plan contracts between carriers and covered persons; to provide for payments to providers; to provide for penalties for violations; to provide for mediation; to provide for related matters; to provide for a short title; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

This Act shall be known and may be cited as the "Consumer Coverage and Protection for Out-of-Network Medical Care Act."

SECTION 2.

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.

This chapter shall apply to all carriers providing a managed care plan that pays for the provision of medical care to covered persons.

33-20E-2.

As used in this chapter, the term:

(1) 'Balance bill' means the amount that a nonparticipating provider may charge a covered person. Such amount charged shall equal the difference between the amount paid by the carrier and the amount of the nonparticipating provider's bill charge but shall not include any amount for coinsurance, copayments, or deductibles due from the covered person.

(2) 'Carrier' means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of emergency medical care or through an emergency medical services system or through a health benefit plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

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

(4) 'Elective medical care' means medical services not defined as 'emergency medical care' under this chapter.

(5) 'Emergency condition' means any medical condition of a recent onset and 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.

(6) 'Emergency medical care' means emergency services which originate in a hospital emergency department after the onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical or surgical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, and services for the first 24 hours after the covered person's emergency condition has stabilized, whether or not the emergency services and services after stabilization occur in an emergency department. Such term shall include care for an emergency condition that continues once a patient is admitted

to the hospital from the hospital emergency department and could include other specialists and providers.

(7) 'Emergency medical provider' means any physician licensed by the Georgia Composite Medical Board who provides emergency medical care and any other health care provider licensed in this state who renders emergency medical care.

(8) 'First dollar coverage' means payment by a carrier directly to a health care provider for services of the entire allowed amount for such services pursuant to Code Section 33-20E-3 without any reduction in payment for the managed care plan's required coinsurance, copayments, deductibles, or other patient financial responsibility. The carrier shall be responsible for collecting these amounts directly from the covered person.

(9) 'Health care provider' means any physician or other person who is licensed or otherwise authorized in this state to furnish emergency medical care.

(10) 'Managed care plan' means a major medical, hospitalization, or dental plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(A) Arrangements with selected providers to furnish health care services;

(B) Explicit standards for the selection of participating providers; and

(C) Cost savings for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

The term 'managed care plan' shall not apply to Chapter 9 of Title 34, relating to workers' compensation.

(11) 'Minimum benefit standard' or 'MBS' means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking data base maintained by a nonprofit organization specified by the Commissioner. The nonprofit organization shall not be affiliated, financially supported, or otherwise supported by a health insurance company.

(12) 'Nonparticipating provider' means a health care provider who has not entered into a direct contract with a carrier for the delivery of emergency medical care to covered persons under a managed care plan.

(13) 'Participating provider' means a health care provider who has entered into a direct contract with a carrier for the delivery of emergency medical care to covered persons under a managed care plan.

(14) 'Stabilized' means the effect of providing medical or surgical treatment for an emergency condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur

during the transfer of the patient from a facility, or that with respect to a pregnant woman who is having contractions, the woman has delivered the child and the placenta.

(15) 'Surprise bill' means a bill to a patient after elective medical care where an unanticipated event results in the provision of services by an out-of-network provider.

(16) 'Usual and customary cost' means the charges routinely billed by the provider for its professional services regardless of the payor involved and before any discounts that are applied pursuant to charity or indigent patient charge policies or insurance carrier contracting discounts.

33-20E-3.

(a) A health care provider who is a physician shall provide a patient or prospective patient with the name or practice name, mailing address, and telephone number of any health care provider that the office or surgery center utilizes for the provision of anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office or an ambulatory surgery center owned by the physician for the patient at least 48 hours prior to the provision of services where possible. Such information may be provided by publication on the provider's website.

(b) Where an unanticipated event causes a change in the providers of radiology, anesthesiology, pathology, or other services, the physician shall be held harmless for any resulting bills from such provider or providers.

(c) 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.

(d) 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; and

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

(e) 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 or 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 on how to timely determine the health benefit plans in which the physicians participate 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, pathology, and radiology.

(f) Unknown or unanticipated services are not subject to the requirements of this Code section.

33-20E-4.

(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) A monthly 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;

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

(D) Notice that the patient may be responsible for the balance of the out-of-network provider's fee if the rate paid by the plan is below the provider's billed amount;

(7) Information in writing and through an Internet 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 based upon the difference between the amount that the insurer will reimburse for out-of-network health care services, the patient's MBS, 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 furnish an explanation of benefits to an out-of-network provider within 30 days of receiving a bill from the insured or directly from the out-of-network provider. The explanation of benefits shall conspicuously indicate whether the health care plan coverage for the patient is subject to the requirements of this chapter, or otherwise preempted under 29 U.S.C. Section 1144(a) as a self-funded employee welfare plan regulated under the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1002(1).

(c) 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 shall not be binding on the insurer and that the approximate dollar amount that the insurer shall pay for a specific out-of-network health care service may change.

(d) Where services have been precertified or preauthorized by an insurer, the insurer shall guarantee coverage of such services at the usual and customary cost regardless of any changes of network status following the precertification or preauthorization.

(e) Where an insurer fails to adequately and correctly keep its directory pursuant to Code Section 33-20C-2 and such failure results in the unanticipated provision of out-network services, the insurer shall compensate the provider at the provider's usual and customary cost or MBS, whichever is less.

(f) Where a delay in the credentialing of a provider causes the service to be deemed out-of-network, the insurer shall compensate the provider at the provider's full rate at no expense to the patient.

33-20E-5.

(a) Notwithstanding any provision of law to the contrary, a carrier that provides any benefits to covered persons with respect to emergency medical care shall pay for such emergency medical care:

(1) Without the need for any prior authorization determination and without any retrospective payment denial for services rendered; and

(2) Regardless of whether the health care provider furnishing emergency medical care is a participating provider with respect to emergency medical care.

(b) In the event a covered person receives emergency medical care by a nonparticipating provider, the nonparticipating provider shall bill the carrier directly and the carrier shall directly pay, within 15 days for electronic claims and 30 days for paper claims, the nonparticipating provider as coded, with first dollar coverage, for the emergency medical care rendered to the covered person by the lesser of:

(1) The nonparticipating provider's actual billed charges; or

(2) The minimum benefit standard. The charges shall be tied to 2017 charges and may be adjusted for inflation according to the Consumer Price Index for medical care or another indicator as determined by the department. Such data base shall be accessible to providers without charge.

Payment shall be made without retrospective denials and without deductions for the plan's coinsurance, copayments, and deductibles. The carrier shall collect any required coinsurance, copayments, deductibles, or other patient financial responsibilities directly from the covered person pursuant to the provisions of the managed care plan contract. Patient responsibility is limited to the in-network payment as required under the managed care plan contract.

(c) A managed care plan shall not deny benefits for emergency medical care previously rendered, based upon a covered person's failure to provide subsequent notification in

accordance with plan provisions, where the covered person's medical condition prevented timely notification.

(d) In the event a covered person receives emergency medical care by a nonparticipating provider, once such covered person is stabilized, as required by the federal Emergency Medical Treatment and Active Labor Act, the carrier shall arrange for transfer of the covered person to a participating provider at the carrier's cost. If the carrier fails to transfer such covered person within 24 hours after the covered person is stabilized, the carrier shall pay the entirety of the nonparticipating provider's charges for the care of the covered person thereafter in accordance with the payment criteria provided in subsection (b) of this Code section.

(e) Carriers shall not communicate or include in written form false, misleading, or confusing information in their explanation of benefits to patients or guarantors regarding usual and customary costs, balance billing, or mediation disputes between physicians and carriers.

(f) For purposes of an enrollee's financial responsibilities, the health care plan shall treat the health care services the enrollee receives from an out-of-network provider pursuant to this Code section as if the services were provided by an in-network provider, including counting the enrollee's cost sharing for such services toward the enrollee's deductible and maximum out-of-pocket limit applicable to services obtained from in-network providers under the health care plan.

33-20E-6.

No managed care plan shall deny or restrict in-network covered benefits to a covered person solely because the covered person obtained treatment outside the network. Notice of such protection shall be provided in writing to the covered person by the carrier.

33-20E-7.

(a)(1) A managed care plan contract issued, amended, or renewed on or after July 1, 2018, shall provide that if a covered person receives emergency medical care from a nonparticipating provider at either an in-network facility or an out-of-network facility, such covered person shall not be required to pay more to the carrier than the same amount that the covered person would have to pay to the carrier for the same emergency medical care received from a similar participating provider at a similar in-network facility. Such amount shall be referred to as the 'in-network cost-sharing amount.'

(2) Neither a nonparticipating provider nor a participating provider shall bill or collect any amount from the covered person for emergency medical care subject to paragraph (1) of this subsection. Coinsurance, copayments, and deductibles shall be collected by the

carrier, and first dollar coverage shall be paid by the carrier directly to the provider in a timely manner, as coded and billed, and without retrospective denials.

(b) A managed care plan contract issued, amended, or renewed on or after July 1, 2018, shall provide that, if a covered person receives emergency medical care from a nonparticipating provider, any cost-sharing amount attributable to an out-of-network deductible shall be applied to such covered person's in-network deductible.

33-20E-8.

(a) A violation of this chapter by a carrier shall be considered an unfair trade practice under Article 1 of Chapter 6 of this title and shall be subject to penalties as determined by the department.

(b) This Code section shall not apply to any health care provider or emergency medical provider.

33-20E-9.

(a) Where a patient obtains elective medical care and an unexpected event arises resulting in a surprise bill to a patient, mediation shall be available from the department where the resulting bill to the patient is greater than $1,000.00. Surprise bills under such threshold shall not qualify for mediation under this subsection, provided that:

(1) Participants in such a mediation shall include the patient or the patient's authorized representative, the insurer, and the provider of the care resulting in the bill to the patient;

(2) Patients shall submit accurate and complete health insurance information prior to receiving services;

(3) Where possible, mediation shall occur by teleconference;

(4) In determining appropriate payment, the Gould Standard shall be taken into account by the parties involved; and

(5) Costs not specific to any one party shall be shared evenly among all parties to the mediation.

(b) The department shall develop rules in accordance with the requirements of this Code section."

SECTION 3.

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