

Senate Bill 303

By: Senators Watson of the 1st, Jones of the 25th, Butler of the 55th, Unterman of the 45th, Martin of the 9th and others

AS PASSED SENATE

**A BILL TO BE ENTITLED
AN ACT**

To amend Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, so as to provide for greater transparency of prices for nonemergency health care services; to provide for a short title; to provide for definitions; to provide for the disclosure of certain pricing information through insurer websites to allow consumers to compare prices; to provide that insurers may use third parties to comply with such requirements; to provide for certain notice requirements; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, is amended by adding a new Code section to read as follows:

"33-24-59.27.

(a) This Code section shall be known and may be cited as the 'Georgia Right to Shop Act.'

(b) As used in this Code section, the term:

(1) 'Covered person' means an individual who is covered under a health benefit policy.

(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) 'Health benefit policy' or 'policy' means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or

renewed in this state, including, but not limited to, those contracts executed by the state on behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer.

(4) 'Health care provider' or 'provider' means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced practice 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.

(5) 'Health care service' 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 but does not include emergency services.

(6) 'Hierarchical Condition Category Methodology' means a coding system designed by the Centers for Medicare and Medicaid Services to estimate future health care costs for patients.

(7) 'Insurer' means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, preferred provider organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

(c) Each insurer shall make available on its publicly accessible website an interactive mechanism and a toll-free number whereby any member of the public may:

(1) For each health benefit policy offered, compare the payment amounts accepted by in-network providers from such insurer for the provision of a particular health care service within the previous year;

(2) For each health benefit policy offered, obtain an estimate of the average amount accepted by in-network providers from such insurer for the provision of a particular health care service within the previous year;

(3) For each health benefit policy offered, obtain an estimate of the out-of-pocket costs that such covered person would owe his or her provider following the provision of a particular health care service;

(4) Compare quality metrics applicable to in-network providers for major diagnostic categories with adjustments by risk and severity based upon the Hierarchical Condition Category Methodology. Metrics shall be based on reasonably universal and uniform data bases with sufficient claim volume. If applicable to the provider, quality metrics shall include, but not be limited to:

(A) Risk adjusted and absolute hospital readmission rates;

(B) Risk adjusted and absolute hospitalization rates;

(C) Admission volume;

(D) Utilization volume;

(E) Risk adjusted rates of adverse events; and

(F) Risk adjusted and absolute relative total cost of care.

The Commissioner shall promulgate rules and regulations which define the following terms: risk adjusted hospital readmission rates, absolute hospital readmission rates, risk adjusted hospitalization rates, absolute hospitalization rates, admission volume, utilization volume, risk adjusted rates of adverse events, risk adjusted total cost of care, and absolute relative total cost of care. Such terms shall be defined in accordance with federal law or regulation or as otherwise determined necessary by the Commissioner; and

(5) Access any all-payer health claims data base which may be maintained by the department.

(d) An insurer shall provide notification on its website that the actual amount that a covered person will be responsible to pay following the receipt of a particular health care service may vary due to unforeseen costs that arise during the provision of such service.

(e) Each estimate of out-of-pocket costs provided pursuant to paragraph (3) of subsection (c) of this Code section shall provide the following:

(1) The out-of-pocket costs a covered person may owe if he or she has exceeded his or her deductible; and

(2) The out-of-pocket costs a covered person may owe if he or she has not exceeded his or her deductible.

(f) An insurer may contract with a third party to satisfy part or all of the requirements of this Code section.

(g) Nothing in this Code section shall prohibit an insurer from charging a covered person cost sharing beyond that included in the estimate provided pursuant to paragraph (3) of subsection (c) of this Code section if such additional cost sharing resulted from the unforeseen provision of additional health care services and the cost-sharing requirements of such unforeseen health care services were disclosed in such covered person's policy or certificate of insurance.

(h) The requirements of this Code section, with the exception of paragraph (4) of subsection (c) of this Code section, shall not apply to any health maintenance organization health benefits plan as defined in paragraph (4) of Code Section 33-21-1."

SECTION 2.

This Act shall become effective on July 1, 2021.

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SECTION 3.

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