Senate Bill 82

By: Senators Au of the 48th, Watson of the 1st, Burke of the 11th, Kirkpatrick of the 32nd, Hufstetler of the 52nd and others

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 11 of Title 31 of the Official Code of Georgia Annotated, relating to emergency medical services, so as to clarify that the prudent layperson standard is not affected by the final diagnosis given; to amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to also clarify that the prudent layperson standard is not affected by the final diagnosis given; to provide for legislative findings; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

The General Assembly finds:

(1) This state recognizes a "prudent layperson" standard with regard to the need for emergency care;

(2) Insurance companies operating in this state are required to adhere to that standard;

(3) Patients in this state have had emergency medical claims denied due to insurer failure to adhere to the prudent layperson standard as intended;

(4) The federal court system has recognized that this standard is not intended to look to the ultimate diagnosis that a patient receives. Rather, the only relevant considerations are

the patient's symptoms and whether a prudent layperson would think that emergency medical attention is necessary based on those symptoms;

(5) This legislative body has intended and continues to intend that the prudent layperson standard be applied in the same manner; and

(6) In order to better protect Georgians seeking emergency care, legislation is needed not to change the meaning but to clarify the intended application of the prudent layperson standard in this state.

SECTION 2.

Chapter 11 of Title 31 of the Official Code of Georgia Annotated, relating to emergency medical services, is amended by revising Code Section 31-11-81, relating to definitions regarding emergency services, as follows:

"31-11-81.

As used in this article, the term:

(1) 'Emergency condition' means any medical condition of a recent onset and severity, including but not limited to severe pain, regardless of the final diagnosis that is given, 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.

(2) 'Emergency medical provider' means any provider of emergency medical transportation licensed or permitted by the Department of Public Health, any hospital licensed or permitted by the Department of Community Health, any hospital based service, or any physician licensed by the Georgia Composite Medical Board who provides emergency services.

(3) 'Emergency services' means emergency medical transportation or health care services provided in a hospital emergency facility to evaluate and treat any emergency condition.

(4) 'Prospective authorization' means contacting for approval or authorization to evaluate and treat a patient any insurer, health maintenance organization, hospital medical service corporation, or health benefit plan, a representative of which is not physically present in the hospital's emergency department at the time such patient presents for emergency services."

SECTION 3.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by revising Code Section 33-20A-3, relating to definitions regarding managed health care plans, as follows:

"33-20A-3.

As used in this article, the term:

(1) 'Emergency services' or 'emergency care' means those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, regardless of the final disposition that is given, 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.

(2) 'Enrollee' means an individual who has elected to contract for or participate in a managed care plan for that individual or for that individual and that individual's eligible dependents.

(3) 'Facility' means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution for examination, diagnosis, treatment, surgery, or maternity care but does not include physicians' or dentists' private offices and treatment rooms in which such physicians or dentists primarily see, consult with, and treat patients.

(4) 'Health benefit plan' has the same meaning as provided in Code Section 33-24-59.5.

(5) '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.

(6) 'Home health care provider' means any provider or agency that provides health care services in a patient's home including the supply of durable medical equipment for use in a patient's home.

(7) 'Limited utilization incentive plan' means any compensation arrangement between the plan and a health care provider or provider group that has the effect of reducing or limiting services to patients.

(8) 'Managed care contractor' means a person who:

(A) Establishes, operates, or maintains a network of participating providers;

(B) Conducts or arranges for utilization review activities; and

(C) Contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(9) 'Managed care entity' includes an insurance company, hospital or medical service plan, hospital, health care provider network, physician hospital organization, health care

provider, health maintenance organization, health care corporation, employer or employee organization, or managed care contractor that offers a managed care plan.

(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; provided, however, that the term 'managed care plan' does not apply to Chapter 9 of Title 34, relating to workers' compensation.

(11) 'Nonurgent procedure' means any nonemergency or elective care that can be scheduled at least 24 hours prior to the service without posing a significant threat to the patient's health or well-being.

(12) 'Out of network' or 'point of service' refers to health care items or services provided to an enrollee by providers who do not belong to the provider network in the managed care plan.

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

(14) 'Precertification' or 'preauthorization' means any written or oral determination made at any time by an insurer or any agent thereof 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.

(15) 'Qualified managed care plan' means a managed care plan that the Commissioner certifies as meeting the requirements of this article.

(16) 'Verification of benefits' means any written or oral determination by an insurer or agent thereof of whether given health care services are a covered benefit under the enrollee's health benefit plan without a determination of precertification or preauthorization as to such services. 'Agent' as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.″

SECTION 4.

Said title is further amended by revising Code Section 33-20E-2, relating to application to insurers and definitions regarding surprise billing, as follows:

″33-20E-2.

(a) This chapter shall apply to all insurers providing a healthcare plan that pays for the provision of healthcare services to covered persons.

(b) As used in this chapter, the term:

(1) 'Balance bill' means the amount that a nonparticipating provider charges for services provided to a covered person. Such amount equals the difference between the amount paid or offered by the insurer and the amount of the nonparticipating provider's bill charge, but shall not include any amount for coinsurance, copayments, or deductibles due by the covered person.

(2) 'Contracted amount' means the median in-network amount paid during the 2017 calendar year by an insurer for the emergency or nonemergency services provided by in-network providers engaged in the same or similar specialties and provided in the same or nearest geographical area. Such amount shall be annually adjusted by the department for inflation which may be based on the Consumer Price Index, and shall not include Medicare or Medicaid rates.

(3) 'Covered person' means an individual who is insured under a healthcare plan.

(4) 'Emergency medical provider' means any physician licensed by the Georgia Composite Medical Board who provides emergency medical services and any other

healthcare provider licensed or otherwise authorized in this state to render emergency medical services.

(5) 'Emergency medical services' means medical services rendered after the recent onset of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of sufficient severity, including, but not limited to, severe pain, regardless of the final diagnosis that is given, 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) 'Facility' means a hospital, an ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution.

(7) 'Geographic area' means a specific portion of this state which shall consist of one or more ~~zip~~ ZIP codes as defined by the Commissioner pursuant to department rule and regulation.

(8) 'Healthcare plan' means any hospital or medical insurance policy or certificate, healthcare plan contract or certificate, qualified higher deductible health plan, health maintenance organization or other managed care subscriber contract, or state healthcare plan. This term shall not include limited benefit insurance policies or plans listed under paragraph (3) of Code Section 33-1-2, air ambulance insurance, or policies issued in accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating to workers' compensation, Part A, B, C, or D of Title XVIII of the Social Security Act (Medicare), or any plan or program not described in this paragraph over which the Commissioner does not have regulatory authority. Notwithstanding paragraph (3) of Code Section 33-1-2 and any other provision of this title, for purposes of this chapter this term shall include stand-alone dental insurance and stand-alone vision insurance.

(9) 'Healthcare provider' or 'provider' means any physician, other individual, or facility other than a hospital licensed or otherwise authorized in this state to furnish healthcare services, including, but not limited to, any dentist, podiatrist, 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.

(10) 'Healthcare services' means emergency or nonemergency medical services.

(11) 'Insurer' means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including those of an accident and sickness insurance company, a health maintenance organization, a healthcare plan, a managed care plan, or any other entity providing a health insurance plan, a health benefit plan, or healthcare services.

(12) 'Nonemergency medical 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 an illness, injury, or other human physical problem which does not qualify as an emergency medical service 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, dentistry, optometry, and other providers; and

(C) Other medical services which, by way of illustration only and without limiting the scope of this chapter, include the provision of appliances and supplies; nursing care by a registered nurse; institutional services, including the general and usual care, services, supplies, and equipment furnished by healthcare institutions and agencies or entities

other than hospitals; physiotherapy; 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 healthcare which does not qualify as an emergency medical service.

(13) 'Out-of-network' refers to healthcare services provided to a covered person by providers or facilities who do not belong to the provider network in the healthcare plan.

(14) 'Nonparticipating provider' means a healthcare provider who has not entered into a contract with a healthcare plan for the delivery of medical services.

(15) 'Participating provider' means a healthcare provider that has entered into a contract with an insurer for the delivery of healthcare services to covered persons under a healthcare plan.

(16) 'Resolution organization' means a qualified, independent, third-party claim dispute resolution entity selected by and contracted with the department.

(17) 'State healthcare plan' means:

(A) The state employees' health insurance plan established pursuant to Article 1 of Chapter 18 of Title 45;

(B) The health insurance plan for public school teachers established pursuant to Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20;

(C) The health insurance plan for public school employees established pursuant to Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20; and

(D) The Regents Health Plan established pursuant to authority granted to the board pursuant to Code Sections 20-3-31, 20-3-51, and 31-2-4.

(18) 'Surprise bill' means a bill resulting from an occurrence in which charges arise from a covered person receiving healthcare services from an out-of-network provider at an in-network facility.″

SECTION 5.

Said title is further amended by revising Code Section 33-21A-2, relating to definitions regarding Medicaid care management organizations, as follows:

"33-21A-2.

As used in this chapter, the term:

(1) 'Care management organization' means an entity that is organized for the purpose of providing or arranging health care, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21 of this title, and which has entered into a contract with the Department of Community Health to provide or arrange health care services on a prepaid, capitated basis to members.

(2) 'Coordination of care' means early identification of members who have or may have special needs; assessment of a member's risk factors; development of a plan of care; referrals and assistance to ensure timely access to providers; actively linking the member to providers, medical services, and residential, social, and other support services where needed; monitoring; continuity of care; and follow-up and documentation, all as further described pursuant to the terms of the contracts between the Department of Community Health and the care management organizations.

(3) 'Critical access hospital' means a hospital that meets the requirements of the federal Centers for Medicare and Medicaid Services to be designated as a critical access hospital and that is recognized by the Department of Community Health as a critical access hospital for purposes of Medicaid.

(4) 'Emergency health care services' means health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, <u>regardless of the final diagnosis that is given,</u> 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.

(5) 'Health care provider' or 'provider' means any person, partnership, professional association, corporation, facility, or institution certified, licensed, or registered by the State of Georgia that has contracted with a care management organization to provide health care services to members.

(6) 'Health care services' has the same meaning as in paragraph (5) of Code Section 33-21-1.

(7) 'Health maintenance organization' means an entity which has been issued a certificate of authority by the Commissioner of Insurance pursuant to Chapter 21 of this title to establish and operate a health maintenance organization.

(8) 'Hospital Statistical and Reimbursement Report' or 'HS&R report' means a report created by a care management organization, using the same format that is used by the Department of Community Health in completing HS&R reports, that includes data related to an individual hospital, including aggregate statistics and reimbursement data for all Medicaid recipients who are covered by the care management organization and who received health care services at such hospital during a specific fiscal year, including data regarding services that were provided out of network. HS&R reports are utilized by the Department of Community Health for purposes of the Indigent Care Trust Fund's disproportionate share hospital survey and are also utilized by hospitals to claim payments under medicare's disproportionate share hospital program.

(9) 'Medicaid' means the joint federal and state program of medical assistance established by Title XIX of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 7 of Chapter 4 of Title 49.

(10) 'Member' means a Medicaid or PeachCare for Kids recipient who is currently enrolled in a care management organization plan.

(11) 'PeachCare for Kids' means the State of Georgia's State Children's Health Insurance Program established pursuant to Title XXI of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 13 of Chapter 5 of Title 49.

(12) 'Post-stabilization services' means covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

(13) 'Responsible health organization' means the entity that a health care provider reasonably identifies to be responsible for providing or arranging health care services for a patient who is a Medicaid or PeachCare for Kids recipient after the provider has properly conducted an eligibility verification in accordance with the procedures of the Department of Community Health."

SECTION 6.

Said title is further amended by revising Code Section 33-24-59.27, relating to right to shop for insurance coverage, disclosure of pricing information, and notice, effective July 1, 2021, 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, <u>regardless of the final diagnosis that is given,</u> 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:

(A) Physical and occupational therapy services;

(B) Obstetrical and gynecological services;

(C) Radiology and imaging services;

(D) Laboratory services;

(E) Infusion therapy;

(F) Inpatient or outpatient surgical procedures;

(G) Outpatient nonsurgical diagnostic tests or procedures; and

(H) Any services designated by the Commissioner as shoppable by health care consumers.

(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 ~~heath~~ 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 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 or a nationally recognized health care quality reporting standard designated by the Commissioner. 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 unforseen 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 unforseen provision of additional health care services and the cost-sharing requirements

of such unforseen 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 7.

Said title is further amended by revising Code Section 33-30-22, relating to definitions regarding preferred provider arrangements, as follows:

″33-30-22.

As used in this article, the term:

(1) 'Emergency services' or 'emergency care' means those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, regardless of the final diagnosis given, 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.

(2) 'Health benefit plan' means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available.

(3) 'Health care insurer' means an insurer, a fraternal benefit society, a health care plan, or a health maintenance organization authorized to sell accident and sickness insurance policies, subscriber certificates, or other contracts of insurance by whatever name called under this title.

(4) 'Health care provider' means any person duly licensed or legally authorized to provide health care services.

(5) 'Health care services' means services rendered or products sold by a health care provider within the scope of the provider's license or legal authorization. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, chiropractic, psychological, and pharmaceutical services or products.

(6) 'Preferred provider' means a health care provider or group of providers who have contracted to provide specified covered services.

(7) 'Preferred provider arrangement' means a contract between or on behalf of the health care insurer and a preferred provider which complies with all the requirements of this article.″

SECTION 8.

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