[Ga. Code Ann. §§ 33-30-20 through 33-30-27.]

§§ 33-30-20 through 33-30-27: Preferred Provider Arrangements Act

§ 33-30-20. Short title
This article shall be known and may be cited as the "Preferred Provider Arrangements Act."

§ 33-30-21. Legislative intent
It is the intent of the General Assembly to encourage health care cost containment while preserving quality of care by allowing health care insurers to enter into preferred provider arrangements and by establishing minimum standards for preferred provider arrangements and the health benefit plans associated with those arrangements.

§ 33-30-22. Definitions
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, 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.

§ 33-30-23. Standards; payments or reimbursement for noncontracting provider of covered services; filing requirements for unlicensed entities; provision for payment solely to provider

(a) Notwithstanding any provisions of law to the contrary, any health care insurer may enter into preferred provider arrangements as provided in this article. Such arrangements shall:

(1) Establish the amount and manner of payment to the preferred provider;

(2) Include fair, reasonable, and equitable mechanisms for the assignment and payment of benefits to nonpreferred providers;

(3) (A) Include mechanisms which are designed to minimize the cost of the health benefit plan such as the review or control of utilization of health care services.

(B) Include procedures for determining whether health care services rendered are medically necessary;

(4) Provide to covered persons eligible to receive health care services under that arrangement a statement of benefits under the arrangement and, at least every 60 days, an updated listing of physicians who are preferred providers under the arrangement, which statement and listing may be made available by mail or by publication on an Internet service site made available by the health care insurer at no cost to such covered persons; and

(5) Require that the covered person, or that person's agent, parent, or guardian if the covered person is a minor, be permitted to appeal to a physician agent or employee of the health care insurer any decision to deny coverage for health care services recommended by a physician.

(b) Such arrangements shall not:

(1) Unfairly deny health benefits for medically necessary covered services;

(2) Have differences in benefit levels payable to preferred providers compared to other providers which unfairly deny benefits for covered services;

(3) Have differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers which differ by more than 30 percentage points;

(4) Have a coinsurance percentage applicable to benefit levels for services provided by nonpreferred providers which exceeds 40 percent of the benefit levels under the policy for such services;

(5) Have an adverse effect on the availability or the quality of services; and

(6) Be a result of a negotiation with a primary care physician to become a preferred provider unless such physician shall be furnished with a schedule showing common office based fees payable for services under such arrangement.

(c)

(1) Notwithstanding the provisions of paragraphs (3) and (4) of subsection (b) of this Code section, health benefit plans providing incentives for covered persons to use pharmaceutical or dental services of preferred providers shall contain a provision which clearly identifies that the payment or reimbursement for a noncontracting provider of covered pharmaceutical or dental services shall be the same as the payment or reimbursement for a preferred provider of covered pharmaceutical or dental services; provided, however, the health benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the actual fee charged by the provider for the dental or pharmaceutical services rendered.

(2) Notwithstanding any provisions of this title to the contrary, paragraphs (3) and (4) of subsection (b) of this Code section shall not apply to routine physical examinations covered under a health benefit plan.

(d) If an entity enters into a contract providing covered services with a health care provider, but is not engaged in activities which would require it to be licensed as a health care insurer, such entity shall file with the Commissioner information describing its activities and a description of the contract or agreement it has

entered into with the health care providers. Employers who enter into contracts with health care providers for the exclusive benefit of their employees and dependents are exempt from this requirement.
(e) Any other provision of law to the contrary notwithstanding, if a covered person provides in writing to a health care provider, whether the health care provider is a preferred provider or not, that payment for health care services shall be made solely to the health care provider and be sent directly to the health care provider by the health care insurer, and the health care provider certifies to same upon filing a claim for the delivery of health care services, the health care insurer shall make payment solely to the health care provider and shall send said payment directly to the health care provider. This subsection shall not be construed to extend coverages or to require payment for services not otherwise covered.

§ 33-30-24. Health benefit plans providing incentives to use services of preferred providers; minimum requirements

Health care insurers may issue health benefit plans which provide for incentives for covered persons to use the health care services of preferred providers. Such policies or subscriber certificates shall contain at least the following provisions:
(1) A provision that if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, that emergency care rendered during the course of the emergency will be paid for in accordance with the terms of the health benefit plan, at benefit levels at least equal to those applicable to treatment by preferred providers for emergency care in an amount based on the usual, customary, and reasonable charges in the area where the treatment is provided; and
(2) A provision which clearly identifies the differences in benefit levels for health care services of preferred providers and benefit levels for health care services of nonpreferred providers.
For purposes of this Code section, when a request for emergency care is made through the emergency 9-1-1 system on behalf of a covered person and the ambulance service licensed under Chapter 11 of Title 31 that was dispatched in response to the request is not a preferred provider, for purposes of payment under paragraph (1) of this Code section, it shall be presumed that the covered person could not reasonably reach a preferred provider.

§ 33-30-25. Reasonable limits on number or classes of preferred providers

Subject to the approval of the Commissioner under such procedures as he may develop, health care insurers may place reasonable limits on the number or classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against providers on the basis of religion, race, color, national origin, age, sex, or marital or corporate status, and provided, further, that all health care providers within any defined service area who are licensed and qualified to render the services covered by the preferred provider arrangement and who satisfy the standards set forth by the health care insurer shall be given the opportunity to apply and to become a preferred provider.

§ **33-30-26. Applicability of Title 33 and related rules and regulations to health care insurers**

Health care insurers as defined in this article shall be subject to and shall be required to comply with all other applicable provisions of this title and rules and regulations promulgated pursuant to this title.

§ 33-30-27. Promulgation of rules and regulations

The Commissioner shall promulgate all rules and regulations necessary or appropriate to the administration and enforcement of this article.