House Bill 888 (AS PASSED HOUSE AND SENATE)

By: Representatives Hawkins of the 27th, Lott of the 122nd, Rogers of the 10th, Lumsden of the 12th, Smyre of the 135th, and others

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 certain consumer protections against surprise billing; to provide for a short title; to provide for applicability; to provide for definitions; to provide mechanisms to resolve payment disputes between insurers and out-of-network providers or facilities regarding the provision of healthcare services; to require the department to provide for the maintenance of an all-payer health claims data base; to establish an arbitration process; to require the Commissioner of Insurance to contract with one or more resolution organizations; to require the promulgation of department rules; 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.

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 be known and may be cited as the 'Surprise Billing Consumer Protection Act.'

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, 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 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.

33-20E-3.

(a) Nothing in this chapter shall be applicable to healthcare plans which are subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.

(b) This chapter shall be applicable only to healthcare plans and state healthcare plans as defined in this chapter.

33-20E-4.

(a) An insurer that provides any benefits to covered persons with respect to emergency medical services shall pay for such emergency medical services regardless of whether the healthcare provider or facility furnishing emergency medical services is a participating provider or facility with respect to emergency medical services, in accordance with this chapter:

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

(2) Regardless of whether the healthcare provider or facility furnishing emergency medical services is a participating provider or facility with respect to emergency medical services.

(b) In the event a covered person receives the provision of emergency medical services from a nonparticipating emergency medical provider, the nonparticipating provider shall collect or bill no more than such person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such person's policy directly and such insurer shall directly pay such provider the greater of:

(1) The verifiable contracted amount paid by all eligible insurers subject to the provisions of this chapter for the provision of the same or similar services as determined by the department;

(2) The most recent verifiable amount agreed to by the insurer and the nonparticipating emergency medical provider for the provision of the same services during such time as such provider was in-network with such insurer; or

(3) Such higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

Any amount that the insurer pays the nonparticipating provider under this subsection shall not be required to include any amount of coinsurance, copayment, or deductible owed by the covered person or already paid by such person.

(c) A healthcare plan shall not deny benefits for emergency medical services 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) For purposes of the covered person's financial responsibilities, the healthcare plan shall treat the emergency medical services received by the covered person from a nonparticipating provider or nonparticipating facility pursuant to this Code section as if such services were provided by a participating provider or participating facility, and shall include applying the covered person's cost-sharing for such services toward the covered person's deductible and maximum out-of-pocket limit applicable to services obtained from a participating provider or a participating facility under the healthcare plan.

(e) In the event a covered person receives emergency medical services from a nonparticipating facility, the nonparticipating facility shall bill the covered person no more than such covered person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such person's policy directly.

(f) All insurer payments made to providers pursuant to this Code section shall be in accord with Code Section 33-24-59.14. Such payments shall accompany notification to the provider from the insurer disclosing whether the healthcare plan is subject to the exclusive

jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.

33-20E-5.

(a) In accordance with Code Section 33-20E-7 and this chapter, an insurer that provides any benefits to covered persons with respect to nonemergency medical services shall pay for such services in the event that such services resulted in a surprise bill regardless of whether the healthcare provider furnishing nonemergency medical services is a participating provider with respect to nonemergency medical services.

(b) In the event a covered person receives a surprise bill for the provision of nonemergency medical services from a nonparticipating medical provider, the nonparticipating provider shall collect or bill the covered person no more than such person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such person's policy directly and such insurer shall directly pay such provider the greater of:

(1) The verifiable contracted amount paid by all eligible insurers subject to the provisions of this chapter for the provision of the same or similar services as determined by the department;

(2) The most recent verifiable amount agreed to by the insurer and the nonparticipating provider for the provision of the same services during such time as such provider was in-network with such insurer; or

(3) Such higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

Any amount that the insurer pays the nonparticipating provider under this subsection shall not be required to include any amount of coinsurance, copayment, or deductible owed by the covered person or already paid by such person.

(c) For purposes of the covered person's financial responsibilities, the healthcare plan shall treat the nonemergency medical services received by the covered person from a nonparticipating provider pursuant to this Code section as if such services were provided by a participating provider, and shall include applying the covered person's cost-sharing for such services toward the covered person's deductible and maximum out-of-pocket limit applicable to services obtained from a participating provider under the healthcare plan.

(d) All insurer payments made to providers pursuant to this Code section shall be in accord with Code Section 33-24-59.14. Such payments shall accompany notification to the provider from the insurer disclosing whether the healthcare plan is subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.

33-20E-6.

No healthcare plan shall deny or restrict the provision of covered benefits from a participating provider to a covered person solely because the covered person obtained treatment from a nonparticipating provider leading to a balance bill. Notice of such protection shall be provided in writing to the covered person by the insurer.

33-20E-7.

(a) Nothing in this chapter shall reduce a covered person's financial responsibilities in the event that such covered person chose to receive nonemergency medical services from an out-of-network provider. Such services shall not be considered a surprise bill for purposes of this chapter.

(b) The covered person's choice described in subsection (a) of this Code section must:

(1) Be documented through such covered person's written and oral consent in advance of the provision of such services; and

(2) Occur only after such person has been provided with an estimate of the potential charges.

(c) If during the provision of nonemergency medical services, a covered person requests that the attending provider refer such covered person to another provider for the immediate provision of additional nonemergency medical services, such referred provider shall be exempt from the requirements in subsection (b) of this Code section if the following requirements are satisfied:

(1) The referring provider advises the covered person that the referred provider may be a nonparticipating provider and may charge higher fees than a participating provider;

(2) The covered person orally and in writing acknowledges that he or she is aware that the referred provider may be a nonparticipating provider and may charge higher fees than a participating provider;

(3) The written acknowledgment referenced in paragraph (2) of this subsection shall be on a document separate from other documents provided by the referring provider and shall include language to be determined by the Commissioner through rule and regulation; and

(4) The referring provider records the satisfaction of the requirements in paragraphs (1), (2), and (3) of this subsection in the covered person's medical file.

33-20E-8.

(a) Subject to appropriation, the department shall provide for the maintenance of an all-payer health claims data base and maintain records of insurer payments which shall track such payments by a wide variety of healthcare services and by geographic areas of

this state. Such appropriation must specifically reference this Act. The department shall update information in the all-payer health claims data base on no less than an annual basis and shall maintain such information on the department's website.

(b) In the event that the appropriation described in subsection (a) of this Code section is not made, the department shall update information from such other verifiable data as the Commissioner shall determine appropriate on no less than an annual basis and shall maintain such information on the department's website.

33-20E-9.

(a) If an out-of-network provider concludes that payment received from an insurer pursuant to Code Section 33-20E-4 or 33-20E-5 or if an out-of-network facility concludes that payment received from an insurer pursuant to Code Section 3-20E-4 is not sufficient given the complexity and circumstances of the services provided, the provider or facility may initiate a request for arbitration with the Commissioner. Such provider or facility shall submit such request within 30 days of receipt of payment for the claim and concurrently provide the insurer with a copy of such request.

(b) A request for arbitration may involve a single patient and a single type of healthcare service, a single patient and multiple types of healthcare services, multiple patients and a single type of healthcare service, or multiple substantially similar healthcare services in the same specialty on multiple patients.

33-20E-10.

The Commissioner shall dismiss certain requests for arbitration if the disputed claim is:

(1) Related to a healthcare plan that is not regulated by the state;

(2) The basis for an action pending in state or federal court at the time of the request for arbitration;

(3) Subject to a binding claims resolution process entered into prior to July 1, 2021;

(4) Made against a healthcare plan subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.; or

(5) In accord with other circumstances as may be determined by department rule.

33-20E-11.

Within 30 days of the insurer's receipt of the provider's or facility's request for arbitration, the insurer shall submit to the Commissioner all data necessary for the Commissioner to determine whether such insurer's payment to such provider or facility was in compliance with Code Section 33-20E-4 or 33-20E-5. The Commissioner shall not be required to

make such a determination prior to referring the dispute to a resolution organization for arbitration.

33-20E-12.

The Commissioner shall promulgate rules implementing an arbitration process requiring the Commissioner to select one or more resolution organizations to arbitrate certain claim disputes between insurers and out-of-network providers or facilities. Prior to proceeding with such arbitration, the Commissioner shall allow the parties 30 days from the date the Commissioner received the request for arbitration to negotiate a settlement. The parties shall timely notify the Commissioner of the result of such negotiation. If the parties have not notified the Commissioner of such result within 30 days of the date that the Commissioner received the request for arbitration, the Commissioner shall refer the dispute to a resolution organization within five days. The department shall contract with one or more resolution organizations by July 1, 2021, to review and consider claim disputes between insurers and out-of-network providers or facilities as such disputes are referred by the Commissioner.

33-20E-13.

Upon the Commissioner's referral of a dispute to a resolution organization, the parties shall have five days to select an arbitrator by mutual agreement. If the parties have not notified the resolution organization of their mutual selection before the fifth day, the resolution organization shall select an arbitrator from among its members. Any selected arbitrator shall be independent of the parties and shall not have a personal, professional, or financial conflict with any party to the arbitration. The arbitrator shall have experience or knowledge in healthcare billing and reimbursement rates. He or she shall not communicate ex parte with either party.

33-20E-14.

The parties shall have ten days after the selection of the arbitrator to submit in writing to the resolution organization each party's final offer and each party's argument in support of such offer. The parties' initial arguments shall be limited to written form and shall consist of no more than 20 pages per party. The parties may submit documents in support of their arguments. The arbitrator may require the parties to submit such additional written argument and documentation as the arbitrator determines necessary, but the arbitrator may require such additional filing no more than once. Such additional written argument shall be limited to no more than ten pages per party. The arbitrator may set filing times and extend such filing times as appropriate. Failure of either party to timely submit the

supportive documentation described herein may result in a default against the party failing to make such timely submission.

33-20E-15.

Each party shall submit one proposed payment amount to the arbitrator. The arbitrator shall pick one of the two amounts submitted and shall reveal that amount in the arbitrator's final decision. The arbitrator may not modify such selected amount. In making such a decision, the arbitrator shall consider the complexity and circumstances of each case, including, but not limited to, the level of training, education, and experience of the relevant physicians or other individuals at the facility who are licensed or otherwise authorized in this state to furnish healthcare services and other factors as determined by the Commissioner through rule. The arbitrator's final decision shall be in writing and shall describe the basis for such decision, including citations to any documents relied upon. Notwithstanding Code Section 33-20E-14, such decision shall be made within 30 days of the Commissioner's referral. Any default or final decision issued by the arbitrator shall be binding upon the parties and is not appealable through the court system.

33-20E-16.

The party whose final offer amount is not selected by the arbitrator shall pay the amount of the verdict, the arbitrator's expenses and fees, and any other fees assessed by the resolution organization, directly to such resolution organization. In the event of default, the defaulting party shall also pay such moneys due directly to such organization. In the event that both parties default, the parties shall each be responsible for paying such organization one-half of all moneys due. Moneys due under this Code section shall be paid in full to the resolution organization within 15 days of arbitrator's final decision. Within three days of such organization's receipt of moneys due to the party whose final offer was selected, such moneys shall be distributed to such party.

33-20E-17.

Following the resolution of arbitration, the Commissioner may refer the decision of the arbitrator to the appropriate state agency or the governing entity with governing authority over such provider or facility if the Commissioner concludes that a provider or facility has either displayed a pattern of acting in violation of this chapter or has failed to comply with a lawful order of the Commissioner or the arbitrator. Such referral shall include a description of such violations and the Commissioner's recommendation for enforcement action. Such state agency or governing entity shall initiate an investigation regarding such

referral within 30 days of receiving such referral and shall conclude the investigation within 90 days of receiving such referral.

33-20E-18.

Once a request for arbitration has been filed with the Commissioner by a provider or facility under this chapter, neither such provider nor such facility nor the insurer in such dispute shall file a lawsuit in court regarding the same out-of-network claim.

33-20E-19.

Each resolution organization contracted with by the department shall report to the department on a quarterly basis the results of all disputes referred to such organization as follows: the number of arbitrations filed, settled, arbitrated, defaulted, or dismissed during the previous calendar year and whether the arbitrators' decisions were in favor of the insurer or the provider or facility.

33-20E-20.

On or before July 1, 2022, and each July 1 thereafter, the Commissioner shall provide a written report to the House Committee on Insurance and the Senate Insurance and Labor Committee, or their successor committees, and shall post the report on the department's website summarizing the number of arbitrations filed, settled, arbitrated, defaulted, and dismissed during the previous calendar year; and a description of whether the arbitration decisions were in favor of the insurer or the provider or facility.

33-20E-21.

The arbitration conducted under this chapter shall be subject to neither Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' nor Chapter 11 of Title 9, the 'Georgia Civil Practice Act.'

33-20E-22.

No nonparticipating provider shall report to any credit reporting agency any covered person who receives a surprise bill for the receipt of healthcare services from such provider and does not pay such provider any copay, coinsurance, deductible, or other cost-sharing amount beyond what such covered person would pay if such nonparticipating provider had been a participating provider.

33-20E-23.

Nothing in this chapter shall reduce a covered person's financial responsibilities with regard to ground ambulance transportation.″

SECTION 2.

Said title is further amended in Code Section 33-6-34, relating to unfair claims settlement practices, by deleting "and" at the end of paragraph (13), by replacing the period with "; and" at the end of paragraph (14) and by adding a new paragraph to read as follows:

″(15) Failure to comply with any insurer requirement in Chapter 20E of Title 33, the 'Surprise Billing Consumer Protection Act,' including the failure to pay a resolution organization as required under Code Section 33-20E-16.″

SECTION 3.

This Act shall become effective on January 1, 2021.

SECTION 4.

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