House Bill 295

By: Representatives Hawkins of the 27th, Bennett of the 94th, Newton of the 127th, Cooper of the 45th, Jones of the 47th, and others

A BILL TO BE ENTITLED

AN ACT

1 To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to
2 revise certain procedures, timelines, and other matters concerning consumer protections
3 against surprise billing; to provide grounds for new violations of unfair claims settlement
4 practices; to provide for payments by insurers; to provide for Commissioner authority; to
5 provide for penalties; to provide for rules and regulations; to provide for related matters; to
6 repeal conflicting laws; and for other purposes.

7 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

8 **SECTION 1.**

9 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended in Code
10 Section 33-6-34, relating to unfair claims settlement practices, by revising paragraph (15) as
11 follows:

12 "(15) Failure to comply with any insurer requirement in Chapter 20E of ~~Title 33~~ this title,
13 the 'Surprise Billing Consumer Protection Act,' including:
14 (A) The failure to designate whether the healthcare plan is subject to the exclusive
15 jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec.
16 1001, et seq.;

17 (B) The failure to directly pay the provider or facility within 15 working days for
18 electronic claims or 30 calendar days for paper claims any moneys due under Code
19 Section 33-20E-4 or 33-20E-5; or
20 (C) The ~~the~~ failure to pay a resolution organization as required under Code
21 Section 33-20E-16; and"

22 **SECTION 2.**

23 Said title is further amended in Code Section 33-20E-4, relating to payment for emergency
24 medical services, by revising subsections (a) and (b) as follows:
25 "(a) An insurer that provides any benefits to covered persons with respect to emergency
26 medical services shall pay for such emergency medical services regardless of whether the
27 healthcare provider or facility furnishing emergency medical services is a participating
28 provider or facility with respect to emergency medical services, in accordance with this
29 chapter:
30 (1) Without need for any prior authorization determination and without any retrospective
31 payment denial for medically necessary services; and
32 (2) Regardless of whether the healthcare provider or facility furnishing emergency
33 medical services is a participating provider or facility with respect to emergency medical
34 services.
35 (b) In the event a covered person receives the provision of emergency medical services
36 from a nonparticipating emergency medical provider or facility, the nonparticipating
37 provider or facility shall collect or bill no more than such person's deductible, coinsurance,
38 copayment, or other cost-sharing amount as determined by such person's policy directly
39 and such insurer shall directly pay such provider or facility the greater of:
40 (1) The verifiable contracted amount paid by all eligible insurers subject to the
41 provisions of this chapter for the provision of the same or similar services as determined
42 by the department;

43 (2) The most recent verifiable amount agreed to by the insurer and the nonparticipating
44 emergency medical provider or facility for the provision of the same services during such
45 time as such provider or facility was in-network with such insurer; or
46 (3) Such higher amount as the insurer may deem appropriate given the complexity and
47 circumstances of the services provided.
48 Any amount that the insurer pays the nonparticipating provider under this subsection shall
49 not be required to include any amount of coinsurance, copayment, or deductible owed by
50 the covered person or already paid by such person."

51 **SECTION 3.**

52 Said title is further amended in Code Section 33-20E-9, relating to arbitration of payment
53 issues, by revising subsection (a) as follows:
54 "(a) If an out-of-network provider concludes that payment received from an insurer
55 pursuant to Code Section 33-20E-4 or 33-20E-5 or if an out-of-network facility concludes
56 that payment received from an insurer pursuant to Code Section 33-20E-4 is not sufficient
57 given the complexity and circumstances of the services provided, the provider or facility
58 may initiate a request for arbitration with the Commissioner. Such provider or facility shall
59 submit such request within ~~30~~ 60 days of receipt of such payment for the claim and
60 concurrently provide the insurer with a copy of such request. Such payment shall be
61 indicated by the insurer on the first page of the insurer's remittance to the out-of-network
62 provider or facility in a manner to be determined by the Commissioner through the
63 promulgation of rules and regulations. Such rules and regulations shall specify when the
64 time period to request arbitration commences."

65 **SECTION 4.**

66 Said title is further amended by revising Code Section 33-20E-10, relating to dismissal of
67 arbitration requests, as follows:

68 "33-20E-10.

69 (a) The Commissioner shall dismiss certain requests for arbitration if the disputed claim
70 is:

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

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

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

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

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

78 (b) The Commissioner may dismiss certain requests for arbitration in the following
79 circumstances:

80 (1) The provider or facility has engaged in a pattern or practice of any of the following:

81 (A) Failing to respond to the department's requests for data under Code
82 Section 33-20E-11.1;

83 (B) Failing to respond to the department's other inquires after filing requests for
84 arbitration; or

85 (C) Failing to pay resolution organizations as required under Code Section 33-20E-16;

86 (2) The provider or facility failed to file its request for arbitration within 60 days of
87 receipt of payment for the claim and concurrently provide the insurer with a copy of such
88 request; or

89 (3) The provider or facility failed to explain in detail the reasons arbitration is needed.
90 Such explanation shall include a representation as to whether the insurer's payment was
91 in accord with the relevant provisions of Code Sections 33-20E-4 or 33-20E-5 if the party
92 requesting arbitration is an out-of-network provider, and Code Section 33-20E-4 if the
93 requesting party is out-of-network facility. If such payment was in such accord, the

94 explanation shall provide in detail the complexity and circumstances of the services
95 provided which necessitate additional payment.″

96 **SECTION 5.**

97 Said title is further amended by revising Code Section 33-20E-11, relating to submission to
98 Commissioner by insurer of data pending arbitration, as follows:
99 ″33-20E-11.
100 Within ~~30~~ 60 days of the insurer's receipt of the provider's or facility's request for
101 arbitration, the insurer shall submit to the Commissioner all data necessary for the
102 Commissioner to determine whether such insurer's payment to such provider or facility was
103 in compliance with Code Section 33-20E-4 or 33-20E-5. The Commissioner shall not be
104 required to make such a determination prior to referring the dispute to a resolution
105 organization for arbitration. When an insurer fails to submit such data within such 60 day
106 period, the Commissioner may assess penalties against such insurer in accord with Code
107 Section 33-2-24 or declare a default judgment against such insurer.″

108 **SECTION 6.**

109 Said title is further amended by adding a new Code section to read as follows:
110 ″33-20E-11.1.
111 The Commissioner may request from a provider or facility requesting arbitration such data
112 as the Commissioner deems necessary to determine whether the insurer's payment to such
113 provider or facility was in compliance with Code Section 33-20E-4 or 33-20E-5. The
114 Commissioner shall not be required to make such determination prior to referring the
115 dispute to a resolution organization for arbitration. If such provider or facility fails to
116 submit such data within 60 days of such request, the Commissioner may fine such provider
117 or facility up to $2,000.00 for each and every violation of the Commissioner's request for
118 data or if such provider or facility knew or reasonably should have known that it was in

119 violation of the Commissioner's request for data, the monetary penalty provided for in this
120 Code section may be increased to an amount up to $5,000.00 for each and every act in
121 violation."

122 **SECTION 7.**

123 Said title is further amended by revising Code Section 33-20E-12, relating to regulation and
124 contracting with resolution organizations, as follows:

125 "33-20E-12.

126 The Commissioner shall promulgate rules implementing an arbitration process requiring
127 the Commissioner to select one or more resolution organizations to arbitrate certain claim
128 disputes between insurers and out-of-network providers or facilities. The Commissioner
129 may promulgate such other rules as reasonably necessary to facilitate the arbitration
130 process. Prior to proceeding with such arbitration, the Commissioner shall allow the
131 parties ~~30~~ 60 days from the date the Commissioner received the request for arbitration to
132 negotiate a settlement. The parties shall timely notify the Commissioner of the result of
133 such negotiation. ~~If the parties have not notified the Commissioner of such result within~~
134 ~~30 days of the date that the Commissioner received the request for arbitration, the~~
135 ~~Commissioner shall refer the dispute to a resolution organization within five days.~~ If
136 within 60 days of the date that the Commissioner received the request for arbitration, the
137 parties have neither agreed upon a settlement nor agreed that more time is needed to
138 negotiate a settlement, or both, or either party has failed to notify the Commissioner of such
139 settlement or need for additional time to negotiate, the Commissioner shall within five
140 days, refer the dispute to a resolution organization. The department shall contract with one
141 or more resolution organizations by July 1, 2021, to review and consider claim disputes
142 between insurers and out-of-network providers or facilities as such disputes are referred by
143 the Commissioner."

144 **SECTION 8.**

145 Said title is further amended by revising Code Section 33-20E-15, relating to proposed
146 payment amounts, as follows:

147 "33-20E-15.

148 Each party shall submit one proposed payment amount to the arbitrator. The arbitrator
149 shall pick one of the two amounts submitted and shall reveal that amount in the arbitrator's
150 final decision. The arbitrator may not modify such selected amount. In making such a
151 decision, the arbitrator shall consider the complexity and circumstances of each case,
152 including, but not limited to, the level of training, education, and experience of the relevant
153 physicians or other individuals at the facility who are licensed or otherwise authorized in
154 this state to furnish healthcare services and other factors as determined by the
155 Commissioner through rule. The arbitrator's final decision shall be in writing and shall
156 describe the basis for such decision, including citations to any documents relied upon.
157 Notwithstanding Code Section 33-20E-14, such decision shall be made within ~~30~~ <u>60</u> days
158 of the Commissioner's referral. Any default or final decision issued by the arbitrator shall
159 be binding upon the parties and is not appealable through the court system."

160 **SECTION 9.**

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