The House Committee on Special Committee on Access to Quality Health Care offers the following substitute to HB 888:

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 provide for certain consumer protections against surprise billing; to provide for a short title;
3 to provide for applicability; to provide for definitions; to provide mechanisms to resolve
4 payment disputes between insurers and out-of-network providers regarding the provision of
5 healthcare services; to require the department to provide for the maintenance of an all-payer
6 health claims data base; to establish an arbitration process; to require the Commissioner of
7 Insurance to contract with one or more resolution organizations; to require the promulgation
8 of department rules; to provide for an effective date; to repeal conflicting laws; and for other
9 purposes.

10 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

11 **SECTION 1.**

12 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
13 adding a new chapter to read as follows:

14 "CHAPTER 20E

15 33-20E-1.

16 This chapter shall be known and may be cited as the 'Surprise Billing Consumer Protection
17 Act.'

18 33-20E-2.

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

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

22 (1) 'Balance bill' means the amount that a nonparticipating provider charges for services
23 provided to a covered person. Such amount equals the difference between the amount

24 paid or offered by the insurer and the amount of the nonparticipating provider's bill
25 charge, but shall not include any amount for coinsurance, copayments, or deductibles due
26 by the covered person.
27 (2) 'Contracted amount' means the median in-network amount paid during 2017 by an
28 insurer for the emergency or nonemergency services provided by in-network providers
29 engaged in the same or similar specialties and provided in the same or nearest
30 geographical area. Such amount shall be annually adjusted according to the Consumer
31 Price Index.
32 (3) 'Covered person' means an individual who is insured under a healthcare plan.
33 (4) 'Emergency medical provider' means any physician licensed by the Georgia
34 Composite Medical Board who provides emergency medical services and any other
35 healthcare provider licensed or otherwise authorized in this state who renders emergency
36 medical services.
37 (5) 'Emergency medical services' means medical services rendered after the recent onset
38 of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of
39 sufficient severity, including, but not limited to, severe pain, that would lead a prudent
40 layperson possessing an average knowledge of medicine and health to believe that his or
41 her condition, sickness, or injury is of such a nature that failure to obtain immediate
42 medical care could result in:
43 (A) Placing the patient's health in serious jeopardy;
44 (B) Serious impairment to bodily functions; or
45 (C) Serious dysfunction of any bodily organ or part.
46 (6) 'Facility' means a hospital, an ambulatory surgical treatment center, birthing center,
47 diagnostic and treatment center, hospice, or similar institution.
48 (7) 'Geographic area' means a specific portion of this state which shall consist of one or
49 more zip codes as defined by the Commissioner pursuant to department rule and
50 regulation.
51 (8) 'Healthcare plan' means any hospital or medical insurance policy or certificate,
52 healthcare plan contract or certificate, qualified higher deductible health plan, health
53 maintenance organization or other managed care subscriber contract, or state healthcare
54 plan. This term shall not include limited benefit insurance policies or plans listed under
55 paragraph (1) of Code Section 33-1-2, air ambulance insurance, or policies issued in
56 accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating to
57 workers' compensation, Part A, B, C, or D of Title XVIII of the Social Security Act
58 (Medicare), or any other plan or program over which the Commissioner does not have
59 regulatory authority. Notwithstanding paragraph (1) of Code Section 33-1-2 and any

60 other provision of this title, for purposes of this chapter this term shall include
61 stand-alone dental insurance and stand-alone vision insurance.
62 (9) 'Healthcare provider' or 'provider' means any physician, other individual, or facility
63 other than a hospital licensed or otherwise authorized in this state to furnish healthcare
64 services, including, but not limited to, any dentist, podiatrist, optometrist, psychologist,
65 clinical social worker, advanced practice registered nurse, registered optician, licensed
66 professional counselor, physical therapist, marriage and family therapist, chiropractor,
67 athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist,
68 speech-language pathologist, audiologist, dietitian, or physician assistant.
69 (10) 'Healthcare services' means emergency or nonemergency medical services.
70 (11) 'Insurer' means an entity subject to the insurance laws and regulations of this state,
71 or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or
72 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the
73 costs of healthcare services, including those of an accident and sickness insurance
74 company, a health maintenance organization, a healthcare plan, a managed care plan, or
75 any other entity providing a health insurance plan, a health benefit plan, or healthcare
76 services.
77 (12) 'Nonemergency medical services' means the examination or treatment of persons
78 for the prevention of illness or the correction or treatment of any physical or mental
79 condition resulting from an illness, injury, or other human physical problem which does
80 not qualify as an emergency medical service and includes, but is not limited to:
81 (A) Hospital services which include the general and usual care, services, supplies, and
82 equipment furnished by hospitals;
83 (B) Medical services which include the general and usual care and services rendered
84 and administered by doctors of medicine, dentistry, optometry, and other providers; and
85 (C) Other medical services which, by way of illustration only and without limiting the
86 scope of this chapter, include the provision of appliances and supplies; nursing care by
87 a registered nurse; institutional services, including the general and usual care, services,
88 supplies, and equipment furnished by healthcare institutions and agencies or entities
89 other than hospitals; physiotherapy; drugs and medications; therapeutic services and
90 equipment, including oxygen and the rental of oxygen equipment; hospital beds; iron
91 lungs; orthopedic services and appliances, including wheelchairs, trusses, braces,
92 crutches, and prosthetic devices, including artificial limbs and eyes; and any other
93 appliance, supply, or service related to healthcare which does not qualify as an
94 emergency medical service.
95 (13) 'Out-of-network' refers to healthcare services provided to a covered person by
96 providers who do not belong to the provider network in the healthcare plan.

97 (14) 'Nonparticipating provider' means a healthcare provider who has not entered into
98 a contract with a healthcare plan for the delivery of medical services.
99 (15) 'Participating provider' means a healthcare provider that has entered into a contract
100 with an insurer for the delivery of healthcare services to covered persons under a
101 healthcare plan.
102 (16) 'Resolution organization' means a qualified, independent, third-party claim dispute
103 resolution entity selected by and contracted with the department.
104 (17) 'State healthcare plan' means:
105 (A) The state employees' health insurance plan established pursuant to Article 1 of
106 Chapter 18 of Title 45;
107 (B) The health insurance plan for public school teachers established pursuant to
108 Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20;
109 (C) The health insurance plan for public school employees established pursuant to
110 Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20; and
111 (D) The Regents Retirement Plan, established pursuant to Article 1 of Chapter 21 of
112 Title 47.
113 (18) 'Surprise bill' means a bill resulting from an occurrence in which charges arise from
114 a covered person receiving healthcare services from an out-of-network provider at an
115 in-network facility.

116 33-20E-3.
117 (a) Nothing in this chapter shall be applicable to healthcare plans which are subject to the
118 exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C.
119 Sec. 1001, et seq.
120 (b) This chapter shall be applicable only to healthcare plans which are subject to the
121 regulatory authority of the Commissioner.

122 33-20E-4.
123 (a) An insurer that provides any benefits to covered persons with respect to emergency
124 medical services shall pay for such emergency medical services in the event that such
125 services resulted in a surprise bill regardless of whether the healthcare provider furnishing
126 emergency medical services is a participating provider with respect to emergency medical
127 services, in accordance with this chapter:
128 (1) Without need for any prior authorization determination and without any retrospective
129 payment denial for medically necessary services; and
130 (2) Regardless of whether the healthcare provider furnishing emergency medical services
131 is a participating provider with respect to emergency medical services.

132 (b) In the event a covered person receives the provision of emergency medical services
133 from a nonparticipating emergency medical provider, the nonparticipating provider shall
134 notify such person that no moneys are owed by such person for the provision of such
135 services except such person's coinsurance, copayment, or other cost-sharing amount as
136 determined by their policy. The provider shall collect or bill for such person's coinsurance,
137 copayment, or other cost-sharing amount as determined by such person's policy directly
138 and such insurer shall directly pay such provider the greater of:
139 (1) The verifiable contracted amount paid by all eligible insurers for the provision of the
140 same or similar services as determined by the department;
141 (2) The most recent verifiable amount agreed to by the insurer and the nonparticipating
142 emergency medical provider for the provision of the same services during such time as
143 such provider was in-network with such insurer; or;
144 (3) Such higher amount as the insurer may deem appropriate given the complexity and
145 circumstances of the services provided.
146 Any amount that the insurer pays the nonparticipating provider under this subsection shall
147 not be required to include any amount of coinsurance, copayment, or deductible owed by
148 the covered person or already paid by such person.
149 (c) A healthcare plan shall not deny benefits for emergency medical services previously
150 rendered based upon a covered person's failure to provide subsequent notification in
151 accordance with plan provisions, where the covered person's medical condition prevented
152 timely notification.
153 (d) For purposes of the covered person's financial responsibilities, the healthcare plan shall
154 treat the emergency medical services received by the covered person from a
155 nonparticipating provider pursuant to this Code section as if such services were provided
156 by a participating provider, and shall include applying the covered person's cost-sharing
157 for such services toward the covered person's deductible and maximum out-of-pocket limit
158 applicable to services obtained from a participating facility under the healthcare plan.
159 (e) All insurer payments made to providers pursuant to this Code section shall be in accord
160 with Code Section 33-24-59.14. Such payments shall accompany notification to the
161 provider from the insurer disclosing whether the healthcare plan is subject to the exclusive
162 jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C.
163 Sec. 1001, et seq.

164 33-20E-5.
165 (a) In accordance with Code Section 33-20E-7 and this chapter, an insurer that provides
166 any benefits to covered persons with respect to nonemergency medical services shall pay
167 for such services in the event that such services resulted in a surprise bill regardless of

168 whether the healthcare provider furnishing nonemergency medical services is a
169 participating provider with respect to nonemergency medical services.
170 (b) In the event a covered person receives the provision of nonemergency medical services
171 from a nonparticipating medical provider, the nonparticipating provider shall notify such
172 person that no moneys are owed by such person for the provision of such services except
173 such person's coinsurance, copayment, or other cost-sharing amount as determined by their
174 policy. The provider shall collect or bill for such person's coinsurance, copayment, or
175 other cost-sharing amount as determined by such person's policy directly and such insurer
176 shall directly pay such provider the greater of:
177 (1) The verifiable contracted amount paid by all eligible insurers for the provision of the
178 same or similar services as determined by the department;
179 (2) The most recent verifiable amount agreed to by the insurer and the nonparticipating
180 provider for the provision of the same services during such time as such provider was
181 in-network with such insurer; or
182 (3) Such higher amount as the insurer may deem appropriate given the complexity and
183 circumstances of the services provided.
184 Any amount that the insurer pays the nonparticipating provider under this subsection shall
185 not be required to include any amount of coinsurance, copayment, or deductible owed by
186 the covered person or already paid by such person.
187 (c) For purposes of the covered person's financial responsibilities, the healthcare plan shall
188 treat the nonemergency medical services received by the covered person from a
189 nonparticipating provider pursuant to this Code section as if such services were provided
190 by a participating provider, and shall include applying the covered person's cost-sharing
191 for such services toward the covered person's deductible and maximum out-of-pocket limit
192 applicable to services obtained from a participating provider under the healthcare plan.
193 (d) All insurer payments made to providers pursuant to this Code section shall be in accord
194 with Code Section 33-24-59.14. Such payments shall accompany notification to the
195 provider from the insurer disclosing whether the healthcare plan is subject to the exclusive
196 jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C.
197 Sec. 1001, et seq.

198 33-20E-6.
199 No healthcare plan shall deny or restrict the provision of covered benefits from a
200 participating provider to a covered person solely because the covered person obtained
201 treatment from a nonparticipating provider leading to a balance bill. Notice of such
202 protection shall be provided in writing to the covered person by the insurer.

203 33-20E-7.
204 (a) Nothing in this chapter shall reduce a covered person's financial responsibilities in the
205 event that such covered person chose to receive nonemergency medical services from an
206 out-of-network provider. Such services shall not be considered a surprise bill for purposes
207 of this chapter.
208 (b) The covered person's choice described in subsection (a) of this Code section must:
209 (1) Be documented through such covered person's written and oral consent in advance
210 of the provision of such services; and
211 (2) Occur only after such person has been provided with an estimate of the potential
212 charges.
213 (c) If during the provision of nonemergency medical services, a covered person requests
214 that the attending provider refer such covered person to another provider for the immediate
215 provision of additional nonemergency medical services, such referred provider shall be
216 exempt from the requirements in subsection (b) of this Code section if the following
217 requirements are satisfied:
218 (1) The referring provider advises the covered person that the referred provider may be
219 a nonparticipating provider and may charge higher fees than a participating provider;
220 (2) The covered person orally and in writing acknowledges that he or she is aware that
221 the referred provider may be a nonparticipating provider and may charge higher fees than
222 a participating provider;
223 (3) The written acknowledgment referenced in paragraph (2) of this subsection shall be
224 on a document separate from other documents provided by the referring provider and
225 shall include language to be determined by the Commissioner through rule and
226 regulation; and
227 (4) The referring provider records the satisfaction of the requirements in
228 paragraphs (1), (2), and (3) of this subsection in the covered person's medical file.

229 33-20E-8.
230 (a) Subject to appropriation, the department shall provide for the maintenance of an
231 all-payer health claims data base and maintain records of insurer payments which shall
232 track such payments by a wide variety of healthcare services and by geographic areas of
233 this state. Such appropriation must specifically reference this Act. The department shall
234 update information in the all-payer health claims data base on no less than an annual basis
235 and shall maintain such information on the department's website.
236 (b) In the event that the appropriation described in subsection (a) of this Code section is
237 not made, the department shall update information from such other verifiable data as the

238 Commissioner shall determine appropriate on no less than an annual basis and shall
239 maintain such information on the department's website.

240 33-20E-9.
241 (a) If a provider concludes that payment received from an insurer pursuant to Code
242 Section 33-20E-4 or 33-20E-5 is not sufficient given the complexity and circumstances of
243 the services provided, the provider may initiate a request for arbitration with the
244 Commissioner. Such provider shall submit such request within 30 days of receipt of
245 payment for the claim and concurrently provide the insurer with a copy of such request.
246 (b) A request for arbitration may involve a single patient and a single type of healthcare
247 service, a single patient and multiple types of healthcare services, or multiple patients and
248 a single type of healthcare service.

249 33-20E-10.
250 The Commissioner shall dismiss certain requests for arbitration if the disputed claim is:
251 (1) Related to a healthcare plan that is not regulated by the state;
252 (2) The basis for an action pending in state or federal court at the time of the request for
253 arbitration;
254 (3) Subject to a binding claims resolution process entered into prior to July 1, 2021;
255 (4) Made against a healthcare plan subject to the exclusive jurisdiction of the Employee
256 Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.; or
257 (5) In accord with other circumstances as may be determined by department rule.

258 33-20E-11.
259 Within 30 days of the insurer's receipt of the provider's request for arbitration, the insurer
260 shall submit to the Commissioner all data necessary for the Commissioner to determine
261 whether such insurer's payment to such provider was in compliance with Code
262 Section 33-20E-4 or 33-20E-5. The Commissioner shall not be required to make such a
263 determination prior to referring the dispute to a resolution organization for arbitration.

264 33-20E-12.
265 The Commissioner shall promulgate rules implementing an arbitration process requiring
266 the Commissioner to select one or more resolution organizations to arbitrate certain claim
267 disputes between insurers and out-of-network providers. Prior to proceeding with such
268 arbitration, the Commissioner shall allow the parties 30 days from the date the
269 Commissioner received the request for arbitration to negotiate a settlement. The parties
270 shall timely notify the Commissioner of the result of such negotiation. If the parties have

271 not notified the Commissioner of such result within 30 days of the date that the
272 Commissioner received the request for arbitration, the Commissioner shall refer the dispute
273 to a resolution organization within five days. The department shall contract with one or
274 more resolution organizations by July 1, 2021, to review and consider claim disputes
275 between insurers and out-of-network providers as such disputes are referred by the
276 Commissioner.

277 33-20E-13.
278 Upon the Commissioner's referral of a dispute to a resolution organization, the parties shall
279 have five days to select an arbitrator by mutual agreement. If the parties have not notified
280 the resolution organization of their mutual selection before the fifth day, the resolution
281 organization shall select an arbitrator from among its members. Any selected arbitrator
282 shall be independent of the parties and shall not have a personal, professional, or financial
283 conflict with any party to the arbitration. The arbitrator shall have experience or
284 knowledge in healthcare billing and reimbursement rates. He or she shall not communicate
285 ex parte with either party.

286 33-20E-14.
287 The parties shall have ten days after the selection of the arbitrator to submit in writing to
288 the resolution organization each party's final offer and each party's argument in support of
289 such offer. The parties' initial arguments shall be limited to written form and shall consist
290 of no more than 20 pages per party. The parties may submit documents in support of their
291 arguments. The arbitrator may require the parties to submit such additional written
292 argument and documentation as the arbitrator determines necessary, but the arbitrator may
293 require such additional filing no more than once. Such additional written argument shall
294 be limited to no more than ten pages per party. The arbitrator may set filing times and
295 extend such filing times as appropriate. Failure of either party to timely submit the
296 supportive documentation described herein may result in a default against the party failing
297 to make such timely submission.

298 33-20E-15.
299 Each party shall submit one proposed payment amount to the arbitrator. The arbitrator
300 shall pick one of the two amounts submitted and shall reveal that amount in the arbitrator's
301 final decision. The arbitrator may not modify such selected amount. In making such a
302 decision, the arbitrator shall consider the complexity and circumstances of each case,
303 including, but not limited to, the level of training, education, and experience of the provider
304 and other factors as determined by the Commissioner through rule. The arbitrator's final

305 decision shall be in writing and shall describe the basis for such decision, including
306 citations to any documents relied upon. Notwithstanding Code Section 33-20E-14, such
307 decision shall be made within 30 days of the Commissioner's referral. Any default or final
308 decision issued by the arbitrator shall be binding upon the parties and is not appealable
309 through the court system.

310 33-20E-16.
311 The party whose final offer amount is not selected by the arbitrator shall pay the amount
312 of the verdict, the arbitrator's expenses and fees, and any other fees assessed by the
313 resolution organization, directly to such resolution organization. In the event of default,
314 the defaulting party shall also pay such moneys due directly to such organization. In the
315 event that both parties default, the parties shall each be responsible for paying such
316 organization one-half of all moneys due. Moneys due under this Code section shall be paid
317 in full to the resolution organization within 15 days of arbitrator's final decision. Within
318 three days of such organization's receipt of moneys due to the party whose final offer was
319 selected, such moneys shall be distributed to such party.

320 33-20E-17.
321 Following the resolution of arbitration, the Commissioner may refer the decision of the
322 arbitrator to the appropriate state agency or the governing entity with governing authority
323 over such provider if the Commissioner concludes that a provider has either displayed a
324 pattern of acting in violation of this chapter or has failed to comply with a lawful order of
325 the Commissioner or the arbitrator. Such referral shall include a description of such
326 violations and the Commissioner's recommendation for enforcement action. Such state
327 agency or governing entity shall initiate an investigation regarding such referral within 30
328 days of receiving such referral and shall conclude the investigation within 90 days of
329 receiving such referral.

330 33-20E-18.
331 Once a request for arbitration has been filed with the Commissioner by a provider under
332 this chapter, neither such provider nor the insurer in such dispute shall file a lawsuit in
333 court regarding the same out-of-network claim.

334 33-20E-19.
335 Each resolution organization contracted with by the department shall report to the
336 department on a quarterly basis the results of all disputes referred to such organization as
337 follows: the number of arbitrations filed, settled, arbitrated, defaulted, or dismissed during

338 the previous calendar year and whether the arbitrators' decisions were in favor of the
339 insurer or the provider.

340 33-20E-20.
341 On or before July 1, 2022, and each July 1 thereafter, the Commissioner shall provide a
342 written report to the House Committee on Insurance and the Senate Insurance and Labor
343 Committee, or their successor committees, and shall post the report on the department's
344 website summarizing the number of arbitrations filed, settled, arbitrated, defaulted, and
345 dismissed during the previous calendar year; and a description of whether the arbitration
346 decisions were in favor of the insurer or the provider.

347 33-20E-21.
348 The arbitration conducted under this chapter shall be subject to neither Chapter 13 of
349 Title 50, the 'Georgia Administrative Procedure Act,' nor Chapter 11 of Title 9, the
350 'Georgia Civil Practice Act.'

351 33-20E-22.
352 No nonparticipating provider shall report to any credit reporting agency any covered person
353 who receives a surprise bill for the receipt of healthcare services from such provider and
354 does not pay such provider any copay, coinsurance, deductible, or other cost-sharing
355 amount beyond what such covered person would pay if such nonparticipating provider had
356 been a participating provider.

357 33-20E-23.
358 Nothing in this chapter shall reduce a covered person's financial responsibilities with regard
359 to ground ambulance transportation."

360 **SECTION 2.**

361 Said title is further amended in Code Section 33-6-34, relating to unfair claims settlement
362 practices, by deleting "and" at the end of paragraph (13), by replacing the period with "; and"
363 at the end of paragraph (14) and by adding a new paragraph to read as follows:
364 "(15) Failure to comply with any insurer requirement in Chapter 20E of Title 33, the
365 'Surprise Billing Consumer Protection Act,' including the failure to pay a resolution
366 organization as required under Code Section 33-20E-16."

367 **SECTION 3.**

368 This Act shall become effective on January 1, 2021.

369 **SECTION 4.**

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