House Bill 720

By: Representatives Harbin of the 113th, Watson of the 70th, Graves of the 125th and Burkhalter of the 41st

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, so as to provide for definitions; to require health care insurers to provide their insureds with explanation of benefits statements; to provide for the contents of such explanation of benefits; to provide for uniformity of such explanation of benefits statements; to provide that the failure to provide explanation of benefits statements in accordance with law shall constitute an unfair trade practice; to authorize the Commissioner of Insurance to promulgate rules and regulations regarding such explanation of benefits statements; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, is amended by inserting following Code Section 33-24-43 a new Code Section 33-24-43.1 to read as follows:

"33-24-43.1.

(a) As used in this Code section, the term:

(1) 'Allowed amount' or 'approved amount' shall mean the amount of a claim payable by the health care insurer or health claims payor in accordance with the terms of the benefit plan and pursuant to the terms of the discount reimbursement agreement between the health care provider and the provider network, if such an agreement exists.

(2) 'Amount paid' means the amount of a claim paid to the health care provider after applicable discounts, patient responsibility portions, and other payments have been applied.

(3) 'Charged amount' means the amount charged by the health care provider for the specific service or procedure performed.

(4) 'CPT code' means the identifying number ascribed to a particular procedure performed by a health care provider during an encounter with a patient. 'CPT' refers to the Current Procedural Terminology of the American Medical Association, as adopted by the federal Health Care Financing Administration.

(5) 'Discount amount' means the amount by which the charged amount is reduced as a result of any discount reimbursement agreement between the health care provider and the provider network.

(6) 'Explanation of Benefits' means a written notification provided by the health insurer or health claim payor upon payment by the insurer or payor to the health care provider for its service or services, which explains how the benefits of the insured´s health benefit plan apply to the charges for the particular service or services rendered on a specific occasion by a health care provider.

(7) 'Health benefit plan' means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any dental or vision care plan or policy, and any managed care plan. 'Health benefit plan' does not include policies issued under Chapter 31 of this title or Chapter 9 of Title 34 or disability income policies.

(8) 'Health claims payor' means the entity which has the responsibility for the payment of claims under the terms of a health benefit plan.

(9) 'Health insurer' means an accident or sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of health care services through a health benefit plan.

(10) 'Insured' means any individual covered under a health benefit plan.

(11) 'Member identification number' means the number assigned by the health insurer or health claims payor for tracking purposes with regard to the transmission of claims and the remittance of payment for such claims.

(12) 'Patient' means the individual receiving the service.

(13) 'Patient account number' means the number assigned to the patient by the health care provider for tracking purposes with regard to the transmission of claims and the remittance of payment for such claims.

(14) 'Patient responsibility amount' means the portion of the allowed amount or approved amount for which the patient has financial responsibility under the health benefit plan, including a deductible, copay, coinsurance, and noncovered service, if applicable.

(15) 'Provider network' means a health care insurer or other organization or entity which has discount reimbursement arrangements for the provision of health care services with health care providers.

(b) All health insurers shall provide a written explanation of benefits to both the insured and to the health care provider following the provision of a health care service to the patient within five days of the date that payment is made by the insurer or payor to the health care provider for its service or services.

(c) All such explanation of benefits shall contain the following information:

(1) Full name of payor;

(2) Full name of physician network accessed for discount, if applicable;

(3) Telephone number for claims information and eligibility;

(4) Full name of insured;

(5) Full name of patient;

(6) Member identification number;

(7) Patient account number; and

(8) An explanation of all charges, discounts, and payments for the particular date of service itemized by the following:

(A) Date of service;

(B) CPT code;

(C) Charged amount;

(D) Allowed amount;

(E) Discount amount;

(F) Patient responsibility amount; and

(G) Amount paid by health insurer or health claim payor.

(d) A separate explanation of benefits shall be provided for each date of service. All health insurers and health claim payors shall use the terminology provided in this Code section in preparing their explanation of benefits statements.

(e) The failure of health care insurers and health claim payors to provide timely explanation of benefits or to provide explanation of benefits in conformity to the requirements of this Code section shall constitute an unfair trade practice punishable under Article 1 of Chapter 6 of this title.

(f) The Commissioner of Insurance is authorized to promulgate such rules and regulations to implement the provisions of this Code section and to provide uniformity in explanation of benefits statements by health care insurers and health claim payors."

SECTION 2.

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