Senate Bill 290

By: Senator Walker of the 22nd

A BILL TO BE ENTITLED

AN ACT

To amend Article 1 of Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to general provisions regarding insurance, so as to enact a new Code section relating to the timely payment of hospital or ambulance service provider claims; to provide for confirmation and expedited processing of claims filed by electronic means by hospitals and ambulance service providers; to establish mechanics for the processing of health care claims submitted by hospitals and ambulance service providers; to establish standards for the processing of health care claims submitted by hospitals or ambulance service providers to health care insurers; to provide for the reporting of health care insurer compliance with such standards; to provide for related matters; to provide for an effective date and applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Article 1 of Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to general provisions regarding insurance, is amended by adding a new Code Section 33-24-59.9 to read as follows:

"33-24-59.9.

(a) Notwithstanding the provisions of Code Section 33-24-59.5, the provisions of this Code section shall apply to payment of all claims submitted to insurers by hospitals and ambulance service providers as defined in this Code section.

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

(1) 'Ambulance service provider' means an organization licensed under Article 2 of Chapter 11 of Title 31 to provide ambulance and emergency transportation services, including the provision of emergency medical treatment to patients in transit.

(2) 'Benefits' means the coverages provided by health benefit plans for financing or delivery of health care goods or services; but such term does not include capitated payment arrangements under managed care plans.

(3) 'Claim' means a request for payment by a hospital or ambulance service provider to an insurer for the delivery of goods and services under a health benefit plan.

(4) 'Electronic claim' means a claim transmitted to the computer of an insurer by a hospital or ambulance service provider by electronic means using an electronic format prescribed by the insurer.

(5) '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, health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or dental or vision care plan or policy or managed care plan; but the term health benefit plan does not include policies issued in accordance with Chapter 31 of this title, disability income policies, or provision of benefits under Chapter 9 of Title 24.

(6) 'Hospital' means a health care facility licensed as a hospital under Article 1 of Chapter 7 of Title 31 to provide inpatient acute care or psychiatric, rehabilitation, or specialty care services.

(7) 'Insurer' means an accident and 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; 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; or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(8) 'Paper claim' means any claim submitted to an insurer by a hospital or ambulance service provider by means other than electronic means using a format prescribed by an insurer and any other claims submitted in writing, reasonably providing similar information and stating the basis for entitlement to payment.

(9) 'Pend' shall mean to provide the letters or notices required of an insurer in paragraphs (1) and (4) of subsection (c) of this Code section stating in good faith the reasons for failure to pay or deny a claim.

(c)(1) Every insurer shall, within 21 calendar days after receipt of an electronic claim and within 30 calendar days after receipt of a paper claim, send to the hospital or ambulance service provider either:

(A) Payment;

(B) A denial of the claim; or

(C) A reply in writing or by electronic means which states all of the applicable reasons identified in paragraph (3) of this subsection that the insurer may have for failing to pay

or deny the claim, either in whole or in part, and which specifies all additional information necessary for the insurer to fully process and pay or deny the claim.

(2) With respect to all electronic claims and all paper claims submitted to insurers who do not accept electronic claims, insurers shall, no later than five business days after receipt, confirm by the same means received to the hospital or its agent or the ambulance service provider or its agent receipt by the insurer of each individual claim received and shall include in each such confirmation the applicable patient control number, date of receipt, dates of service, and total charges claimed. An insurer shall respond promptly to any inquiry by a hospital or its agent or an ambulance service provider or its agent regarding the failure to provide timely confirmation of the receipt of a claim and shall immediately take all reasonable steps to investigate and confirm receipt of the claim.

(3) An insurer may only pend a claim under paragraph (1) of this subsection if the insurer determines in good faith that one or more of the following exists:

(A) A lack of specific information required by the insurer to pay or deny the claim;

(B) A need for detailed clinical review of the claim;

(C) A need to coordinate benefits with another insurer if the insurer reasonably believes that another insurer might also have liability for that claim;

(D) A reasonable suspicion that the particular claim is fraudulent; or

(E) The insured is not current in its obligation to the insurer and the insurer has sent a notice of cancellation to the insured that would affect the insurer´s obligation to pay the claim.

(4) When, in response to an insurer´s request for additional information under paragraph (1) of this subsection, a hospital or ambulance service provider delivers additional information requested for processing a claim, the insurer shall then have 21 additional calendar days after receipt of the information within which to reevaluate the claim and either:

(A) Pay the claim;

(B) Deny the claim; or

(C) Send the hospital or ambulance service provider another reply in writing or by electronic means stating all applicable reasons set forth in paragraph (3) of this subsection for continuing to pend the claim and explaining why the additional information remains insufficient to satisfy the insurer´s previous request.

(5) Any denial of a claim under paragraph (1) or (4) of this subsection or otherwise shall be made by sending the hospital or ambulance service provider a reply in writing or by electronic means which shall include all of the insurer´s specific reasons for the denial.

(6) Where an insurer disputes a portion of a claim, any undisputed portion of the claim shall be paid by the insurer in accordance with this Code section.

(d)(1) Every insurer may prescribe one or more permissible forms or formats for submission of electronic or paper claims by hospitals and ambulance service providers. A failure to file a claim fully in accordance with a form or format prescribed by an insurer shall not permit an insurer to fail to confirm receipt of a claim as required by paragraph (1) of subsection (c) of this Code section.

(2) Receipt of any claim, proof, or documentation by an entity which administers or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(3) Except where the form or format changes are mandated by state or federal regulation or law, every insurer shall notify the hospitals and ambulance service providers and their agents or intermediaries who submit claims to the insurer on their behalf at least 60 calendar days in advance of the effective date of any changes in the insurer´s claims payment form or format.

(e)(1) The Commissioner shall measure and require compliance by insurers with the standards set forth in this subsection for the timely payment of claims. Insurers shall meet the following standards for payment of claims:

(A) Every insurer shall pay, deny, or pend 95 percent of the number of all electronic claims within 21 calendar days of receipt;

(B) Every insurer shall pay, deny, or pend 95 percent of the number of all paper claims within 30 calendar days of receipt; and

(C) Every insurer shall pay or deny 95 percent of the number of all claims within 60 calendar days of receipt.

(2) The Commissioner shall measure the compliance of insurers with the standards set forth in paragraph (1) of this subsection for each calendar quarter. Each insurer shall be required to report in writing or by electronic means to the Commissioner on or before 45 days after the end of each calendar quarter the following information on each claim it receives:

(A) The name of the hospital or ambulance service provider;

(B) The name of the health benefit plan;

(C) Whether the claim was received electronically;

(D) Date of the receipt of the claim;

(E) Dates of the original disposition and final disposition, if any, of the claim;

(F) The nature of the disposition including the reason or reasons for pending the claim;

(G) The amount of the charges and the amount paid by the insurer to the claimant with respect to each claim; and

(H) Any other information deemed necessary by the Commissioner.

(3) The Commissioner shall publish quarterly the compliance performance of each insurer subject to this Code section. The report shall state for each insurer:

(A) The number of claims and charges for those claims which are paid within 21 calendar days of receipt or less, between 22 and 30 calendar days of receipt, between 31 and 60 calendar days of receipt, and more than 60 calendar days after receipt;

(B) The number of claims and charges for those claims which are denied within 21 calendar days of receipt or less, between 22 and 30 calendar days of receipt, between 31 and 60 calendar days of receipt, and more than 60 calendar days after receipt;

(C) The number of claims and charges for those claims which are pended for lack of specific information required by the insurer within 21 calendar days of receipt or less, between 22 and 30 calendar days of receipt, between 31 and 60 calendar days of receipt, and more than 60 calendar days after receipt;

(D) The number of claims and charges for those claims which are pended for detailed clinical review for the claim within 21 calendar days of receipt or less, between 22 and 30 calendar days of receipt, between 31 and 60 calendar days of receipt, and more than 60 calendar days after receipt;

(E) The number of claims and charges for those claims which are pended for coordination of benefits with another insurer within 21 calendar days of receipt or less, between 22 and 30 calendar days of receipt, between 31 and 60 calendar days of receipt, and more than 60 calendar days after receipt;

(F) The number of claims and charges for those claims which are pended because the insurer asserted a reasonable suspicion that the claim was fraudulent within 21 calendar days of receipt or less, between 22 and 30 calendar days of receipt, between 31 and 60 calendar days of receipt, and more than 60 calendar days after receipt;

(G) The number of claims and charges for those claims which are pended because the insured is not current in its obligation to the insurer and the insurer has sent a notice of cancellation to the insured that would affect the insurer´s obligation to pay the claim within 21 calendar days of receipt or less, between 22 and 30 calendar days of receipt, between 31 and 60 calendar days of receipt, and more than 60 calendar days after receipt; and

(H) The number of claims and charges for those claims which are pended for more than one reason specified in paragraph (3) of subsection (c) of this Code section within 21 calendar days of receipt or less, between 22 and 30 calendar days of receipt, between 31 and 60 calendar days of receipt, and more than 60 calendar days after receipt.

(4) Insurers which fail to meet the minimum standards of paragraph (1) of this subsection shall be subject to fines and other sanctions as deemed necessary by the Commissioner to ensure compliance with the standards set forth in paragraph (1) of this subsection after

giving consideration to the factors causing an insurer´s failure to comply. A failure to comply due solely to an act of God shall not be subject to a fine or other sanctions.

(5) The Commissioner may prescribe regulations and take other actions consistent with this Code section to ensure that the provisions of this Code section do not result in the payment of claims by insurers less timely than insurers have paid claims at any time prior to the date of the enactment of this Code section.

(f) Each insurer shall pay to the hospital or ambulance service provider entitled to the payment of a claim, in addition to all other amounts legally owed, interest at a rate of 18 percent per annum on the amount owed for every claim neither paid nor denied in good faith within 60 days of the insurer´s receipt of the claim. For electronic claims, interest shall being accruing 22 calendar days after receipt of the claim. For paper claims, interest shall begin accruing 31 calendar days after receipt of the claim. If the hospital or ambulance service provider fails to respond within 18 calendar days to a reply from an insurer under paragraph (1) of subsection (c) of this Code section requesting additional information, then any interest payable by the insurer shall not begin accruing until the date the reply is received.

(g) The provisions of this Code section are cumulative to any and all rights under existing law except for the provisions of Code Section 33-24-59.5.″

SECTION 2.

This Act shall become effective on July 1, 2001, and shall stand repealed in its entirety on June 30, 2003, at which time the provisions of Code Section 33-24-59.5 shall once again apply to claims submitted by hospitals and ambulance service providers.

SECTION 3.

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