

House Bill 843

By: Representative Harbin of the 80th

A BILL TO BE ENTITLED
AN ACT

1 To amend Article 1 of Chapter 24 of Title 33 of the Official Code of Georgia Annotated,
2 relating to general provisions regarding insurance, so as to provide definitions; to provide for
3 confirmation and expedited processing of claims filed by electronic means by providers; to
4 establish mechanics for the processing of health care claims submitted by providers; to
5 establish standards for the processing of health care claims submitted by providers to health
6 care insurers; to provide for the reporting of health care insurer compliance with such
7 standards; to provide for fines against health insurers who fail to meet standards of timely
8 payment; to provide for related matters; to provide for an effective date and applicability; to
9 repeal conflicting laws; and for other purposes.

10 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

11 **SECTION 1.**

12 Article 1 of Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to
13 general provisions regarding insurance, is amended by striking Code Section 33-24-59.5 in
14 its entirety and inserting in its place a new Code Section 33-24-59.5 to read as follows:

15 "33-24-59.5.

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

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

20 (2) ~~'Health benefit plan' means any hospital or medical insurance policy or certificate,~~
21 ~~health care plan contract or certificate, qualified higher deductible health plan, health~~
22 ~~maintenance organization subscriber contract, any health benefit plan established~~
23 ~~pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy,~~
24 ~~or managed care plan; but health benefit plan does not include policies issued in~~
25 ~~accordance with Chapter 31 of this title; disability income policies; or Chapter 9 of Title~~
26 ~~34, relating to workers' compensation.~~

~~(3) '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 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, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.~~

~~(b)(1) All benefits under a health benefit plan will be payable by the insurer which is obligated to finance or deliver health care services under that plan upon such insurer's receipt of written proof of loss or claim for payment for health care goods or services provided. The insurer shall within 15 working days after such receipt mail to the insured or other person claiming payments under the plan payment for such benefits or a letter or notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the person so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer in accordance with this chapter. When all of the listed documents or other information needed to process the claim have been received by the insurer, the insurer shall then have 15 working days within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the insured or other person claiming payments under the plan the insurer's reasons for such denial.~~

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

~~(c) Each insurer shall pay to the insured or other person claiming payments under the health benefit plan interest equal to 18 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.~~
The provisions of this Code section shall apply to payment of all claims submitted to insurers for benefits as defined in this Code section.

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

(1) '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.

(2) 'Claim' means a request for payment to an insurer for the delivery of goods and services under a health benefit plan.

1 (3) 'Claimant' means a person or entity who submits to an insurer a claim as defined by
 2 this Code section.

3 (4) 'Electronic claim' means a claim transmitted to the computer of an insurer or its agent
 4 by a claimant or its agent through electronic means using an electronic format prescribed
 5 by the insurer.

6 (5) 'Health benefit plan' means any hospital or medical insurance policy or certificate,
 7 health care plan contract or certificate, qualified higher deductible health plan, health
 8 maintenance organization subscriber contract, health benefit plan established pursuant to
 9 Article 1 of Chapter 18 of Title 45, or dental or vision care plan or policy or managed
 10 care plan; but the term 'health benefit plan' does not include policies issued in accordance
 11 with Chapter 31 of this title, disability income policies, or provision of benefits under
 12 Chapter 9 of Title 24.

13 (6) 'Insurer' means an accident and sickness insurer; fraternal benefit society; nonprofit
 14 hospital service corporation; nonprofit medical service corporation; health care
 15 corporation; health maintenance organization; provider sponsored health care corporation
 16 or any similar entity; any self-insured health benefit plan not subject to the exclusive
 17 jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C.
 18 Section 1001, et seq., which entity provides for the financing or delivery of health care
 19 services through a health benefit plan; or the plan administrator of any health benefit plan
 20 established pursuant to Article 1 of Chapter 18 of Title 45.

21 (7) 'Paper claim' means a claim submitted to an insurer on HCFA Form 1500, Form UB
 22 92, or the successors of those forms.

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

26 (c)(1) Every insurer shall, within 21 calendar days after receipt of an electronic claim and
 27 within 45 calendar days after receipt of a paper claim, send to the hospital or ambulance
 28 service provider:

29 (A) Payment;

30 (B) A denial of the claim; or

31 (C) A reply in writing or by electronic means which states all of the applicable reasons
 32 identified in paragraph (3) of this subsection that the insurer may have for failing to pay
 33 or denying the claim, either in whole or in part, and which specifies all additional
 34 information necessary for the insurer to fully process and pay or deny the claim.

35 (2) With respect to all electronic claims submitted to insurers, insurers shall, no later than
 36 five business days after receipt, confirm to the person or entity or their respective agent
 37 by the same means received receipt by the insurer of each claim received and shall

1 include in each such confirmation the applicable patient control number, date of receipt,
 2 and dates of service. An insurer shall respond promptly to any inquiry submitted by the
 3 claimant or its agent regarding the failure to provide timely confirmation of the receipt
 4 of a claim and shall immediately take all reasonable steps to investigate and confirm
 5 receipt of the claim.

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

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

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

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

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

13 (E) The insured is not current in its obligation to the insurer.

14 (4)(A) When an insurer makes a request for additional information under paragraph (1)
 15 of this subsection, a claimant or its agent must provide information responsive to the
 16 request within 21 days. Failure of the claimant or its agent to provide such a response
 17 shall relieve the insurer of any liability for interest or penalties under this Code section.

18 (B) When, in response to an insurer's request for additional information under
 19 paragraph (1) of this subsection a claimant delivers additional information requested
 20 for processing a claim, the insurer shall then have 21 additional calendar days after
 21 receipt of the information within which to reevaluate the claim and:

22 (i) Pay the claim;

23 (ii) Deny the claim; or

24 (iii) Send the claimant another reply in writing or by electronic means stating all
 25 applicable reasons set forth in paragraph (3) of this subsection for continuing to pend
 26 the claim and explaining why the additional information remains insufficient to
 27 satisfy the insurer's previous request.

28 (C) In any event, an insurer must pay or deny a claim within 90 days of its first
 29 submission.

30 (5) Any denial of a claim under paragraph (1) or (4) of this subsection or otherwise shall
 31 be made by sending the claimant a reply in writing or by electronic means which shall
 32 include all of the insurer's specific reasons for the denial.

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

35 (d)(1) Every insurer may prescribe permissible forms or formats for submission of
 36 electronic claims by claimants. A failure to file a claim fully in accordance with a form

1 or format prescribed by an insurer shall not permit an insurer to fail to confirm receipt of
 2 a claim as required by paragraph (1) of subsection (c) of this Code section.

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

6 (3) Except where the form or format changes are mandated by state or federal regulation
 7 or law, every insurer shall notify the claimants or their agents or intermediaries who
 8 submit claims to the insurer on their behalf at least 60 calendar days in advance of the
 9 effective date of any changes in the insurer's claims payment form or format.

10 (e)(1) The Commissioner shall measure and require compliance by insurers with the
 11 standards set forth in this subsection for the timely payment of claims. Every insurer
 12 shall pay, deny, or pend 95 percent of the number of all electronic claims within 21
 13 calendar days of receipt;

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

18 (A) NAIC number;

19 (B) List number;

20 (C) Claim number;

21 (D) Line item number;

22 (E) Date of service;

23 (F) Claim received date;

24 (G) First response date;

25 (H) First response type (paid, denied, or requested additional information);

26 (I) Claim complete date;

27 (J) Final adjudication date;

28 (K) Claim status;

29 (L) Whether the claim is related to PPO, HMO, indemnity, or dental;

30 (M) Paid amount;

31 (N) Check date; and

32 (O) Amount of interest paid.

33 (3) The Commissioner shall publish annually the compliance performance of each
 34 insurer subject to this Code section.

35 (4) Insurers which fail to meet the minimum standards of paragraph (1) of this subsection
 36 shall be subject to penalties. If the Commissioner finds that an insurer has failed during
 37 any calendar year to properly process 95 percent of claims received from claimants

1 during that year in accordance with this Code section, the Commissioner may levy an
2 aggregate penalty up to \$10,000.00. If the Commissioner finds an insurer has failed
3 during any calendar year to properly process 85 percent of claims received from
4 claimants during that year in accordance with this Code section, the Commissioner may
5 levy an aggregate penalty in an amount of not less than \$10,000.00 nor more than
6 \$50,000.00, if reasonable notice in writing is given of the intent to levy the penalty. If
7 the Commissioner finds that an insurer has failed during any calendar year to properly
8 process 60 percent of all claims received from claimants during that year in accordance
9 with this Code section, the Commissioner may levy an aggregate penalty in an amount
10 not less than \$50,000.00 nor more than \$100,000.00. In determining the amount of such
11 fine, the Commissioner shall take into account whether the failure to achieve the
12 standards in this section is due to circumstances beyond the insurer's control. An insurer
13 may request an administrative hearing contesting the assessment of any penalty imposed
14 by the Commissioner within 30 days after receipt of the notice of assessment.

15 (f) Each insurer shall pay to the claimants entitled to the payment of a claim, in addition
16 to all other amounts legally owed, interest at a rate of 18 percent per annum on the amount
17 owed for every claim neither paid nor denied in good faith within 60 days of the insurer's
18 receipt of the claim. For electronic claims, interest shall begin accruing 22 calendar days
19 after receipt of the claim. For paper claims, interest shall begin accruing 46 calendar days
20 after receipt of the claim. If the claimant fails to respond within 18 calendar days to a reply
21 from an insurer under paragraph (1) of subsection (c) of this Code section requesting
22 additional information, then any interest payable by the insurer shall not begin accruing
23 until the date the reply is received."

24 SECTION 2.

25 This Act shall become effective on January 1, 2004.

26 SECTION 3.

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