

Senate Bill 8 - Senate Prefile

By: Senator Unterman of the 45<sup>th</sup>

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 consumer protections regarding health insurance; to provide for definitions; to  
3 provide for disclosure requirements of providers, hospitals, and insurers; to provide for  
4 billing and reimbursement of out-of-network services; to provide for procedures for dispute  
5 resolution for surprise bills for nonemergency services; to provide for payment of emergency  
6 services; to provide for an out-of-network reimbursement rate workgroup; to provide for  
7 related matters; to repeal conflicting laws; and for other purposes.

8 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

9 **SECTION 1.**

10 This Act shall be known and may be referred to as the "Surprise Billing and Consumer  
11 Protection Act."

12 **SECTION 2.**

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

15 "CHAPTER 20E

16 33-20E-1.

17 As used in this chapter, the term:

18 (1) 'Covered person' means an individual who is covered under a health care plan.

19 (2) 'Emergency services' means those health care services that are provided for a  
20 condition of recent onset and sufficient severity, including, but not limited to, severe pain,  
21 that would lead a prudent layperson possessing an average knowledge of medicine and  
22 health to believe that his or her condition, sickness, or injury is of such a nature that  
23 failure to obtain immediate medical care could result in:

24 (A) Placing the patient's health in serious jeopardy;

25 (B) Serious impairment to bodily functions; or

26 (C) Serious dysfunction of any bodily organ or part.

27 (3) 'Enrollee' means a policyholder, subscriber, covered person, or other individual  
28 participating in a health benefit plan.

29 (4) 'Health care plan' means any hospital or medical insurance policy or certificate,  
30 health care plan contract or certificate, qualified higher deductible health plan, health  
31 maintenance organization subscriber contract, any health benefit plan established  
32 pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy;  
33 but health care plan shall not include policies issued in accordance with Chapter 31 of  
34 this title, relating to credit life insurance and credit accident and sickness insurance,  
35 Chapter 9 of Title 34, relating to workers' compensation, Chapter 20A of this title,  
36 relating to managed health care plans, or disability income policies.

37 (5) 'Health care provider' or 'provider' means any physician, dentist, podiatrist,  
38 pharmacist, optometrist, psychologist, clinical social worker, advanced practice registered  
39 nurse, registered optician, licensed professional counselor, physical therapist, marriage  
40 and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section  
41 43-5-8, occupational therapist, speech-language pathologist, audiologist, dietitian, or  
42 physician assistant.

43 (6) 'Health care services' means the examination or treatment of persons for the  
44 prevention of illness or the correction or treatment of any physical or mental condition  
45 resulting from illness, injury, or other human physical problem and includes, but is not  
46 limited to:

47 (A) Hospital services which include the general and usual care, services, supplies, and  
48 equipment furnished by hospitals;

49 (B) Medical services which include the general and usual services and care rendered  
50 and administered by doctors of medicine, doctors of dental surgery, and doctors of  
51 podiatry; and

52 (C) Other health care services which include appliances and supplies; nursing care by  
53 a registered nurse or a licensed practical nurse; institutional services, including the  
54 general and usual care, services, supplies, and equipment furnished by health care  
55 institutions and agencies or entities other than hospitals; physiotherapy; ambulance  
56 services; drugs and medications; therapeutic services and equipment, including oxygen  
57 and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and  
58 appliances, including wheelchairs, trusses, braces, crutches, and prosthetic devices,  
59 including artificial limbs and eyes; and any other appliance, supply, or service related  
60 to health care.

61 (7) 'Health center' means an entity that serves a population that is medically underserved,  
62 or a special medically underserved population comprised of migratory and seasonal  
63 agricultural workers, the homeless, and residents of public housing, by providing, either  
64 through the staff and supporting resources of the center or through contracts or  
65 cooperative arrangements for required primary health services and as may be appropriate  
66 for particular centers, additional health services necessary for the adequate support of the  
67 primary health services for all residents of the area served by the health center.

68 (8) 'Insurer' means any person engaged as indemnitor, surety, or contractor who issues  
69 insurance, annuity or endowment contracts, subscriber certificates, or other contracts of  
70 insurance by whatever name called. Hospital service nonprofit corporations, nonprofit  
71 medical service corporations, health care plans, and health maintenance organizations are  
72 insurers within the meaning of this chapter.

73 (9) 'Medically underserved population' means the population of an urban or rural area  
74 designated by the United States Secretary of Health and Human Services as an area with  
75 a shortage of personal health services or a population group designated by the Secretary  
76 in consultation with the state as having a shortage of such services.

77 (10) 'Out-of-network' refers to health care items or services provided to an enrollee by  
78 providers who do not belong to the provider network in the health care plan.

79 (11) 'Patient' means a person who seeks or receives health care services under a health  
80 benefit plan.

81 (12) 'Precertification' means any written or oral determination made at any time by an  
82 insurer or any agent of such insurer that an enrollee's receipt of health care services is a  
83 covered benefit under the applicable plan and that any requirement of medical necessity  
84 or other requirements imposed by such plan as prerequisites for payment for such  
85 services have been satisfied. 'Agent' as used in this paragraph shall not include an agent  
86 or agency as defined in Code Section 33-23-1.

87 (13) 'Required primary health services' means health services related to family medicine,  
88 internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians  
89 and when appropriate, physician assistants, nurse practitioners, and nurse midwives;  
90 diagnostic laboratory and radiologic services; preventive health care services including  
91 prenatal and perinatal services; appropriate cancer screening; well child services;  
92 immunizations against vaccine-preventable diseases; screenings for elevated blood lead  
93 levels, communicable diseases, or cholesterol; pediatric eye, ear, and dental screenings  
94 to determine the need for vision and hearing correction and dental care; family planning  
95 services; and preventive dental services.

96 (14) 'Surprise bill' means a bill for health care services, other than emergency services,  
97 received by:

98 (A) An insured for services rendered by a nonparticipating physician at a participating  
 99 hospital or ambulatory surgical center when a participating physician is unavailable or  
 100 a nonparticipating physician renders services without the insured's knowledge or when  
 101 unforeseen medical services arise at the time the health care services are rendered;  
 102 provided, however, that a surprise bill shall not mean a bill received for health care  
 103 services when a participating physician is available and the insured has elected to obtain  
 104 services from a nonparticipating physician;

105 (B) An insured for services rendered by a nonparticipating provider when the services  
 106 were referred by a participating physician to a nonparticipating provider without the  
 107 explicit written consent of the insured acknowledging that the participating physician  
 108 is referring the insured to a nonparticipating provider and that the referral may result  
 109 in costs not covered by the health care plan; or

110 (C) A patient who is not an insured for services rendered by a physician at a hospital  
 111 or ambulatory surgical center when the patient has not timely received all of the  
 112 disclosures required by Code Section 33-20E-2.

113 (15) 'Usual and customary cost' means the eightieth percentile of all charges for the  
 114 particular health care service performed by a provider in the same or similar specialty and  
 115 provided in the same geographical area reported in a benchmarking data base maintained  
 116 by the department.

117 33-20E-2.

118 (a) A health care provider, group practice of health care providers, diagnostic and  
 119 treatment center, or health center on behalf of health care providers rendering services at  
 120 a group practice, diagnostic and treatment center, or health center shall disclose to patients  
 121 or prospective patients in writing or through an Internet website the health care plans in  
 122 which the health care provider, group practice, diagnostic and treatment center, or health  
 123 center is a participating provider and the hospitals with which the health care provider is  
 124 affiliated prior to the provision of nonemergency services and verbally at the time an  
 125 appointment is scheduled.

126 (b) If a health care provider, group practice of health care providers, diagnostic and  
 127 treatment center, or health center on behalf of health care providers rendering services at  
 128 a group practice, diagnostic and treatment center, or health center does not participate in  
 129 the network of a patient's or prospective patient's health care plan, the health care provider,  
 130 group practice, diagnostic and treatment center, or health center shall:

131 (1) Prior to the provision of nonemergency services, inform a patient or prospective  
 132 patient that the estimated amount the health care provider will bill the patient for health  
 133 care services is available upon request; and

134 (2) Upon receipt of a request from a patient or prospective patient, disclose to the patient  
135 or prospective patient in writing the amount or estimated amount or, with respect to a  
136 health center, a schedule of fees that the health care provider, group practice, diagnostic  
137 and treatment center, or health center will bill the patient or prospective patient for health  
138 care services provided or anticipated to be provided to the patient or prospective patient  
139 absent unforeseen medical circumstances that may arise when the health care services are  
140 provided.

141 (c) A health care provider who is a physician shall provide a patient or prospective patient  
142 with the name, practice name, mailing address, and telephone number of any health care  
143 provider scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant  
144 surgeon services in connection with care to be provided in the physician's office for the  
145 patient or coordinated or referred by the physician for the patient at the time of referral to  
146 or coordination of services with such provider.

147 (d) A health care provider who is a physician shall, for a patient's scheduled hospital  
148 admission or scheduled outpatient hospital services, provide a patient and the hospital with  
149 the name, practice name, mailing address, and telephone number of any other physician  
150 whose services will be arranged for by the physician and are scheduled at the time of the  
151 preadmission testing, registration, or admission at the time nonemergency services are  
152 scheduled; and information as to how to determine the health care plans in which the  
153 physician participates.

154 (e) A hospital shall establish, update, and make public through posting on the hospital's  
155 website, to the extent required by federal guidelines, a list of the hospital's standard charges  
156 for items and services provided by the hospital, including for diagnosis related groups  
157 established under Section 1886(d)(4) of the federal Social Security Act.

158 (f) A hospital shall post on the hospital's website:

159 (1) The health care plans in which the hospital is a participating provider;

160 (2) A statement that physician services provided in the hospital are not included in the  
161 hospital's charges, that physicians who provide services in the hospital may or may not  
162 participate with the same health care plans as the hospital, and that the prospective patient  
163 should check with the physician arranging for the hospital services to determine the  
164 health care plans in which the physician participates;

165 (3) As applicable, the name, mailing address, and telephone number of the physician  
166 groups that the hospital has contracted with to provide services, including anesthesiology,  
167 pathology, or radiology, and instructions on how to contact these groups to determine the  
168 health care plan participation of the physicians in these groups; and

169 (4) As applicable, the name, mailing address, and telephone number of physicians  
170 employed by the hospital and whose services may be provided at the hospital with the  
171 health care plans in which they participate.

172 (g) In registration or admission materials provided in advance of nonemergency hospital  
173 services, a hospital shall:

174 (1) Advise the patient or prospective patient to check with the physician arranging the  
175 hospital services to determine:

176 (A) The name, practice name, mailing address, and telephone number of any other  
177 physician whose services will be arranged for by the physician; and

178 (B) Whether the services of physicians who are employed or contracted by the hospital  
179 to provide services including anesthesiology, pathology, and radiology, are reasonably  
180 anticipated to be provided to the patient; and

181 (2) Provide patients or prospective patients with information as to how to timely  
182 determine the health care plans participated in by physicians who are reasonably  
183 anticipated to provide services to the patient at the hospital, as determined by the  
184 physician arranging the patient's hospital services, and who are employees of the hospital  
185 or contracted by the hospital to provide services, including anesthesiology, radiology, and  
186 pathology.

187 33-20E-3.

188 (a) An insurer shall provide to an enrollee:

189 (1) Information that an enrollee may obtain a referral to a health care provider outside  
190 of the health maintenance organization's network or panel when the health maintenance  
191 organization does not have a health care provider who is geographically accessible to the  
192 enrollee and who has appropriate training and experience in the network or panel to meet  
193 the particular health care needs of the enrollee and the procedure by which the enrollee  
194 can obtain such referral;

195 (2) Notice that the enrollee shall have direct access to primary and preventive obstetric  
196 and gynecologic services, including annual examinations, care resulting from such annual  
197 examinations, and treatment of acute gynecologic conditions, or for any care related to  
198 a pregnancy, from a qualified provider of such services of her choice from within the  
199 plan;

200 (3) All appropriate mailing addresses and telephone numbers to be utilized by enrollees  
201 seeking information or authorization; and

202 (4) An annually updated listing by specialty, which may be in a separate document, of  
203 the name, address, and telephone number of all participating providers, including  
204 facilities, and in the case of physicians, the board certification, languages spoken, and any

205 affiliations with participating hospitals. The listing shall also be posted on the health  
206 maintenance organization's website and the health maintenance organization shall update  
207 the website within 15 days of the addition or termination of a provider from the health  
208 maintenance organization's network or a change in a physician's hospital affiliation;  
209 (5) Where applicable, a description of the method by which an enrollee may submit a  
210 claim for health care services;  
211 (6) With respect to out-of-network coverage:  
212 (A) A clear description of the methodology used by the health maintenance  
213 organization to determine reimbursement for out-of-network health care services;  
214 (B) The amount that the health maintenance organization will reimburse under the  
215 methodology for out-of-network health care services set forth as a percentage of the  
216 usual and customary cost for out-of-network health care services;  
217 (C) Examples of anticipated out-of-pocket costs for frequently billed out-of-network  
218 health care services;  
219 (7) Information in writing and through an Internet website that reasonably permits an  
220 enrollee or prospective enrollee to estimate the anticipated out-of-pocket cost for  
221 out-of-network health care services in a geographical area or ZIP code based upon the  
222 difference between what the health maintenance organization will reimburse for  
223 out-of-network health care services and the usual and customary cost for out-of-network  
224 health care services;  
225 (8) The written application procedures and minimum qualification requirements for  
226 health care providers to be considered by the insurer; and  
227 (9) Other information as required by the Commissioner.  
228 (b) An insurer shall disclose whether a health care provider scheduled to provide a health  
229 care service is an in-network provider and, with respect to out-of-network coverage,  
230 disclose the approximate dollar amount that the insurer will pay for a specific  
231 out-of-network health care service. Insurers shall also inform an enrollee through such  
232 disclosure that such approximation is not binding on the insurer and that the approximate  
233 dollar amount that the insurer will pay for a specific out-of-network health care service  
234 may change.

235 33-20E-4.

236 An out-of-network referral denial means a denial of a request for an authorization or  
237 referral to an out-of-network provider on the basis that the health care plan has a health  
238 care provider in the network benefits portion of its network with appropriate training and  
239 experience to meet the particular health care needs of an enrollee and who is able to  
240 provide the requested health service. The notice of an out-of-network referral denial

241 provided to an enrollee shall have information explaining what information the enrollee  
242 must submit in order to appeal the out-of-network referral denial. An out-of-network  
243 denial shall not constitute an adverse determination.

244 33-20E-5.

245 (a) An insurer shall provide a description of the method by which an enrollee may submit  
246 a claim for health care services.

247 (b) An insurer shall provide a clear description of the methodology used by such insurer  
248 to determine reimbursement for out-of-network health care services and the amount that  
249 the insurer will reimburse under the methodology for out-of-network health care services  
250 set forth as a percentage of the usual and customary cost for out-of-network health care  
251 services.

252 (c) An insurer shall provide examples of anticipated out-of-pocket costs for frequently  
253 billed out-of-network health care services and information in writing and through an  
254 Internet website that reasonably permits an enrollee or prospective enrollee to estimate the  
255 anticipated out-of-pocket cost for out-of-network health care services in a geographical  
256 area or ZIP code based upon the difference between what the insurer will reimburse for  
257 out-of-network health care services and the usual and customary cost for out-of-network  
258 health care services.

259 (d) An insurer shall disclose whether a health care provider scheduled to provide a health  
260 care service is an in-network provider and, with respect to out-of-network coverage,  
261 disclose the approximate dollar amount that the health maintenance organization will pay  
262 for a specific out-of-network health care service. The insurer shall also inform an enrollee  
263 through such disclosure that such approximation is not binding on the health maintenance  
264 organization and that the approximate dollar amount that the health maintenance  
265 organization will pay for a specific out-of-network health care service may change.

266 33-20E-6.

267 (a) The Commissioner shall establish a dispute resolution process by which a dispute for  
268 a bill for emergency services or a surprise bill may be resolved. The Commissioner shall  
269 have the power to grant and revoke certifications of independent dispute resolution entities  
270 to conduct the dispute resolution process.

271 (b) The Commissioner shall promulgate regulations establishing standards for the dispute  
272 resolution process, including a process for certifying and selecting independent dispute  
273 resolution entities. An independent dispute resolution entity shall use licensed physicians  
274 in active practice in the same or similar specialty as the physician providing the service that



275 is subject to the dispute resolution process. To the extent practicable, the physician shall  
 276 be licensed in this state.

277 (c) This chapter shall not apply to health care services, including emergency services,  
 278 where physician fees are subject to schedules or other monetary limitations under any other  
 279 law, including workers' compensation law.

280 (d) The dispute resolution process established in this chapter shall not apply when:

281 (1) The amount billed for American Medical Association current procedural terminology  
 282 (CPT) codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220,  
 283 99224 through 99226, and 99234 through 99236 meets the requirements set forth in  
 284 subsection (f) of this Code section, after any applicable coinsurance, copayment and  
 285 deductible; and

286 (2) The amount billed for any such CPT code does not exceed 120 percent of the usual  
 287 and customary cost for such CPT code.

288 (e) The health care plan shall ensure that an insured shall not incur any greater  
 289 out-of-pocket costs for emergency services billed under a CPT code as set forth in this  
 290 Code section than the insured would have incurred if such emergency services were  
 291 provided by a participating physician.

292 (f) Beginning January 1, 2018, and on each January 1 thereafter, the Commissioner shall  
 293 publish on a website maintained by the department, and provide in writing to each health  
 294 care plan, a dollar amount for which bills for the procedure codes identified in this Code  
 295 section shall be exempt from the dispute resolution process established in this chapter.  
 296 Such amount shall equal the amount from the prior year, beginning with \$600.00 in 2017,  
 297 adjusted by the average of the annual average inflation rates for the medical care  
 298 commodities and medical care services components of the Consumer Price Index. In no  
 299 event shall an amount exceeding \$1,200.00 for a specific CPT code billed be exempt from  
 300 the dispute resolution process established in this chapter.

301 33-20E-7.

302 In determining the appropriate amount to pay for a health care service, an independent  
 303 dispute resolution entity shall consider all relevant factors, including whether there is a  
 304 gross disparity between the fee charged by the physician for services rendered as compared  
 305 to:

306 (1) Fees paid to the involved physician for the same services rendered by the physician  
 307 to other patients in health care plans in which the physician is not participating;

308 (2) In the case of a dispute involving a health care plan, fees paid by the health care plan  
 309 to reimburse similarly qualified physicians for the same services in the same region who  
 310 are not participating in the health care plan;

- 311 (3) The level of training, education, and experience of the physician;  
312 (4) The physician's usual charge for comparable services with regard to patients in health  
313 care plans in which the physician is not participating;  
314 (5) The circumstances and complexity of the particular case, including time and place  
315 of the service;  
316 (6) Individual patient characteristics; and  
317 (7) The usual and customary cost of the service.

318 33-20E-8.

319 (a) When a health care plan receives a bill for emergency services from a nonparticipating  
320 physician, the health care plan shall pay an amount that it determines is reasonable for the  
321 emergency services rendered by the nonparticipating physician in accordance with Code  
322 Section 33-20E-7 except for the insured's copayment, coinsurance, or deductible, if any,  
323 and shall ensure that the insured shall incur no greater out-of-pocket costs for the  
324 emergency services than the insured would have incurred with a participating physician.

325 (b) A nonparticipating physician or a health care plan may submit a dispute regarding a  
326 fee or payment for emergency services for review to an independent dispute resolution  
327 entity. The independent dispute resolution entity shall make a determination within 30  
328 days of receipt of the dispute for review.

329 (c) In determining a reasonable fee for the services rendered, an independent dispute  
330 resolution entity shall select either the health care plan's payment or the nonparticipating  
331 physician's fee. The independent dispute resolution entity shall determine which amount  
332 to select based upon the conditions and factors set forth in Code Section 33-20E-7 of this  
333 chapter. If an independent dispute resolution entity determines, based on the health care  
334 plan's payment and the nonparticipating physician's fee, that a settlement between the  
335 health care plan and nonparticipating physician is reasonably likely, or that both the health  
336 care plan's payment and the nonparticipating physician's fee represent unreasonable  
337 extremes, then the independent dispute resolution entity may direct both parties to attempt  
338 a good faith negotiation for settlement. The health care plan and nonparticipating  
339 physician may be granted up to ten business days for this negotiation, which shall run  
340 concurrently with the 30 day period for dispute resolution.

341 (d) A patient who is not an insured or the patient's physician may submit a dispute  
342 regarding a fee for emergency services for review to an independent dispute resolution  
343 entity upon approval of the Commissioner. An independent dispute resolution entity shall  
344 determine a reasonable fee for the services based upon the same conditions and factors  
345 pursuant to Code Section 33-20E-7 of this chapter.

346 (e) A patient who is not an insured shall not be required to pay the physician's fee in order  
347 to be eligible to submit the dispute for review to an independent dispute resolution entity.

348 (f) The determination of an independent dispute resolution entity shall be binding on the  
349 health care plan, physician, and patient and shall be admissible in any court proceeding  
350 between the health care plan, physician, or patient, or in any administrative proceeding  
351 between this state and the physician.

352 33-20E-9.

353 When an insured assigns benefits for a surprise bill in writing to a nonparticipating  
354 physician who knows that the insured is insured under a health care plan, the  
355 nonparticipating physician shall not bill the insured except for any applicable copayment,  
356 coinsurance, or deductible that would be owed if the insured utilized a participating  
357 physician.

358 33-20E-10.

359 (a) If an insured assigns benefits to a nonparticipating physician, the health care plan shall  
360 pay the nonparticipating physician in accordance with subsections (c) and (d) of this Code  
361 section.

362 (b) The nonparticipating physician may bill the health care plan for the health care services  
363 rendered, and the health care plan shall pay the nonparticipating physician the billed  
364 amount or attempt to negotiate reimbursement with the nonparticipating physician.

365 (c) If the health care plan's attempts to negotiate reimbursement for health care services  
366 provided by a nonparticipating physician does not result in a resolution of the payment  
367 dispute between the nonparticipating physician and the health care plan, the health care  
368 plan shall pay the nonparticipating physician an amount the health care plan determines is  
369 reasonable for the health care services rendered, except for the insured's copayment,  
370 coinsurance, or deductible.

371 (d) Either the health care plan or the nonparticipating physician may submit the dispute  
372 regarding the surprise bill for review to an independent dispute resolution entity; provided,  
373 however, that the health care plan may not submit the dispute unless it has complied with  
374 the requirements of subsections (a), (b), and (c) of this Code section.

375 (e) The independent dispute resolution entity shall make a determination within 30 days  
376 of receipt of the dispute for review.

377 (f) When determining a reasonable fee for the services rendered, the independent dispute  
378 resolution entity shall select either the health care plan's payment or the nonparticipating  
379 physician's fee. An independent dispute resolution entity shall determine which amount  
380 to select based upon the conditions and factors set forth in Code Section 33-20E-7. If an

381 independent dispute resolution entity determines, based on the health care plan's payment  
382 and the nonparticipating physician's fee, that a settlement between the health care plan and  
383 nonparticipating physician is reasonably likely, or that both the health care plan's payment  
384 and the nonparticipating physician's fee represent unreasonable extremes, then the  
385 independent dispute resolution entity may direct both parties to attempt a good faith  
386 negotiation for settlement. The health care plan and nonparticipating physician may be  
387 granted up to ten business days for this negotiation, which shall run concurrently with the  
388 30 day period for dispute resolution.

389 (g) An insured who does not assign benefits under subsection (a) of this Code section or  
390 a patient who is not an insured and who receives a surprise bill may submit a dispute  
391 regarding the surprise bill for review to an independent dispute resolution entity.

392 (h) The independent dispute resolution entity shall determine a reasonable fee for the  
393 services rendered based upon the conditions and factors set forth in Code Section  
394 33-20E-7.

395 (i) A patient or insured who does not assign benefits in accordance with subsection (a) of  
396 this Code section shall not be required to pay the physician's fee to be eligible to submit the  
397 dispute for review to the independent dispute entity.

398 (j) The determination of an independent dispute resolution entity shall be binding on the  
399 patient, physician, and health care plan, and shall be admissible in any court proceeding  
400 between the patient or insured, physician or health care plan, or in any administrative  
401 proceeding between this state and the physician.

402 (k) In disputes involving an insured, when the independent dispute resolution entity  
403 determines the health care plan's payment is reasonable, payment for the dispute resolution  
404 process shall be the responsibility of the nonparticipating physician. When the independent  
405 dispute resolution entity determines the nonparticipating physician's fee is reasonable,  
406 payment for the dispute resolution process shall be the responsibility of the health care  
407 plan. When a good faith negotiation directed by the independent dispute resolution entity  
408 pursuant to Code Sections 33-20E-8 and 33-20E-9 of this chapter results in a settlement  
409 between the health care plan and nonparticipating physician, the health care plan and the  
410 nonparticipating physician shall evenly divide and share the prorated cost for dispute  
411 resolution.

412 (l) When there is a dispute involving a patient who is not an insured and the independent  
413 dispute resolution entity determines the physician's fee is reasonable, payment for the  
414 dispute resolution process shall be the responsibility of the patient unless payment for the  
415 dispute resolution process would pose a hardship to the patient. The Commissioner shall  
416 promulgate a regulation to determine payment for the dispute resolution process in cases  
417 of hardship. When the independent dispute resolution entity determines the physician's fee

418 is unreasonable, payment for the dispute resolution process shall be the responsibility of  
419 the physician.

420 33-20E-11.

421 (a) An out-of-network reimbursement rate workgroup shall be established consisting of  
422 nine members appointed by the Governor. Two members shall be appointed on the  
423 recommendation of the Speaker of the House of Representatives and two members shall  
424 be appointed on the recommendation of the President of the Senate. The workgroup shall  
425 consist of two physicians, two representatives of health plans, and three consumers and  
426 shall be chaired by the Commissioner. Such representatives of the workgroup shall  
427 represent different regions of the state. The members shall receive no compensation for  
428 their services but shall be allowed their actual and necessary expenses incurred in the  
429 performance of their duties.

430 (b) The workgroup shall review the current out-of-network reimbursement rates used by  
431 health insurers licensed under this title and make recommendations regarding an alternative  
432 rate methodology, taking into consideration the following factors:

433 (1) Current physician charges for out-of-network services;

434 (2) Trends in medical care and the actual costs of medical care;

435 (3) Regional differences regarding medical costs and trends;

436 (4) The current methodologies and levels of reimbursement for out-of-network services  
437 currently paid by health plans, including insurers, health maintenance organizations,  
438 medicare, and Medicaid;

439 (5) The current in-network rates paid by health plans, including insurers, health  
440 maintenance organizations, medicare, and Medicaid for the same service and by the same  
441 provider;

442 (6) The impact different rate methodologies would have on out-of-pocket costs for  
443 consumers who access out-of-network services;

444 (7) The impact different rate methodologies would have on premium costs in different  
445 regions of the state;

446 (8) Reimbursement data from all health plans, both public and private, as well as charge  
447 data from medical professionals and hospitals available through an all-payor data base  
448 to be developed and maintained by the department; and

449 (9) Other issues deemed appropriate by the Commissioner.

450 (c) The workgroup shall review out-of-network coverage in the individual and small group  
451 markets and make recommendations regarding the availability and adequacy of the  
452 coverage, taking into consideration the following factors:

- 453 (1) The extent to which out-of-network coverage is available in each rating region in this  
454 state;
- 455 (2) The extent to which a significant level of out-of-network benefits is available in  
456 every rating region in this state, including the prevalence of coverage based on the usual  
457 and customary cost as well as coverage based on other set reimbursement methodologies,  
458 such as medicare; and
- 459 (3) Other issues deemed appropriate by either the commissioner of revenue or the  
460 commissioner of public health.
- 461 (d) The workgroup shall report its findings and make recommendations for legislation and  
462 regulations to the Governor, the Speaker of the House of Representative, the President of  
463 the Senate, and the chairpersons of the House Committee on Insurance and the Senate  
464 Insurance and Labor Committee no later than January 1, 2018."

465 **SECTION 3.**

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