

Senate Bill 359

By: Senators Hufstetler of the 52nd, Tillery of the 19th, Strickland of the 17th, Albers of the 56th, Kirkpatrick of the 32nd and others

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 provide for in-network cost-sharing amounts in healthcare plan  
7 contracts; to establish an arbitration process; to require the Commissioner of Insurance to  
8 contract with one or more resolution organizations; to require the promulgation of  
9 department rules; to provide for an effective date; to repeal conflicting laws; and for other  
10 purposes.

11 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

12 style="text-align:center">**SECTION 1.**

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 style="text-align:center">"CHAPTER 20E

16 33-20E-1.

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

19 33-20E-2.

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

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

23 (1) 'Balance bill' means the amount that a nonparticipating provider charges for services  
 24 provided to a covered person. Such amount equals the difference between the amount  
 25 paid or offered by the insurer and the amount of the nonparticipating provider's bill  
 26 charge, but shall not include any amount for coinsurance, copayments, or deductibles due  
 27 by the covered person.

28 (2) 'Contracted amount' means the median in-network amount negotiated during 2017  
 29 by an insurer for the emergency or nonemergency services provided by in-network  
 30 providers engaged in the same or similar specialties and provided in the same or nearest  
 31 geographical area, exclusive of any coinsurance, copayment, deductible, or other  
 32 cost-sharing amount specified in the healthcare plan. Such amount shall be annually  
 33 adjusted according to the Consumer Price Index.

34 (3) 'Covered person' means an individual who is insured under a healthcare plan.

35 (4) 'Emergency medical provider' means any physician licensed by the Georgia  
 36 Composite Medical Board who provides emergency medical services and any other  
 37 healthcare provider licensed or otherwise authorized in this state who renders emergency  
 38 medical services.

39 (5) 'Emergency medical services' means medical services rendered after the recent onset  
 40 of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of  
 41 sufficient severity, including, but not limited to, severe pain, that would lead a prudent  
 42 layperson possessing an average knowledge of medicine and health to believe that his or  
 43 her condition, sickness, or injury is of such a nature that failure to obtain immediate  
 44 medical care could result in:

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

46 (B) Serious impairment to bodily functions; or

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

48 (6) 'Facility' means a hospital, an ambulatory surgical treatment center, birthing center,  
 49 diagnostic and treatment center, hospice, or similar institution.

50 (7) 'Geographic area' means a specific portion of this state which shall consist of one or  
 51 more entire counties as defined by the Commissioner pursuant to department rule and  
 52 regulation.

53 (8) 'Healthcare plan' means any hospital or medical insurance policy or certificate,  
 54 healthcare plan contract or certificate, qualified higher deductible health plan, health  
 55 maintenance organization or other managed care subscriber contract, or state healthcare  
 56 plan. This term shall not include limited benefit insurance policies or plans listed under  
 57 paragraph (1) of Code Section 33-1-2, air ambulance insurance, or policies issued in  
 58 accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating to  
 59 workers' compensation, Part A or B of Title XVIII of the Social Security Act (Medicare),

60 or any other plan or program over which the Commissioner does not have regulatory  
 61 authority. Notwithstanding paragraph (1) of Code Section 33-1-2 and any other provision  
 62 of this title, for purposes of this chapter this term shall include stand-alone dental  
 63 insurance and stand-alone vision insurance.

64 (9) 'Healthcare provider' or 'provider' means any physician, other individual, or facility  
 65 other than a hospital licensed or otherwise authorized in this state to furnish healthcare  
 66 services, including, but not limited to, any dentist, podiatrist, optometrist, psychologist,  
 67 clinical social worker, advanced practice registered nurse, registered optician, licensed  
 68 professional counselor, physical therapist, marriage and family therapist, chiropractor,  
 69 athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist,  
 70 speech-language pathologist, audiologist, dietitian, or physician assistant.

71 (10) 'Healthcare services' means emergency or nonemergency medical services.

72 (11) 'Insurer' means an entity subject to the insurance laws and regulations of this state,  
 73 or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or  
 74 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the  
 75 costs of healthcare services, including those of an accident and sickness insurance  
 76 company, a health maintenance organization, a healthcare plan, a managed care plan, or  
 77 any other entity providing a health insurance plan, a health benefit plan, or healthcare  
 78 services.

79 (12) 'Nonemergency medical services' means the examination or treatment of persons  
 80 for the prevention of illness or the correction or treatment of any physical or mental  
 81 condition resulting from an illness, injury, or other human physical problem which does  
 82 not qualify as an emergency medical service and includes, but is not limited to:

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

85 (B) Medical services which include the general and usual care and services rendered  
 86 and administered by doctors of medicine, dentistry, optometry, and other providers; and

87 (C) Other medical services which, by way of illustration only and without limiting the  
 88 scope of this chapter, include the provision of appliances and supplies; nursing care by  
 89 a registered nurse; institutional services, including the general and usual care, services,  
 90 supplies, and equipment furnished by healthcare institutions and agencies or entities  
 91 other than hospitals; physiotherapy; drugs and medications; therapeutic services and  
 92 equipment, including oxygen and the rental of oxygen equipment; hospital beds; iron  
 93 lungs; orthopedic services and appliances, including wheelchairs, trusses, braces,  
 94 crutches, and prosthetic devices, including artificial limbs and eyes; and any other  
 95 appliance, supply, or service related to healthcare which does not qualify as an  
 96 emergency medical service.

- 97 (13) 'Out-of-network' refers to healthcare services provided to a covered person by  
98 providers who do not belong to the provider network in the healthcare plan.
- 99 (14) 'Nonparticipating provider' means a healthcare provider who has not entered into  
100 a contract with a healthcare plan for the delivery of medical services.
- 101 (15) 'Participating provider' means a healthcare provider that has entered into a contract  
102 with an insurer for the delivery of healthcare services to covered persons under a  
103 healthcare plan.
- 104 (16) 'Resolution organization' means a qualified, independent, third-party claim dispute  
105 resolution entity selected by and contracted with the department.
- 106 (17) 'Stabilized' means the effect of providing medical treatment for an emergency  
107 condition as may be necessary to assure, within reasonable medical probability, that no  
108 material deterioration of the condition is likely to result from or occur during the transfer  
109 of the patient from a facility, or that with respect to a pregnant woman who is having  
110 contractions, the woman has delivered the child and the placenta.
- 111 (18) 'State healthcare plan' means:
- 112 (A) The state employees' health insurance plan established pursuant to Article 1 of  
113 Chapter 18 of Title 45;
- 114 (B) The health insurance plan for public school teachers established pursuant to  
115 Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20;
- 116 (C) The health insurance plan for public school employees established pursuant to  
117 Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20; and
- 118 (D) The Regents Retirement Plan, established pursuant to Article 1 of Chapter 21 of  
119 Title 47.
- 120 (19) 'Surprise bill' means a bill resulting from an occurrence in which charges arise from  
121 a covered person receiving healthcare services from an out-of-network provider at an  
122 in-network facility.
- 123 33-20E-3.
- 124 (a) Nothing in this chapter shall be applicable to healthcare plans which are subject to the  
125 exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C.  
126 Sec. 1001, et seq.
- 127 (b) This chapter shall is applicable only to healthcare plans which are subject to the  
128 regulatory authority of the Commissioner.

129 33-20E-4.

130 (a) An insurer that provides any benefits to covered persons with respect to emergency  
131 medical services shall pay for such emergency medical services in accordance with this  
132 chapter:

133 (1) Without need for any prior authorization determination and without any retrospective  
134 payment denial for medically necessary services; and

135 (2) Regardless of whether the healthcare provider furnishing emergency medical services  
136 is a participating provider with respect to emergency medical services.

137 (b) In the event a covered person receives emergency medical services by a  
138 nonparticipating emergency medical provider, the nonparticipating provider shall bill the  
139 insurer directly and the insurer shall directly pay the nonparticipating provider the greater  
140 of:

141 (1) The verifiable contracted amount paid by all eligible insurers for the provision of the  
142 same or similar services as determined by the department; or

143 (2) Such higher amount as the insurer may deem appropriate given the complexity and  
144 circumstances of the services provided.

145 (c) A healthcare plan shall not deny benefits for emergency medical services previously  
146 rendered based upon a covered person's failure to provide subsequent notification in  
147 accordance with plan provisions, where the covered person's medical condition prevented  
148 timely notification.

149 (d) For purposes of the covered person's financial responsibilities, the healthcare plan shall  
150 treat the emergency medical services received by the covered person from a  
151 nonparticipating facility pursuant to this Code section as if such services were provided by  
152 a participating facility, and shall include applying the covered person's cost-sharing for  
153 such services toward the covered person's deductible and maximum out-of-pocket limit  
154 applicable to services obtained from a participating facility under the healthcare plan.

155 (e) In the event a covered person receives emergency medical services provided by a  
156 nonparticipating facility, once such covered person is stabilized, as determined by the  
157 attending physician, the insurer may arrange for transfer of such covered person to a  
158 participating facility, at the insurer's cost. If, however, such insurer receives notice from  
159 the nonparticipating facility that such covered person is stabilized and does not transfer  
160 such covered person within 24 hours after the insurer receives such notice, such insurer  
161 shall pay the entirety of the nonparticipating facility's contracted amount for the care of  
162 such covered person with such nonparticipating facility.

163 (f) All insurer payments made to providers pursuant to this Code section shall be in accord  
164 with Code Section 33-24-59.14. Such payments shall accompany notification to the  
165 provider from the insurer disclosing whether the healthcare plan is subject to the exclusive

166 jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec.  
167 1001, et seq.

168 33-20E-5.

169 (a) In accordance with Code Section 33-20E-7 and this chapter, an insurer that provides  
170 any benefits to covered persons with respect to nonemergency medical services shall pay  
171 for such services in the event that such services resulted in a surprise bill regardless of  
172 whether the healthcare provider furnishing nonemergency medical services is a  
173 participating provider with respect to nonemergency medical services.

174 (b) In the event a covered person receives nonemergency medical services by a  
175 nonparticipating provider, the nonparticipating provider shall bill the insurer directly and  
176 the insurer shall directly pay the nonparticipating provider the contracted amount paid by  
177 such insurer for the provision of the same or similar services. If such contracted amount  
178 does not exist, then the greater of the following shall be paid:

179 (1) The verifiable contracted amount paid by all eligible insurers for the provision of the  
180 same or similar services as determined by the department; or

181 (2) Such higher amount as the insurer may deem appropriate given the complexity and  
182 circumstances of the services provided.

183 (c) For purposes of the covered person's financial responsibilities, the healthcare plan shall  
184 treat the nonemergency medical services received by the covered person from a  
185 nonparticipating provider pursuant to this Code section as if such services were provided  
186 by a participating provider, and shall include applying the covered person's cost-sharing  
187 for such services toward the covered person's deductible and maximum out-of-pocket limit  
188 applicable to services obtained from a participating provider under the healthcare plan.

189 (d) All insurer payments made to providers pursuant to this Code section shall be in accord  
190 with Code Section 33-24-59.14. Such payments shall accompany notification to the  
191 provider from the insurer disclosing whether the healthcare plan is subject to the exclusive  
192 jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec.  
193 1001, et seq.

194 33-20E-6.

195 No healthcare plan shall deny or restrict the provision of covered benefits from a  
196 participating provider to a covered person solely because the covered person obtained  
197 treatment from a nonparticipating provider leading to a balance bill. Notice of such  
198 protection shall be provided in writing to the covered person by the insurer.

199 33-20E-7.

200 (a) Nothing in this chapter shall reduce a covered person's financial responsibilities in the  
201 event that such covered person chose to receive nonemergency medical services from an  
202 out-of-network provider.

203 (b) The covered person's choice described in subsection (a) of this Code section must:

204 (1) Be documented through such covered person's written and oral consent and at  
205 least 48 hours in advance of the provision of such services; and

206 (2) Occur only after such person has been provided with an estimate of the potential  
207 charges.

208 (c) If during the provision of nonemergency medical services, a covered person requests  
209 that the attending provider refer such covered person to another provider for the immediate  
210 provision of additional nonemergency medical services, such referring provider shall be  
211 exempt from the requirements in subsection (b) of this Code section if the following  
212 requirements are satisfied:

213 (1) The referring provider advises the covered person that the referred provider may be  
214 a nonparticipating provider and may charge higher fees than a participating provider;

215 (2) The covered person orally and in writing acknowledges that he or she is aware that  
216 the referred provider may be a nonparticipating provider and may charge higher fees than  
217 a participating provider; and

218 (3) The written acknowledgment referenced in paragraph (2) of this subsection shall be  
219 on a document separate from other documents provided by the referring provider and  
220 shall include language to be determined by the Commissioner through rule and  
221 regulation.

222 (4) The referring provider records the satisfaction of the requirements in  
223 paragraphs (1), (2), and (3) of this subsection in the covered person's medical file.

224 33-20E-8.

225 Notwithstanding the provisions in the remainder of this chapter, if within one year after the  
226 effective date of this chapter, an in-network provider terminates a contract with an insurer  
227 for cause or an insurer terminates such contract without cause, the initial payment from  
228 such insurer to such provider under this chapter shall be the most recent amount agreed to  
229 by such insurer and such provider during such time as such provider was in-network with  
230 such insurer.

231 33-20E-9.

232 (a) Subject to appropriation, the department shall provide for the maintenance of an  
233 all-payer health claims data base and maintain records of insurer payments which shall

234 track such payments by a wide variety of healthcare services and by geographic areas of  
 235 this state. Such appropriation must specifically reference this Act. The department shall  
 236 update information in the all-payer health claims data base on no less than an annual basis  
 237 and shall maintain such information on the department's website.

238 (b) In the event that the appropriation described in subsection (a) of this Code section is  
 239 not made, the department shall update information from such other verifiable data as the  
 240 Commissioner shall determine appropriate on no less than an annual basis and shall  
 241 maintain such information on the department's website.

242 33-20E-10.

243 (a) If a provider concludes that payment received from an insurer pursuant to Code  
 244 Section 33-20E-4 or 33-20E-5 is not sufficient given the complexity and circumstances of  
 245 the services provided, the provider may initiate a request for arbitration with the  
 246 Commissioner. Such provider shall submit such request within 30 days of receipt of  
 247 payment for the claim and concurrently provide the insurer with a copy of such request.

248 (b) A request for arbitration may involve a single patient and a single type of healthcare  
 249 service, a single patient and multiple types of healthcare services, or multiple patients and  
 250 a single type of healthcare service.

251 33-20E-11.

252 The Commissioner shall dismiss certain requests for arbitration if the disputed claim is:

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

260 33-20E-12.

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

266 33-20E-13.

267 The Commissioner shall promulgate rules implementing an arbitration process requiring  
268 the Commissioner to select one or more resolution organizations to arbitrate certain claim  
269 disputes between insurers and out-of-network providers. Prior to proceeding with such  
270 arbitration, the Commissioner shall allow the parties 30 days from the date the  
271 Commissioner received the request for arbitration to negotiate a settlement. The parties  
272 shall timely notify the Commissioner of the result of such negotiation. If the parties have  
273 not notified the Commissioner of such result within 30 days of the date that the  
274 Commissioner received the request for arbitration, the Commissioner shall refer the dispute  
275 to a resolution organization within five days. The department shall contract with one or  
276 more resolution organizations by July 1, 2021, to review and consider claim disputes  
277 between insurers and out-of-network providers as such disputes are referred by the  
278 Commissioner.

279 33-20E-14.

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

288 33-20E-15.

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

300 33-20E-16.

301 Each party shall submit one proposed payment amount to the arbitrator. The arbitrator  
302 shall pick one of the two amounts submitted and shall reveal that amount in the arbitrator's  
303 final decision. The arbitrator may not modify such selected amount. In making such a  
304 decision, the arbitrator shall consider the complexity and circumstances of each case,  
305 including, but not limited to, the level of training, education, and experience of the provider  
306 and other factors as determined by the Commissioner through rule. The arbitrator's final  
307 decision shall be in writing and shall describe the basis for such decision, including  
308 citations to any documents relied upon. Notwithstanding Code Section 33-20E-16, such  
309 decision shall be made within 30 days of the Commissioner's referral. Any default or final  
310 decision issued by the arbitrator shall be binding upon the parties and is not appealable  
311 through the court system.

312 33-20E-17.

313 The party whose final offer amount is not selected by the arbitrator shall pay the arbitrator's  
314 expenses and fees, and any other fees accessed by the resolution organization, directly to  
315 such resolution organization. In the event of default, the defaulting party shall also be  
316 responsible for the resolution organization's accessed fees. In the event that both parties  
317 default, the parties shall evenly split all fees. Moneys due under this Code section shall be  
318 paid in full to the resolution organization within 15 days of the losing party's receipt of the  
319 arbitrator's final decision.

320 33-20E-18.

321 Following the resolution of arbitration, the Commissioner shall refer any case in which the  
322 Commissioner concludes that a provider has acted in violation of this chapter to the  
323 appropriate state agency or governing entity with governing authority over such provider.  
324 Such referral shall include a description of such violations and the Commissioner's  
325 recommendation for enforcement action. Such agency or governing entity shall initiate an  
326 investigation regarding such referral within 30 days of receiving such referral and conclude  
327 the investigation within 90 days of receiving such referral.

328 33-20E-19.

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

332 33-20E-20.

333 Each resolution organization contracted with by the department shall report to the  
 334 department on a quarterly basis the results of all disputes referred to such organization as  
 335 follows: the number of arbitrations filed, settled, arbitrated, defaulted, or dismissed during  
 336 the previous calendar year and whether the arbitrators' decisions were in favor of the  
 337 insurer or the provider.

338 33-20E-21.

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

345 33-20E-22.

346 The arbitration conducted under this chapter shall be subject to neither Chapter 13 of  
 347 Title 50, the 'Georgia Administrative Procedure Act,' nor Chapter 11 of Title 9, the 'Civil  
 348 Practice Act.'

349 33-20E-23.

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

355 33-20E-24.

356 Nothing in this chapter shall reduce a covered person's financial responsibilities with regard  
 357 to ground ambulance transportation."

358 **SECTION 2.**

359 Said title is further amended in Code Section 33-6-34, relating to unfair claims settlement  
 360 practices, by deleting "and" at the end of paragraph (13), by replacing the period with "; and"  
 361 at the end of paragraph (14) and by adding a new paragraph to read as follows:

362 "(15) Failure to comply with any insurer requirement in Chapter 20E of Title 33, the  
363 'Surprise Billing Consumer Protection Act,' including the failure to pay a resolution  
364 organization as required under Code Section 33-20E-18."

365 **SECTION 3.**

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

367 **SECTION 4.**

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