

The House Special Committee on Access to Quality Health Care offers the following substitute to HB 888:

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 or facilities regarding the
5 provision of healthcare services; to require the department to provide for the maintenance of
6 an all-payer health claims data base; to establish an arbitration process; to require the
7 Commissioner of Insurance to contract with one or more resolution organizations; to require
8 the promulgation of department rules; to provide for an effective date; to repeal conflicting
9 laws; and for other purposes.

10 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

11 **SECTION 1.**

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

14 "CHAPTER 20E

15 33-20E-1.

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

18 33-20E-2.

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

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

22 (1) 'Balance bill' means the amount that a nonparticipating provider charges for services
23 provided to a covered person. Such amount equals the difference between the amount

24 paid or offered by the insurer and the amount of the nonparticipating provider's bill
25 charge, but shall not include any amount for coinsurance, copayments, or deductibles due
26 by the covered person.

27 (2) 'Contracted amount' means the median in-network amount paid during the 2017
28 calendar year by an insurer for the emergency or nonemergency services provided by
29 in-network providers engaged in the same or similar specialties and provided in the same
30 or nearest geographical area. Such amount shall be annually adjusted by the department
31 for inflation which may be based on the Consumer Price Index, and shall not include
32 Medicare or Medicaid rates.

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

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

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

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

45 (B) Serious impairment to bodily functions; or

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

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

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

52 (8) 'Healthcare plan' means any hospital or medical insurance policy or certificate,
53 healthcare plan contract or certificate, qualified higher deductible health plan, health
54 maintenance organization or other managed care subscriber contract, or state healthcare
55 plan. This term shall not include limited benefit insurance policies or plans listed under
56 paragraph (3) of Code Section 33-1-2, air ambulance insurance, or policies issued in
57 accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating to
58 workers' compensation, Part A, B, C, or D of Title XVIII of the Social Security Act
59 (Medicare), or any plan or program not described in this paragraph over which the
60 Commissioner does not have regulatory authority. Notwithstanding paragraph (3) of

61 Code Section 33-1-2 and any other provision of this title, for purposes of this chapter this
 62 term shall include stand-alone dental insurance and stand-alone vision insurance.

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

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

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

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

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

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

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

96 (13) 'Out-of-network' refers to healthcare services provided to a covered person by
 97 providers or facilities who do not belong to the provider network in the healthcare plan.

- 98 (14) 'Nonparticipating provider' means a healthcare provider who has not entered into
 99 a contract with a healthcare plan for the delivery of medical services.
- 100 (15) 'Participating provider' means a healthcare provider that has entered into a contract
 101 with an insurer for the delivery of healthcare services to covered persons under a
 102 healthcare plan.
- 103 (16) 'Resolution organization' means a qualified, independent, third-party claim dispute
 104 resolution entity selected by and contracted with the department.
- 105 (17) 'State healthcare plan' means:
- 106 (A) The state employees' health insurance plan established pursuant to Article 1 of
 107 Chapter 18 of Title 45;
- 108 (B) The health insurance plan for public school teachers established pursuant to
 109 Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20;
- 110 (C) The health insurance plan for public school employees established pursuant to
 111 Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20; and
- 112 (D) The Regents Health Plan established pursuant to authority granted to the board
 113 pursuant to Code Sections 20-3-31, 20-3-51, and 31-2-4.
- 114 (18) 'Surprise bill' means a bill resulting from an occurrence in which charges arise from
 115 a covered person receiving healthcare services from an out-of-network provider at an
 116 in-network facility.

117 33-20E-3.

- 118 (a) Nothing in this chapter shall be applicable to healthcare plans which are subject to the
 119 exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C.
 120 Sec. 1001, et seq.
- 121 (b) This chapter shall be applicable only to healthcare plans and state healthcare plans as
 122 defined in this chapter.

123 33-20E-4.

- 124 (a) An insurer that provides any benefits to covered persons with respect to emergency
 125 medical services shall pay for such emergency medical services regardless of whether the
 126 healthcare provider or facility furnishing emergency medical services is a participating
 127 provider or facility with respect to emergency medical services, in accordance with this
 128 chapter:
- 129 (1) Without need for any prior authorization determination and without any retrospective
 130 payment denial for medically necessary services; and

131 (2) Regardless of whether the healthcare provider or facility furnishing emergency
132 medical services is a participating provider or facility with respect to emergency medical
133 services.

134 (b) In the event a covered person receives the provision of emergency medical services
135 from a nonparticipating emergency medical provider, the nonparticipating provider shall
136 collect or bill no more than such person's deductible, coinsurance, copayment, or other
137 cost-sharing amount as determined by such person's policy directly and such insurer shall
138 directly pay such provider the greater of:

139 (1) The verifiable contracted amount paid by all eligible insurers subject to the
140 provisions of this chapter for the provision of the same or similar services as determined
141 by the department;

142 (2) The most recent verifiable amount agreed to by the insurer and the nonparticipating
143 emergency medical provider for the provision of the same services during such time as
144 such provider was in-network with such insurer; or

145 (3) Such higher amount as the insurer may deem appropriate given the complexity and
146 circumstances of the services provided.

147 Any amount that the insurer pays the nonparticipating provider under this subsection shall
148 not be required to include any amount of coinsurance, copayment, or deductible owed by
149 the covered person or already paid by such person.

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

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

161 (e) In the event a covered person receives emergency medical services from a
162 nonparticipating facility, the nonparticipating facility shall bill the covered person no more
163 than such covered person's deductible, coinsurance, copayment, or other cost-sharing
164 amount as determined by such person's policy directly.

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

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

170 33-20E-5.

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

176 (b) In the event a covered person receives a surprise bill for the provision of
177 nonemergency medical services from a nonparticipating medical provider, the
178 nonparticipating provider shall collect or bill the covered person no more than such
179 person's deductible, coinsurance, copayment, or other cost-sharing amount as determined
180 by such person's policy directly and such insurer shall directly pay such provider the
181 greater of:

182 (1) The verifiable contracted amount paid by all eligible insurers subject to the
183 provisions of this chapter for the provision of the same or similar services as determined
184 by the department;

185 (2) The most recent verifiable amount agreed to by the insurer and the nonparticipating
186 provider for the provision of the same services during such time as such provider was
187 in-network with such insurer; or

188 (3) Such higher amount as the insurer may deem appropriate given the complexity and
189 circumstances of the services provided.

190 Any amount that the insurer pays the nonparticipating provider under this subsection shall
191 not be required to include any amount of coinsurance, copayment, or deductible owed by
192 the covered person or already paid by such person.

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

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

204 33-20E-6.

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

209 33-20E-7.

210 (a) Nothing in this chapter shall reduce a covered person's financial responsibilities in the
211 event that such covered person chose to receive nonemergency medical services from an
212 out-of-network provider. Such services shall not be considered a surprise bill for purposes
213 of this chapter.

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

215 (1) Be documented through such covered person's written and oral consent in advance
216 of the provision of such services; and

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

219 (c) If during the provision of nonemergency medical services, a covered person requests
220 that the attending provider refer such covered person to another provider for the immediate
221 provision of additional nonemergency medical services, such referred provider shall be
222 exempt from the requirements in subsection (b) of this Code section if the following
223 requirements are satisfied:

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

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

229 (3) The written acknowledgment referenced in paragraph (2) of this subsection shall be
230 on a document separate from other documents provided by the referring provider and
231 shall include language to be determined by the Commissioner through rule and
232 regulation; and

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

235 33-20E-8.

236 (a) Subject to appropriation, the department shall provide for the maintenance of an
237 all-payer health claims data base and maintain records of insurer payments which shall
238 track such payments by a wide variety of healthcare services and by geographic areas of

239 this state. Such appropriation must specifically reference this Act. The department shall
 240 update information in the all-payer health claims data base on no less than an annual basis
 241 and shall maintain such information on the department's website.

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

246 33-20E-9.

247 (a) If an out-of-network provider concludes that payment received from an insurer
 248 pursuant to Code Section 33-20E-4 or 33-20E-5 or if an out-of-network facility concludes
 249 that payment received from an insurer pursuant to Code Section 3-20E-4 is not sufficient
 250 given the complexity and circumstances of the services provided, the provider or facility
 251 may initiate a request for arbitration with the Commissioner. Such provider or facility shall
 252 submit such request within 30 days of receipt of payment for the claim and concurrently
 253 provide the insurer with a copy of such request.

254 (b) A request for arbitration may involve a single patient and a single type of healthcare
 255 service, a single patient and multiple types of healthcare services, multiple patients and a
 256 single type of healthcare service, or multiple substantially similar healthcare services in the
 257 same specialty on multiple patients.

258 33-20E-10.

259 The Commissioner shall dismiss certain requests for arbitration if the disputed claim is:
 260 (1) Related to a healthcare plan that is not regulated by the state;
 261 (2) The basis for an action pending in state or federal court at the time of the request for
 262 arbitration;
 263 (3) Subject to a binding claims resolution process entered into prior to July 1, 2021;
 264 (4) Made against a healthcare plan subject to the exclusive jurisdiction of the Employee
 265 Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.; or
 266 (5) In accord with other circumstances as may be determined by department rule.

267 33-20E-11.

268 Within 30 days of the insurer's receipt of the provider's or facility's request for arbitration,
 269 the insurer shall submit to the Commissioner all data necessary for the Commissioner to
 270 determine whether such insurer's payment to such provider or facility was in compliance
 271 with Code Section 33-20E-4 or 33-20E-5. The Commissioner shall not be required to

272 make such a determination prior to referring the dispute to a resolution organization for
273 arbitration.

274 33-20E-12.

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

287 33-20E-13.

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

296 33-20E-14.

297 The parties shall have ten days after the selection of the arbitrator to submit in writing to
298 the resolution organization each party's final offer and each party's argument in support of
299 such offer. The parties' initial arguments shall be limited to written form and shall consist
300 of no more than 20 pages per party. The parties may submit documents in support of their
301 arguments. The arbitrator may require the parties to submit such additional written
302 argument and documentation as the arbitrator determines necessary, but the arbitrator may
303 require such additional filing no more than once. Such additional written argument shall
304 be limited to no more than ten pages per party. The arbitrator may set filing times and
305 extend such filing times as appropriate. Failure of either party to timely submit the

306 supportive documentation described herein may result in a default against the party failing
307 to make such timely submission.

308 33-20E-15.

309 Each party shall submit one proposed payment amount to the arbitrator. The arbitrator
310 shall pick one of the two amounts submitted and shall reveal that amount in the arbitrator's
311 final decision. The arbitrator may not modify such selected amount. In making such a
312 decision, the arbitrator shall consider the complexity and circumstances of each case,
313 including, but not limited to, the level of training, education, and experience of the relevant
314 physicians or other individuals at the facility who are licensed or otherwise authorized in
315 this state to furnish healthcare services and other factors as determined by the
316 Commissioner through rule. The arbitrator's final decision shall be in writing and shall
317 describe the basis for such decision, including citations to any documents relied upon.
318 Notwithstanding Code Section 33-20E-14, such decision shall be made within 30 days of
319 the Commissioner's referral. Any default or final decision issued by the arbitrator shall be
320 binding upon the parties and is not appealable through the court system.

321 33-20E-16.

322 The party whose final offer amount is not selected by the arbitrator shall pay the amount
323 of the verdict, the arbitrator's expenses and fees, and any other fees assessed by the
324 resolution organization, directly to such resolution organization. In the event of default,
325 the defaulting party shall also pay such moneys due directly to such organization. In the
326 event that both parties default, the parties shall each be responsible for paying such
327 organization one-half of all moneys due. Moneys due under this Code section shall be paid
328 in full to the resolution organization within 15 days of arbitrator's final decision. Within
329 three days of such organization's receipt of moneys due to the party whose final offer was
330 selected, such moneys shall be distributed to such party.

331 33-20E-17.

332 Following the resolution of arbitration, the Commissioner may refer the decision of the
333 arbitrator to the appropriate state agency or the governing entity with governing authority
334 over such provider or facility if the Commissioner concludes that a provider or facility has
335 either displayed a pattern of acting in violation of this chapter or has failed to comply with
336 a lawful order of the Commissioner or the arbitrator. Such referral shall include a
337 description of such violations and the Commissioner's recommendation for enforcement
338 action. Such state agency or governing entity shall initiate an investigation regarding such

339 referral within 30 days of receiving such referral and shall conclude the investigation
340 within 90 days of receiving such referral.

341 33-20E-18.

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

345 33-20E-19.

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

351 33-20E-20.

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

358 33-20E-21.

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

362 33-20E-22.

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

368 33-20E-23.

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

371 **SECTION 2.**

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

375 "(15) Failure to comply with any insurer requirement in Chapter 20E of Title 33, the
376 'Surprise Billing Consumer Protection Act,' including the failure to pay a resolution
377 organization as required under Code Section 33-20E-16."

378 **SECTION 3.**

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

380 **SECTION 4.**

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