Senate Bill 293

By: Senators Hufstetler of the 52nd, Kirkpatrick of the 32nd, Harrell of the 40th, Cowsert of the 46th, Ginn of the 47th and others

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide for certain consumer protections against balance billing; to provide for a short title; to provide for applicability; to provide for definitions; to provide mechanisms to resolve payment disputes between insurers and out-of-network providers regarding the provision of health care services; to require the department to create an all-payer health claims data base; to provide for in-network cost-sharing amounts in health care plan contracts; to establish an arbitration process; to require the Insurance Commissioner to contract with one or more resolution organizations; to require the promulgation of department rules; to amend Chapter 1 of Title 10 of the Official Code of Georgia Annotated, relating to selling and other trade practices, so as to provide the Attorney General with new enforcement authority against providers; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

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

"CHAPTER 20E

33-20E-1.

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

33-20E-2.

This chapter shall apply to all insurers providing a health care plan that pays for the provision of health care services to covered persons.

As used in this chapter, the term:

(1) 'Average contracted amount' means the median in-network amount negotiated by an insurer for the emergency or nonemergency services provided by in-network providers engaged in the same or similar specialties and provided in the same or nearest

geographical area, exclusive of any copay, coinsurance, deductible, or other cost-sharing amount specified in the health care plan.

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

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

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

(5) 'Emergency medical services' means:

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

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

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part;

(B) Services for the first 24 hours after the covered person's emergency condition has stabilized, as determined by the treating health care provider, whether or not the emergency services and services after stabilization occur in an emergency department; and

(C) The term shall include care for an emergency condition that continues once a patient is admitted to the hospital from the hospital emergency department and could include other specialists and providers.

(6) 'Facility' means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice or similar institution, or private office used for patient examination, diagnosis, treatment, surgery, or the provision of other health care services.

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

(8) 'Gould factors' means the following criteria:

(A) If the provider is a person, the provider's training, qualifications, and length of time in practice;

(B) The nature of the services provided;

(C) The fees usually charged by the provider for such services;

(D) Prevailing provider rates charged in the geographic area in which the services were rendered;

(E) The previously contracted rate, if the provider had a contract with the insurer that was terminated or expired within one year prior to the dispute;

(F) Other aspects of the economics of the medical provider's practice that the provider deems relevant; and

(G) Other relevant and unusual circumstances of the case if such circumstances exist.

(9) 'Health care plan' means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization or other managed care subscriber contract, or any health insurance plan established pursuant to Article 1 of Chapter 18 of Title 45. The term shall not include certain limited benefit insurance policies or plans listed under paragraph (1.1) of Code Section 33-1-2, or policies issued in accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating to workers' compensation.

(10) 'Health care provider' or 'provider' means any physician, other individual, or facility licensed or otherwise authorized in this state to furnish health care services, including, but not limited to, any dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced practice registered nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist, speech-language pathologist, audiologist, dietitian, or physician assistant.

(11) 'Health care services' means emergency or nonemergency medical services.

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

(13) 'Nonemergency medical services' means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from illness, injury, or other human physical problem and includes, but is not limited to:

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

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

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

(14) 'Out-of-network' refers to health care services provided to a covered person by providers who do not belong to the provider network in the health care plan.

(15) 'Nonparticipating provider' means a health care provider who has not entered into a direct contract with a health care plan for the delivery of medical services.

(16) 'Participating provider' means a health care provider that has entered into a direct contract with an insurer for the delivery of medical services to covered persons under a health care plan.

(17) 'Resolution organization' means a qualified, independent, third-party claim dispute resolution entity selected by and contracted with the department.

(18) 'Stabilized' means the effect of providing medical or surgical treatment for an emergency condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility, or that with respect to a pregnant woman who is having contractions, the woman has delivered the child and the placenta.

(19) 'Surprise bill' means a bill resulting from an occurrence in which charges arise from a covered person inadvertently receiving care from an out-of-network provider.

33-20E-3.

(a) Notwithstanding any provision of law to the contrary, an insurer that provides any benefits to covered persons with respect to emergency medical services shall pay for such emergency medical services:

(1) Without need for any prior authorization determination and without any retrospective payment denial for services rendered; and

(2) Regardless of whether the health care provider furnishing emergency medical services is a participating provider with respect to emergency medical services.

(b) In the event a covered person receives emergency medical services by a nonparticipating provider, the nonparticipating provider shall bill the insurer directly and the insurer shall directly pay the nonparticipating provider the average contracted amount paid by such insurer for the provision of the same or similar services within one year of the filing of the request for arbitration with the Commissioner. If such average contracted amount does not exist, then the greater of:

(1) The average contracted amount paid by all eligible insurers for the provision of the same or similar services as determined by the department and maintained on the department's all-payer health claims data base; or

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

(c) All insurer payments made to providers pursuant to this Code section shall be in accord with Code Section 33-24-59.14.

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

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

(f) In the event a covered person receives emergency medical services provided by a nonparticipating provider, once such covered person is stabilized, as determined by the attending physician, the insurer may arrange for transfer of the covered person to a participating provider, at the insurer's cost. If the insurer fails to transfer such covered person within 24 hours after the insurer receives notice that the covered person is stabilized, the insurer shall pay the entirety of the nonparticipating provider's charges for the care of such covered person.

33-20E-4.

(a) Notwithstanding any provision of law to the contrary, an insurer that provides any benefits to covered persons with respect to nonemergency medical services shall pay for such services in the event that such services arose from a surprise bill:

(1) Without need for any prior authorization determination and without any retrospective payment denial for services rendered; and

(2) Regardless of whether the health care provider furnishing nonemergency medical services is a participating provider with respect to nonemergency medical services.

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

(1) The average contracted amount paid by such insurer for the provision of the same or similar services;

(2) The average contracted amount paid by all eligible insurers for the provision of the same or similar services as determined by the department and maintained on the department's all-payer health claims data base; or

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

(c) All insurer payments made to providers pursuant to this Code section shall be in accord with Code Section 33-24-59.14.

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

33-20E-5.

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

33-20E-6.

Nothing in this chapter shall reduce a covered person's financial responsibilities in the event that such covered person chose to receive nonemergency medical services from an out-of-network provider. Such choice must be documented through such covered person's written acknowledgment that the provider is out-of-network and the agreement to be financially responsible for the out-of-network provider's billed charges.

33-20E-7.

The department shall create an all-payer health claims database which shall maintain records of insurer payments which shall track such payments by a wide variety of health care services and by geographic areas of this state. The department shall update information in the data base on no less than an annual basis and shall maintain such information on the department's website.

33-20E-8.

(a) A health care plan contract issued, amended, or renewed on or after July 1, 2021, shall provide that if a covered person receives health care services from a nonparticipating provider, such covered person shall not be required to pay more to the insurer than the same amount such covered person would have to pay to the insurer for the same health care services received from a similar participating provider at a similar in-network facility. Such amount shall be known as the 'in-network cost-sharing amount.'

(b) Neither a nonparticipating provider nor a participating provider shall bill or collect any amount from the covered person for health care services subject to subsection (a) of this Code section other than the covered person's coinsurance, copayments, and deductibles, which shall be limited to the in-network cost-sharing amount.

33-20E-9.

The Commissioner may refer to the Consumer Protection Division of the Department of Law any case in which the Commissioner has determined that a provider has acted in violation of this chapter. Such referral shall include a description of such violations and the Commissioner's recommendation for enforcement action.

33-20E-10.

If a provider concludes that payment received from an insurer pursuant to Code Section 33-20E-3 or 33-20E-4 is not sufficient given the complexity and circumstances of the services provided, the provider may initiate a request for arbitration with the Commissioner. Such provider shall submit such request within 90 days of receipt of payment for the claim and concurrently provide the insurer with a copy of such request.

33-20E-11.

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

(1) Related to a health care plan that is not regulated by the state;

(2) The basis for an action pending in state or federal court at the time of the request for arbitration;

(3) Subject to a binding claims resolution process entered into prior to July 1, 2021; or

(4) In accord with other circumstances as may be determined by department rule.

33-20E-12.

Within 30 days of the insurer's receipt of the provider's request for arbitration, the insurer shall submit to the Commissioner all data necessary for the Commissioner to determine whether such insurer's payment to such provider was in compliance with Code Section 33-20E-3 or 33-20E-4. The Commissioner shall not be required to make such a determination prior to referring the dispute to a resolution organization for arbitration.

33-20E-13.

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

33-20E-14.

Upon the Commissioner's referral of a dispute to a resolution organization, the parties shall have 15 days to select an arbitrator by mutual agreement. If the parties have not notified the resolution organization of their mutual selection before the sixteenth day, the resolution organization shall select an arbitrator from among its members. Any selected arbitrator shall be independent of the parties and shall not have a personal, professional, or financial conflict with any party to the arbitration. The arbitrator shall have experience or knowledge in health care billing and reimbursement rates. He or she shall not communicate ex parte with either party.

33-20E-15.

The parties shall have 15 days after the selection arbitrator to submit in writing to the resolution organization each party's final offer and each party's argument in support of such offer. The parties' initial arguments shall be limited to written form and shall consist of no more than 20 pages per party. The parties may submit documents in support of their arguments. The arbitrator may require the parties to submit such additional written argument and documentation as the arbitrator determines necessary, but the arbitrator may require such additional filing no more than once. Such additional written argument shall be limited to no more than ten pages per party. The arbitrator may set filing times and extend such filing times as appropriate. Failure of either party to timely submit the supportive documentation described herein may result in a default against the party failing to make such timely submission.

33-20E-16.

Each party shall submit one proposed payment amount to the arbitrator. The arbitrator shall pick one of the two amounts submitted and shall reveal that amount in the arbitrator's final decision. The arbitrator may not modify such selected amount. In making such a decision, the arbitrator shall consider the complexity and circumstances of each case, including the Gould factors. The arbitrator's final decision shall be in writing and shall describe the basis for such decision, including citations to any documents relied upon. Notwithstanding Code Section 33-20E-15, such decision shall be made within 60 days of the Commissioner's referral. Any default or final decision issued by the arbitrator shall be binding upon the parties and is not appealable through the court system.

33-20E-17.

The party whose final offer amount is not selected by the arbitrator shall pay the arbitrator's expenses and fees, and any other fees accessed by the resolution organization, directly to the resolution organization. In the event of default, the defaulting party shall also be responsible for the resolution organization's accessed fees. In the event that both parties default, the parties shall evenly split all fees. Moneys due under this Code section shall be paid in full to the resolution organization within 30 days of the losing party's receipt of the arbitrator's final decision.

33-20E-18.

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

33-20E-19.

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

33-20E-20.

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

33-20E-21.

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

33-20E-22.

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

SECTION 2.

Chapter 1 of Title 10 of the Official Code of Georgia Annotated, relating to selling and other trade practices, is amended by adding a new paragraph to subsection (b) of Code Section 10-1-393, relating to unfair or deceptive practices in consumer transactions unlawful and examples, to read as follows:

″(14.1) Failure of a health care provider as defined in Code Section 33-20E-2 to comply with any provider requirement in Chapter 20E of Title 33, the 'Balance Billing Consumer Protection Act,' including the failure to pay a resolution organization as required under Code Section 33-20E-17.″

SECTION 3.

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