

Senate Bill 8

By: Senators Unterman of the 45th, Kirk of the 13th, Parent of the 42nd, Butler of the 55th and Orrock of the 36th

**AS PASSED SENATE**

**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 a 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 composed 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) A covered person for services rendered by a nonparticipating physician at a  
 99 participating hospital or ambulatory surgical center when a participating physician is  
 100 unavailable or a nonparticipating physician renders services without the covered  
 101 person's knowledge or when unforeseen medical services arise at the time the health  
 102 care services are rendered; provided, however, that a surprise bill shall not mean a bill  
 103 received for health care services when a participating physician is available and the  
 104 covered person has elected to obtain services from a nonparticipating physician;  
 105 (B) A covered person for services rendered by a nonparticipating provider when the  
 106 services were referred by a participating physician to a nonparticipating provider  
 107 without the explicit written consent of the covered person acknowledging that the  
 108 participating physician is referring the covered person to a nonparticipating provider  
 109 and that the referral may result in costs not covered by the health care plan; or  
 110 (C) A patient who is not a covered person for services rendered by a physician at a  
 111 hospital or ambulatory surgical center when the patient has not timely received all of  
 112 the disclosures required by Code Section 33-20E-2.

113 33-20E-2.

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

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

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

130 (2) Upon receipt of a request from a patient or prospective patient, disclose to the patient  
 131 or prospective patient in writing the amount or estimated amount or, with respect to a  
 132 health center, a schedule of fees that the health care provider, group practice, diagnostic  
 133 and treatment center, or health center will bill the patient or prospective patient for health

134 care services provided or anticipated to be provided to the patient or prospective patient  
135 absent unforeseen medical circumstances that may arise when the health care services are  
136 provided.

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

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

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

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

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

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

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

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

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

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

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

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

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

183 33-20E-3.

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

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

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

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

198 (4) An annually updated listing by specialty, which may be in a separate document, of  
199 the name, address, and telephone number of all participating providers, including  
200 facilities, and in the case of physicians, the board certification, languages spoken, and any  
201 affiliations with participating hospitals. The listing shall also be posted on the health  
202 maintenance organization's website and the health maintenance organization shall update  
203 the website within 15 days of the addition or termination of a provider from the health  
204 maintenance organization's network or a change in a physician's hospital affiliation;

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

231 33-20E-4.

232 An out-of-network referral denial means a denial of a request for an authorization or  
 233 referral to an out-of-network provider on the basis that the health care plan has a health  
 234 care provider in the network benefits portion of its network with appropriate training and  
 235 experience to meet the particular health care needs of an enrollee and who is able to  
 236 provide the requested health service. The notice of an out-of-network referral denial  
 237 provided to an enrollee shall have information explaining what information the enrollee  
 238 must submit in order to appeal the out-of-network referral denial. An out-of-network  
 239 denial shall not constitute an adverse determination.

240 33-20E-5.

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

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

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

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

262 33-20E-6.

263 (a) The Commissioner shall establish a dispute resolution process by which a dispute for  
264 a bill for emergency services or a surprise bill may be resolved if either party disputes the  
265 payment indicated by the data base established pursuant to Code Section 33-20E-7.1. The  
266 Commissioner shall have the power to grant and revoke certifications of independent  
267 dispute resolution entities to conduct the dispute resolution process.

268 (b) The Commissioner shall promulgate regulations establishing standards for the dispute  
269 resolution process, including a process for certifying and selecting independent dispute  
270 resolution entities. An independent dispute resolution entity shall use licensed physicians  
271 in active practice in the same or similar specialty as the physician providing the service that  
272 is subject to the dispute resolution process. To the extent practicable, the physician shall  
273 be licensed in this state.



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

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

278 (1) The amount billed for American Medical Association current procedural terminology  
 279 (CPT) codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220,  
 280 99224 through 99226, and 99234 through 99236 meets the requirements set forth in  
 281 subsection (f) of this Code section, after any applicable coinsurance, copayment and  
 282 deductible; and

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

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

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

298 33-20E-7.

299 In determining the appropriate amount to pay for a health care service, an independent  
 300 dispute resolution entity shall consider all relevant factors, including:

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

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

306 (3) The level of training, education, and experience of the physician;

307 (4) The physician's usual charge for comparable services with regard to patients in health  
 308 care plans in which the physician is not participating;

- 309 (5) The circumstances and complexity of the particular case, including time and place  
310 of the service;  
311 (6) Individual patient characteristics; and  
312 (7) The usual and customary cost of the service pursuant to Code Section 33-20E-7.1.

313 33-20E-7.1

314 The Department of Community Health shall develop and maintain the benchmarking data  
315 base to establish usual and customary cost under Code Section 33-20E-7. Such usual and  
316 customary cost shall mean the eightieth percentile of all charges for the particular health  
317 care service performed by a provider in the same or similar geographical area as reported  
318 in such benchmarking data base. Such data base shall develop a benchmark utilizing data  
319 from a nonprofit organization specified by the Commissioner of Community Health, which  
320 is not affiliated with a health care plan.

321 33-20E-8.

322 (a) When a health care plan receives a bill for emergency services from a nonparticipating  
323 physician, the health care plan shall pay the amount indicated by the data base established  
324 pursuant to Code Section 33-20E-7.1 for the emergency services rendered by the  
325 nonparticipating physician in accordance with Code Section 33-20E-7 except for the  
326 covered person's copayment, coinsurance, or deductible, if any, and shall ensure that the  
327 covered person shall incur no greater out-of-pocket costs for the emergency services than  
328 the covered person would have incurred with a participating physician.

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

333 (c) In determining a reasonable fee for the services rendered, the independent dispute  
334 resolution entity shall determine which amount to select based upon the conditions and  
335 factors set forth in Code Section 33-20E-7 of this chapter. If an independent dispute  
336 resolution entity determines, based on the health care plan's payment and the  
337 nonparticipating physician's fee, that a settlement between the health care plan and  
338 nonparticipating physician is reasonably likely, or that both the health care plan's payment  
339 and the nonparticipating physician's fee represent unreasonable extremes, then the  
340 independent dispute resolution entity may direct both parties to attempt a good faith  
341 negotiation for settlement. The health care plan and nonparticipating physician may be  
342 granted up to ten business days for this negotiation, which shall run concurrently with the  
343 30 day period for dispute resolution.

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

349 (e) A patient who is not a covered person shall not be required to pay the physician's fee  
350 in order to be eligible to submit the dispute for review to an independent dispute resolution  
351 entity.

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

356 33-20E-9.

357 When a covered person assigns benefits for a surprise bill in writing to a nonparticipating  
358 physician who knows that the covered person is insured under a health care plan, the  
359 nonparticipating physician shall not bill the covered person except for any applicable  
360 copayment, coinsurance, or deductible that would be owed if the covered person utilized  
361 a participating physician.

362 33-20E-10.

363 (a) If a covered person assigns benefits to a nonparticipating physician, the health care  
364 plan shall pay the nonparticipating physician in accordance with subsections (c) and (d) of  
365 this Code section.

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

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

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

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

381 (f) When determining a reasonable fee for the services rendered, the independent dispute  
382 resolution entity shall select either the health care plan's payment or the nonparticipating  
383 physician's fee. An independent dispute resolution entity shall determine which amount  
384 to select based upon the conditions and factors set forth in Code Section 33-20E-7. If an  
385 independent dispute resolution entity determines, based on the health care plan's payment  
386 and the nonparticipating physician's fee, that a settlement between the health care plan and  
387 nonparticipating physician is reasonably likely, or that both the health care plan's payment  
388 and the nonparticipating physician's fee represent unreasonable extremes, then the  
389 independent dispute resolution entity may direct both parties to attempt a good faith  
390 negotiation for settlement. The health care plan and nonparticipating physician may be  
391 granted up to ten business days for this negotiation, which shall run concurrently with the  
392 30 day period for dispute resolution.

393 (g) A covered person who does not assign benefits under subsection (a) of this Code  
394 section or a patient who is not a covered person and who receives a surprise bill may  
395 submit a dispute regarding the surprise bill for review to an independent dispute resolution  
396 entity.

397 (h) The independent dispute resolution entity shall determine a reasonable fee for the  
398 services rendered based upon the conditions and factors set forth in Code Section  
399 33-20E-7.

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

403 (j) The determination of an independent dispute resolution entity shall be binding on the  
404 patient, physician, and health care plan, and shall be admissible in any court proceeding  
405 between the patient or covered person, physician or health care plan, or in any  
406 administrative proceeding between this state and the physician.

407 (k) In disputes involving a covered person, when the independent dispute resolution entity  
408 determines the health care plan's payment is reasonable, payment for the dispute resolution  
409 process shall be the responsibility of the nonparticipating physician. When the independent  
410 dispute resolution entity determines the nonparticipating physician's fee is reasonable,  
411 payment for the dispute resolution process shall be the responsibility of the health care  
412 plan. When a good faith negotiation directed by the independent dispute resolution entity  
413 pursuant to Code Sections 33-20E-8 and 33-20E-9 of this chapter results in a settlement  
414 between the health care plan and nonparticipating physician, the health care plan and the

415 nonparticipating physician shall evenly divide and share the prorated cost for dispute  
416 resolution.

417 (l) When there is a dispute involving a patient who is not a covered person and the  
418 independent dispute resolution entity determines the physician's fee is reasonable, payment  
419 for the dispute resolution process shall be the responsibility of the patient unless payment  
420 for the dispute resolution process would pose a hardship to the patient. The Commissioner  
421 shall promulgate a regulation to determine payment for the dispute resolution process in  
422 cases of hardship. When the independent dispute resolution entity determines the  
423 physician's fee is unreasonable, payment for the dispute resolution process shall be the  
424 responsibility of the physician.

425 33-20E-10.1.

426 In the event a covered person incurs an out-of-pocket expense for a covered procedure for  
427 less than the procedure cost to the insurer by an in network provider, the insurer shall  
428 provide a credit to the covered person's deductible for the amount of the out-of-pocket  
429 expense. The credit or credits are cumulative for the policy period incurred and shall not  
430 be transferable to the next policy period.

431

432 33-20E-11.

433 (a) An out-of-network reimbursement rate workgroup shall be established consisting of  
434 the Commissioner, four members appointed by the Governor, two members appointed by  
435 the Speaker of the House of Representatives, and two members appointed by the President  
436 of the Senate. The workgroup shall consist of: two physicians, one of each appointed by  
437 the Speaker of the House of Representatives and by the President of the Senate; two  
438 representatives of health plans, one of each appointed by the Speaker of the House of  
439 Representatives and by the President of the Senate; and four consumers, and shall be  
440 chaired by the Commissioner. Such representatives of the workgroup shall represent  
441 different regions of the state. The members shall receive no compensation for their  
442 services, but shall be allowed their actual and necessary expenses incurred in the  
443 performance of their duties.

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

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

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

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

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

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

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

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

460 (8) Reimbursement data from all health plans, both public and private, as well as charge  
 461 data from medical professionals and hospitals available through an all-payor data base  
 462 to be developed and maintained by the Department of Community Health; and

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

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

467 (1) The extent to which out-of-network coverage is available in each rating region in this  
 468 state;

469 (2) The extent to which a significant level of out-of-network benefits is available in  
 470 every rating region in this state, including the prevalence of coverage based on the usual  
 471 and customary cost as well as coverage based on other set reimbursement methodologies,  
 472 such as medicare; and

473 (3) Other issues deemed appropriate by either the commissioner of revenue or the  
 474 commissioner of public health.

475 (d) The workgroup shall report its findings and make recommendations for legislation and  
 476 regulations to the Governor, the Speaker of the House of Representative, the President of  
 477 the Senate, and the chairpersons of the House Committee on Insurance and the Senate  
 478 Insurance and Labor Committee no later than January 1, 2018."

479 **SECTION 3.**

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