

O.C.G.A. § 33-24-59.5

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*** Current Through the 2012 Regular Session ***

TITLE 33. INSURANCE
CHAPTER 24. INSURANCE GENERALLY
ARTICLE 1. GENERAL PROVISIONS

O.C.G.A. § 33-24-59.5 (2012)

§ 33-24-59.5. Definitions; timely payment of health benefits; notification of failure to pay; penalties; applicability

(a) As used in this Code section, the term:

(1) "Benefits" means the coverages provided by a health benefit plan for financing or delivery of health care goods or services; but such term does not include capitated payment arrangements under managed care plans.

(2) "Health benefit plan" means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy, or managed care plan or self-insured plan; but health benefit plan does not include policies issued in accordance with Chapter 31 of this title; disability income policies; or Chapter 9 of Title 34, relating to workers' compensation.

(3) "Insurer" means an accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan, which entity provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45 or any other administrator as defined in paragraph (1) of subsection (a) of Code Section 33-23-100.

(b) (1) All benefits under a health benefit plan will be payable by the insurer which is obligated to finance or deliver health care services under that plan upon such insurer's receipt of written or electronic proof of loss or claim for payment for health care goods or services provided. The insurer shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the insured or other person claiming payments under the plan payment for such benefits or a letter or electronic notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the person so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer disputes a portion of the claim, any undisputed

portion of the claim shall be paid by the insurer in accordance with this chapter. When all of the listed documents or other information needed to process the claim has been received by the insurer, the insurer shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the insured or other person claiming payments under the plan the insurer's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administrates or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer shall pay to the insured or other person claiming payments under the health benefit plan interest equal to 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) An insurer may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator.

HISTORY: Code 1981, § 33-24-59.5, enacted by Ga. L. 1999, p. 289, § 2; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2011, p. 595, § 5/HB 167.

O.C.G.A. § 33-24-59.14

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TITLE 33. INSURANCE
CHAPTER 24. INSURANCE GENERALLY
ARTICLE 1. GENERAL PROVISIONS

O.C.G.A. § 33-24-59.14 (2012)

§ 33-24-59.14. Definitions; prompt pay requirements; penalties

(a) As used in this Code section, the term:

- (1) "Administrator" shall have the same meaning as provided in Code Section 33-23-100.
- (2) "Benefits" shall have the same meaning as provided in Code Section 33-24-59.5.
- (3) "Facility" shall have the same meaning as provided in Code Section 33-20A-3.
- (4) "Health benefit plan" shall have the same meaning as provided in Code Section 33-24-59.5.
- (5) "Health care provider" shall have the same meaning as provided in Code Section 33-20A-3.
- (6) "Insurer" means an accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity, which entity provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(b) (1) All benefits under a health benefit plan will be payable by the insurer or administrator which is obligated to finance or deliver health care services or process claims under that plan upon such insurer's or administrator's receipt of written or electronic proof of loss or claim for payment for health care goods or services provided. The insurer or administrator shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the facility or health care provider claiming payments under the plan payment for such benefits or a letter or notice which states the reasons the insurer or administrator may have for failing to pay the claim, either in whole or in part, and which also gives the facility or health care provider so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer or administrator disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer or administrator in accordance with this chapter. When all of the listed documents or other

information needed to process the claim have been received by the insurer or administrator, the insurer or administrator shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the facility or health care provider claiming payments under the plan the insurer's or administrator's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administers or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer or administrator shall pay to the facility or health care provider claiming payments under the health benefit plan interest equal to 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) An insurer or administrator may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer or administrator processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator.

(f) This Code section shall not apply to limited benefit insurance policies. For the purpose of this subsection, the term "limited benefit insurance" means accident or sickness insurance designed, advertised, and marketed to supplement major medical insurance and specifically shall include accident only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or specified disease insurance.

HISTORY: Code 1981, § 33-24-59.14, enacted by Ga. L. 2011, p. 595, § 6/HB 167.