Updated 02/03/2021

Surprise Billing Consumer Protection Act
Frequently Asked Questions (FAQs)

GENERAL

1. What is the *Surprise Billing Consumer Protection Act* (the "Act")?

The Act was passed as House Bill 888 in the 2020 legislative session after years of working with various stakeholders on a mechanism to resolve payment disputes between health insurers and out-of-network providers for emergency and some types of non-emergency services. The Act was signed by the Governor on July 16, 2020, and is codified as O.C.G.A. § 33-20E-1 *et seq*. The corresponding Rules and Regulations (Chapter 120-2-106) implementing the Act were finalized by the Office of the Commissioner of Insurance (OCI) on December 30, 2020. Both the law and regulations became effective January 1, 2021.

2. Which insurers are subject to the Act?

Healthcare plans licensed by the Georgia Office of the Commissioner of Insurance (OCI) including fully insured managed care plans, HMOs, qualified health plans, Exchange plans, high deductible plans, and stand-alone dental and vision plans, as well as state healthcare plans, including the Georgia State Health Benefit Plan, public school teachers and employees and Board of Regents plans.

The Act does not apply to Medicaid managed care plans or care management organizations, limited benefit plans, air ambulance insurance, supplemental plans, Medicare plans, workers' compensation or plans governed by the *Employee Retirement Income Security Act of 1974*, 29 U.S.C. Sec. 1001, et seq (ERISA). Insurers are required to note on the remittance advice whether coverage is subject to the exclusive jurisdiction of ERISA. (Updated 02/03/2021)

3. What kinds of services and bills are subject to the Act?

Emergency Services – Insurers must pay for covered emergency medical services for covered persons regardless of network participation of the providers or facilities, without prior authorization and without retrospective denial of services deemed medically necessary.

Non-Emergency Services (Surprise Bills) – If charges arise from a covered person receiving non-emergency services from an out-of-network provider at an in-network facility, this is considered a "surprise bill," and insurers must pay for covered services regardless of network participation of the provider.

4. How does the Act protect patients?

A covered person cannot be held liable for any amount that exceeds the in-network deductible, coinsurance, copayment or other cost sharing amount defined in their health plan for the emergency services or surprise bills. A covered person's cost sharing amount for such claims shall count toward the deductible and any maximum out of pocket policy provisions as if the services were obtained from a participating or in-network provider.

5. How does the Act apply to hospitals?

The Act regulates both healthcare providers and healthcare facilities. Hospitals are not included in the definition of a "health care provider," but they are included in the definition of "facility." This means hospitals are subject to the provisions of the Act related only to claims for emergency services in O.C.G.A. § 33-20E-4 and corresponding Rule 120-2-106-.05. Hospitals may also request arbitration under O.C.G.A. § 33-20E-9 and corresponding Rule 120-2-106-.10 if they believe payment received from an insurer for out-of-network emergency services is not sufficient given the complexity and circumstances of the services provided.

Hospitals are not subject to the provisions of the Act related to surprise bills for non-emergency services in O.C.G.A. § 33-20E-5. However, Rule 120-2-106-.06(4) states that out-of-network facilities are prohibited from billing a covered person more than his or her deductible, coinsurance, copayment, or other cost-sharing for non-emergency services. There is no corresponding requirement that insurers pay out-of-network for such covered services. Likewise, these claims are not subject to the arbitration provisions in O.C.G.A § 33-20E-9 or corresponding Rule 120-2-106-.10, meaning a hospital has no recourse if an insurer refused to pay for an out-of-network covered service in a non-emergency situation.

The OCI has indicated the inclusion of hospitals in Rule 120-2-106-.06 is intended to apply to a narrow set of circumstances where a covered person initially enters an out-of-network facility for emergency services, and then remains in the facility for follow-up non-emergency services. GHA is working with the OCI to resolve this issue in a manner that is consistent with the intent of the Act.

6. **Which types of health care providers and facilities besides hospitals are subject to the Act?**

   Under the Act, a provider includes any physician, other individual, or facility other than a hospital licensed or otherwise authorized in this state to furnish healthcare services, including, but not limited to, any dentist, podiatrist, optometrist, psychologist, clinical social worker, advanced practice registered nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, qualified athletic trainer, occupational therapist, speech-language pathologist, audiologist, dietitian, or physician assistant.

7. **A facility or provider has a participation agreement with a health plan but is not included in the particular network assigned to a patient for a particular service. Is the facility or provider considered in-network or out-of-network for purposes of the Act?** (Added 02/02/2021)

   The facility or provider would be considered out-of-network if the participation agreement between the facility or provider and the health plan does not apply to the patient's group plan or to the particular service the patient is receiving.

8. **How does the federal No Surprises Act impact Georgia's law?** (Added 02/02/2021)

   For now, the federal No Surprises Act does not impact the requirements of Georgia's surprise billing law. The first portions of the federal law do not go into effect until January 1, 2022. GHA is currently analyzing how the provisions of the federal law compare to Georgia's law. However, we will likely not truly understand its full impact until the federal government finalizes its implementing regulations. The first set of proposed regulations is scheduled to be published by July 1, 2021.

EMERGENCY SERVICES

9. **A patient receives emergency services at an out-of-network hospital by an out-of-network provider.**
   a. **Does the Act prohibit the hospital from balance billing the patient for the difference in the cost or charges for the services provided and the amount paid by the patient's insurer?** (Added 02/02/2021)

      YES. The hospital is only allowed to bill the patient for the applicable deductible, coinsurance, copayment or other cost sharing amount that the patient would have paid if the services were provided at an in-network facility. The patient's in-network copayment for visits to the Emergency Department may be printed on the patient's insurance card. However, in many instances, out-of-network hospitals will not know

what the patient's in-network cost sharing would be. This information will need to be provided by the patient's insurer.

b. Does the Act prohibit the provider from balance billing the patient for the difference in the cost or charges for the services provided and the amount paid by the patient's insurer? (Added 02/02/2021)

YES. The provider is only allowed to bill the patient for the applicable deductible, coinsurance, copayment or other cost sharing amount that the patient would have paid if the services were provided by an in-network provider. In many instances, out-of-network providers will not know what the patient's in-network cost sharing would be. This information will need to be provided by the patient's insurer.

10. A patient receives emergency services at an in-network hospital by an out-of-network provider.

a. Does the Act prohibit the hospital from balance billing the patient for the difference in the cost or charges for the services provided and the amount paid by the patient's insurer? (Added 02/02/2021)

NO. However, the hospital is likely prohibited by its participation agreement with the health plan from billing the patient any more than the deductible, coinsurance, copayment or other cost sharing amount owed by the patient under his or her health plan.

b. Does the Act prohibit the provider from balance billing the patient for the difference in the cost or charges for the services provided and the amount paid by the patient's insurer? (Added 02/02/2021)

YES. The provider is only allowed to bill the patient for the applicable deductible, coinsurance, copayment or other cost sharing amount that the patient would have paid if the services were provided by an in-network provider. In many instances, out-of-network providers will not know what the patient's in-network cost sharing would be. This information will need to be provided by the patient's insurer.

11. A patient presents at an out-of-network hospital for treatment of an emergency medical condition and the attending physician determines that the patient requires transfer to a facility offering a higher level of care. Must the originating facility obtain the patient's written acknowledgement that the network status of the transport service, the receiving facility or providers at the receiving facility is not known? (Added 02/02/2021)

NO. The Act does not require the patient's written acknowledgement for the provision of emergency services. However, many hospitals do routinely advise patients or their family members in these situations that the network status of the transport service, receiving facility or providers at the receiving facility is not known.

12. The patient's health plan requires that they timely notify the plan of any emergency medical services received but the patient fails to do so due to their medical condition at the time. Can the health plan deny the claim submitted by the hospital or provider for those emergency services? (Added 02/02/2021)

NO. The Act prohibits a health plan from denying 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. However, if the emergency services are provided by an in-network hospital, the hospital's participation agreement with the health plan may require the hospital to provide notification of emergency services within a certain time.

NON-EMERGENCY SERVICES

13. A patient receives non-emergency services at an out-of-network hospital by an out-of-network provider.

a. Does the Act prohibit the hospital from balance billing the patient for the difference in the cost or charges for the services provided and the amount paid by the patient's insurer? (Added 02/02/2021)

NO. The Act does not limit the amount the hospital can bill the patient for non-emergency out-of-network services. However, OCI Rule 120-2-106-.06(4) states that out-of-network facilities are prohibited from billing a covered person more than his or her deductible, coinsurance, copayment, or other cost-sharing for non-emergency services. The OCI has indicated the inclusion of hospitals in Rule 120-2-106-.06 is intended to apply to a narrow set of circumstances where a covered person initially enters an out-of-network facility for emergency services, and then remains in the facility for follow-up non-emergency services.

Neither the Act nor the OCI regulations addresses situations where a patient receives emergency services from an out-of-network hospital and is then admitted to the hospital as an inpatient. Typically, once the patient is admitted as an inpatient, the emergency services are bundled into the hospital bill for the inpatient stay. From a practical standpoint, it may not be administratively feasible for the hospital to separate the patient's cost-sharing for the initial emergency services from the cost-sharing for the inpatient stay. GHA is working with the OCI to resolve this issue in a manner that is consistent with the intent of the Act.

b. Does the Act prohibit the <u>provider</u> from balance billing the patient for the difference in the cost or charges for the services provided and the amount paid by the patient's insurer? (Added 02/02/2021)

NO. The Act does not limit the amount the provider can bill the patient for non-emergency services provided at an out-of-network facility.

14. A patient receives non-emergency services at an <u>in-network</u> <u>hospital</u> by an <u>out-of-network</u> <u>provider</u>.

a. Does the Act prohibit the <u>hospital</u> from balance billing the patient for the difference in the cost or charges for the services provided and the amount paid by the patient's insurer? (Added 02/02/2021)

NO. However, the hospital is likely prohibited by its participation agreement with the health plan from billing the patient any more than the deductible, coinsurance, copayment or other cost sharing amount owed by the patient under his or her health plan.

b. Does the Act prohibit the <u>provider</u> from balance billing the patient for the difference in the cost or charges for the services provided and the amount paid by the patient's insurer? (Added 02/02/2021)

YES. The Act defines this scenario as a "surprise bill." Unless the provider has obtained the patient's written acknowledgement in accordance with O.C.G.A. § 33-20E-7 and Rule 120-2-106-.08, the provider is only allowed to bill the patient for the applicable deductible, coinsurance, copayment or other cost sharing amount that the patient would have paid if the services were provided by an in-network provider. In many instances, out-of-network providers will not know what the patient's in-network cost sharing would be. This information will need to be provided by the patient's insurer.

15. A covered person's health plan benefit summary specifies that coverage is not provided for non-emergency services when ordered or referred by an out-of-network provider. If a patient receives non-emergency services from an out-of-network provider that leads to a balance bill and the patient requires follow-up care ordered by the out-of-network provider, can the plan deny or restrict coverage for such services? (02/02/2021)

NO. The Act prohibits a health plan from denying or restricting coverage solely because the covered person obtained treatment from a non-participating provider leading to a balance bill. The plan is required to notify covered persons in writing of this protection.

PAYMENT

16. What is the minimum amount an insurer must pay out-of-network individual providers (*e.g.*, physicians or midlevel providers) for claims for emergency services or for non-emergency services provided at in-network facility?

The insurer must pay the greater of:

a) the verifiable median contracted amount paid by all eligible insurers for similar services;
b) the most recent verifiable contracted amount agreed to by the insurer and the provider for the same services during such time the provider was in-network with the insurer, if applicable;
c) a higher amount deemed appropriate by the insurer considering the complexity and circumstances of the services provided.

17. How will the "verifiable median contracted amount" by determined?

The OCI will initially contract with FAIR Health to provide the median contracted amount. A link to the data will be posted on the OCI website. The median contracted amount will be based on the amount paid during the 2017 calendar year by an insurer for the emergency or non-emergency services provided by in-network providers engaged in the same or similar specialties and provided in the same or nearest geographical area. The amount will be adjusted annually for inflation which may be based on the Consumer Price Index and shall not include Medicare or Medicaid rates. The OCI has the authority to develop an all-payer claims database to use for this purpose in the future, but funds have not been appropriated at this time.

18. Will a previous participating provider agreement between a health plan and an individual provider's group practice rather than the individual provider him or herself be considered for purposes of determining the "most recent verifiable contracted amount" agreed to between the insurer and the provider?

According to the OCI, there may be cases where there is no individual contract, in which case, the group contract may be the only verifiable amount. It should be noted that under Rule 120-2-106-.05(2) the verifiable amount is one of three potential amounts that the provider may receive. The OCI intends to monitor the impact of this provision.

19. What recourse does an out of network provider or hospital have if the payment received from an insurer is not sufficient given the complexity and circumstance of the services provided?

The provider or hospital may submit a request for arbitration to the Administrative Procedure Division of the OCI within thirty (30) days of receipt of payment for the claim. A copy of the arbitration request must be concurrently provided to the insurer.

The Act provides the OCI until July 1, 2021 to contract with one or more arbitration organizations. If an arbitration request is submitted prior to the OCI's finalization of an arbitration contract, the request will be held until such contract is finalized.

Under O.C.G.A. § 33-20E-9(b), a request for arbitration may involve a single patient and a single type of healthcare service, a single patient and multiple types of healthcare services, multiple patients and a single type of healthcare service, or multiple substantially similar healthcare services in the same specialty for multiple patients. The Rules and Regulations do not distinguish between the process for filing these different types of arbitration requests. However, the OCI has indicated it is developing a "How Do I" document concerning the process for requesting arbitration which will be posted to its website.

PATIENT CHOICE

20. What if a patient chooses to receive non-emergency services from an out-of-network provider or hospital?

A covered person may still choose to receive non-emergency services from an out-of-network provider or hospital. The Act does not reduce a covered person's financial responsibilities if the covered person chooses to receive out-of-network services as long as certain requirements are met.

For services scheduled in advance that will be provided by an out-of-network healthcare provider(s) in an in-network facility, the provider must provide an estimate of potential charges, and the covered person must give oral and written consent in advance of the provision of such services.

If, upon a covered person's request, a healthcare provider refers the covered person to another provider for the immediate provision of non-emergency services, the referring provider shall be exempt from the requirement that an estimate of potential charges be provided if:

a) the provider advises the covered person that the provider to which the covered person is being referred may be out-of-network and may charge higher fees than an in-network provider;

b) the covered person acknowledges that they have been advised both orally and in writing that he or she is aware the provider to which they are being referred may be out-of-network and may charge higher fees than an in-network provider;
c) the written acknowledgement is separate from other documents provided by the referring provider and includes language provided by the OCI;[1] and
d) satisfaction of the requirements is documented in the medical record.

Note these documentation requirements do not apply to hospitals directly, but they do apply to healthcare providers employed by a hospital or health system. If the documentation requirements are not met, it is the provider to which the patient has been referred for immediate non-emergency services that will be prohibited from balance billing the patient in the event the provider is out-of-network. For this reason, hospitals may desire to confirm with the patient that the documentation requirements have been met when the non-emergency services for which the patient has been immediately referred will be provided in a hospital department or clinic.

21. If a patient is an inpatient at an in-network hospital and is referred by his or her attending physician to a specialty provider on the hospital's medical staff for a certain test, evaluation or treatment, is the hospital required to obtain the patient's written acknowledgement that the provider to which the patient is being referred may be out-of-network? (02/02/2021)

Technically, it is the referring individual provider that is required to obtain the patient's written consent under the Act. Hospitals may want to consider including the requisite acknowledgement language in their electronic health record systems. If the hospital or individual provider does not obtain the necessary written acknowledgement, there are no direct penalties on the hospital or provider. However, the specialty provider's bill will be considered a "surprise bill," meaning the specialty provider is only allowed to bill the patient for the applicable deductible, coinsurance, copayment or other cost sharing amount that the patient would have paid if the services were provided by an in-network provider.

ARBITRATION

22. How does a provider or facility file a request for arbitration?

The provider or hospital may submit a request for arbitration to the Administrative Procedure Division of the OCI within thirty (30) days of receipt of payment for the claim. A copy of the arbitration request must be concurrently provided to the insurer.

[1] This language is not yet available. However, OCI has indicated that it will being providing the requisite language or referral form in the near future.

The Act provides the OCI until July 1, 2021 to contract with one or more arbitration organizations. If an arbitration request is submitted prior to the OCI's finalization of an arbitration contract, the request will be held until such contract is finalized.

Under O.C.G.A. § 33-20E-9(b), a request for arbitration may involve a single patient and a single type of healthcare service, a single patient and multiple types of healthcare services, multiple patients and a single type of healthcare service, or multiple substantially similar healthcare services in the same specialty for multiple patients. The Rules and Regulations do not distinguish between the process for filing these different types of arbitration requests. However, the OCI has indicated it is developing a "How Do I" document concerning the process for requesting arbitration which will be posted to its website.

23. What types of claims are not eligible for arbitration under the Act?

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

(a) related to a healthcare plan that is not regulated by the state;
(b) the basis for an action pending in state or federal court at the time of the request for arbitration;
(c) subject to a binding claims resolution process entered into prior to July 1, 2021;
(d) made against a healthcare plan subject to the exclusive jurisdiction of ERISA; or
(e) the covered person has chosen to receive non-emergency services from an out-of-network provider pursuant to Rule 120-2-106-.08.

If an arbitration request is dismissed in accordance with this provision, the provider or facility may request a hearing under Rule 120-2-2.

24. Can the parties negotiate a settlement instead of going to arbitration?

Yes. The parties may negotiate a settlement on their own before a request for arbitration is filed.

If the provider or facility has already filed a request for arbitration, the parties may still negotiate a settlement within 30 days of the date of receipt of the request. However, the parties must notify the OCI within the 30-day period if an agreement is reached. If the OCI is not notified within the 30 -day period, the claim will be sent to arbitration. The parties may still reach a negotiated settlement after the claim is referred but before arbitration begins. However, the parties will be responsible for splitting any costs incurred by the arbitrator due to the referral.

25. How is the arbitrator selected?

The OCI must contract with one or more arbitration organizations by July 1, 2021. The arbitration or resolution organizations will be contractually required to protect trade

secrets. A list of the selected organizations and their approved fee schedules will be kept by the OCI Administrative Procedure Division and available for review upon request.

Arbitrators should possess training and experience in health care billing, reimbursement, and usual and customary charges in consultation with a licensed doctor in active practice in the same or similar specialty as the doctor providing the service that is the subject of the dispute.

If the OCI has not been notified that a settlement has been reached within 30 days of receipt of an arbitration request, the dispute will be submitted to an independent resolution organization contracted with the OCI. The parties will have five (5) days to select an arbitrator by mutual agreement. If they have not notified the resolution organization of a selection by the fifth (5^{th}) day, the organization shall select an arbitrator from among its members. If the parties do not agree with the resolution organization's selection, the OCI will select an arbitrator and that decision will be final.

26. How does the arbitration process work?

The insurer must submit all data necessary to determine compliance with the regulations to the OCI within thirty (30) days of receipt of the arbitration request. Once an arbitrator is selected, each party shall submit in writing to the arbitrator one proposed payment amount (final offer) with supporting arguments within ten (10) days. The final offer and initial arguments, including supporting documents, may consist of no more than twenty (20) pages per party. If the arbitrator determines more information is needed, he or she may require additional written argument and documentation of up to ten (10) pages per party no more than one time. The arbitrator may set filing times and extend such filing times as appropriate. Failure of either party to timely submit the required documentation may result in a default against that party.

Within thirty (30) days of the referral to the arbitrator, he or she shall select one of the two final offers and shall provide the final decision in writing with a description of the basis for the decision, including citations to any documents relied upon. The final decision may not be subsequently modified. Any default or final decision issued by the arbitrator shall be binding upon the parties and is not appealable through the court system.

27. What factors will the arbitrator consider in determining which final offer to select?

The arbitrator shall consider:

(a) whether there is a gross disparity between the fee charged by the provider and (1) fees paid to the provider for the same services provided to other patients in health care plans in which the provider is non-participating, and (2) the fees paid by the health plan to reimburse similarly qualified out-of-network providers for the same services in the same region;

(b) the provider's training, education, experience, and the usual charge for comparable services when the provider does not participate with the patient's health plan;
(c) in the case of a hospital, the teaching status, scope of services, and case mix;
(d) the circumstances and complexity of the case;
(e) patient characteristics; and
(f) for physician services, the usual and customary cost of the service.

28. Who is responsible for payment of fees and other costs for the arbitration process?

The party whose final offer is not selected by the arbitrator shall pay the amount of the offer selected, if applicable, the arbitrator's expenses and fees, and any other fees assessed by the resolution organization, directly to such resolution organization. In the event of default, the defaulting party shall also pay such moneys due directly to such organization. If both parties default, the parties shall each be responsible for paying such organization one-half of all moneys due. Amounts due shall be paid in full to the resolution organization within fifteen (15) days of an arbitrator's final decision. Within three (3) days of the resolution organization's receipt of funds due to the party whose final offer was selected, such funds shall be distributed to such party.

29. Will decisions of the arbitrator be made public?

No. However, each resolution organization will be required to submit quarterly reports to the OCI showing the results of all disputes referred to such organization with the following information: 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 or facility. In addition, the report must include the name of each arbitrator and the number of disputes they settled in favor of either the insurer or the provider or facility.

ENFORCEMENT

30. What actions can the OCI take if it concludes that an insurer is not in compliance with the Act?

The OCI may use its other existing regulatory and enforcement authority under the Insurance Code to ensure insurers are complying with the requirements of the Act.

31. What action can the OCI take if it concludes that a provider or facility is not in compliance with the Act?

If the OCI concludes that a provider or facility has either displayed a pattern of acting in violation of the Act or has failed to comply with a lawful order of the OCI or the arbitrator, the OCI may refer the decision of the arbitrator to the appropriate state agency or the entity with governing authority over such provider or facility. For individual providers, enforcement referrals would be made to the applicable professional licensing board. For facilities, enforcement referrals would be made to the Health Facilities Regulation Division of the Department of Community Health. If the provider or facility's violations or actions fall under the OCI's jurisdiction, the OCI may investigate and proceed under the provisions of Insurance Code.

ADDITIONAL QUESTIONS

32. What if my question was not answered in the FAQs?

Please send additional questions to Keri Conley or Donna Hatcher. We will continue to update the FAQs. Watch GHA Today for updates or check the Healthcare Finance page of the GHA website for the most recent version.