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# Georgia's "Surprise Billing" Law to Impose New Restrictions on Healthcare Providers and Facilities

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On July 16, 2020, Governor Kemp signed into law HB 888, the Surprise Billing Consumer Protection Act, to take effect starting January 1, 2021. The new law aims to stop "surprise" billing to patients who have received out-of-network care from healthcare providers and facilities. These unexpectedly high medical bills are often called "surprise" or "balance" bills and often result from specialty procedures like emergency room or trauma surgery and anesthesiology performed by out-of-network specialists.

This bulletin highlights key points of the new law.

*When Balance Billing is Prohibited:*

Under the new law, balance billing[1] is prohibited in the following circumstances:

1. Emergency Care: Whenever any out-of-network provider or out-of-network facility furnishes emergency medical services to an insured patient, regardless of whether the patient has advance notice of a provider's or facility's out-of-network status; and
2. Non-Emergency Care: Whenever any out-of-network provider furnishes non-emergency medical services to an insured patient at an ***in-network facility***, if that patient has not first consented to receive that care from out-of-network providers at the in-network facility.

*When Balance Billing is **Not** Prohibited:*

The new law does ***not*** prohibit balance billing when an insured patient receives non-emergency medical services at an ***out-of-network facility***, whether furnished by the out-of-network facility or an out-of-network provider.

*What Constitutes Emergency Medical Services:*

"Emergency medical services" are defined based on what would lead "a prudent layperson possessing an average knowledge of medicine and health to believe" that immediate medical care is necessary so as to avoid (a) "serious jeopardy" to the patient's health, (b) "serious impairment to bodily functions," or (c) "serious

1 The Surprise Billing Consumer Protection Act defines "balance bill" as "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 by the covered person."

dysfunction of any bodily organ or part." "Non-emergency medical services" by contrast are defined broadly and generally include anything that does not qualify as "emergency medical services."

*What Facilities and Providers are Covered by the New Law:*

A "facility" means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice facility, or a "similar institution." A "provider" in turn is defined more broadly and generally includes provider types not falling within the definition of "facility." "Provider" expressly includes "facilities other than a hospital licensed or otherwise authorized in this state to furnish healthcare services" as well as a variety of healthcare professionals such as physicians, physician assistants, advanced practice registered nurses, licensed professional counselors and other therapists, physical therapists and related professionals, clinical social workers, and even athletic trainers.

*What Out-of-Network Providers May Collect Under the New Law[2]:*

When the new law prohibits balance billing, an out-of-network provider may bill a patient only for the cost-sharing amount (e.g., deductible, coinsurance, copayment, etc.) that the patient is ordinarily responsible for under the terms of his or her insurance policy.[3] The insurer will then be required to pay the out-of-network provider the greater of (i) the verifiable "contracted amount" paid by all eligible insurers for the same or similar services[4]; (ii) the most recent verifiable amount agreed to by the insurer and the out-of-network provider for the provision of the same services during the time the provider was in-network; or (iii) a higher amount that the insurer deems appropriate given the complexity and circumstances.

The new law contains a formula for calculating the "contracted amount" and whether the out-of-network provider was previously included in the applicable insurer's provider network. The new law also establishes an arbitration process for out-of-network providers and out-of-network facilities who believe they should be entitled to additional funds under certain provisions of the new law. Providers and facilities would have 30 days from receipt of payment to request arbitration and the arbitration requests may involve a single or multiple patients and healthcare services.

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2 While these specific provisions expressly apply to out-of-network "providers," the new law requires insurers to pay out-of-network providers ***and*** out-of-network facilities for emergency services and the arbitration process is available for out-of-network providers ***and*** out-of-network facilities.

3 The new law expressly prohibits an out-of-network provider from reporting a patient to credit reporting agencies for a patient's failure to pay any portion beyond the cost-sharing amount.

4 The "contracted amount" is the median in-network amount paid during the 2017 calendar year by an insurer for the services provided by in-network providers in the same or nearby geographic area. The contracted amount will be adjusted annually for inflation and will not include Medicare or Medicaid rates.

*Patient Consent Required to Balance Bill for Non-Emergency Care Provided by Out-of-Network Provider in In-Network Facility:*

The new law allows out-of-network providers furnishing non-emergency medical services at in-network facilities to issue balance bills upon compliance with pre-service patient notice and consent procedures. Such out-of-network providers must:

1. Provide the patient with an estimate of the potential charges associated with receiving the out-of-network services; and
2. Document the patient's informed choice to receive the out-of-network services by obtaining the patient's oral and written consent prior to administering the services.

Notably, if a patient requests an attending provider to refer the patient to another provider for the immediate provision of additional non-emergency medical services, the referred provider can only balance bill the referred patient for non-emergency medical services if the referring provider:

1. Advises the patient that the referred provider may be a "nonparticipating" or out-of-network provider and may charge higher fees than a participating provider;
2. Obtains the patient's oral and written acknowledgement of that fact;
3. Ensures that the written acknowledgement includes statutorily required language and is a separate document from other documents furnished by the referring provider; and
4. Records in the patient's medical file that the first three of these requirements have been satisfied.

Interestingly, the new law puts the burden on the referring provider—rather than on the referred provider—for fulfilling the notice and consent requirements. The referred provider, however, should confirm that the notice and consent requirements were satisfied by the referring provider prior to balance billing.

*Exemptions and Limitations of the New Law:*

While the new law applies to a variety of State and private health insurance plans regulated by Georgia's Commissioner of Insurance, the law does ***not*** apply to Medicare, Medicaid, the State's worker's compensation program, or limited benefit insurance policies designed to supplement major health insurance plans (with the exception that stand-alone dental and vision policies are included). The new law also does ***not*** apply to plans exclusively subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). Finally, the new law does ***not*** apply to air ambulance insurance plans or any ground ambulance transportation services, regardless of insurer.

*Other Notable Features:*

- Gives the Commissioner of Insurance jurisdiction in administering the new law, including limited rulemaking powers;
- Authorizes the creation of a publicly available all-payer health claims database;
- Creates a detailed arbitration system for providers to resolve reimbursement disputes with insurers; and

- Authorizes the Commissioner of Insurance to refer arbitration decisions to agencies or entities having governing authority over providers or facilities if the Commissioner finds that a provider or facility has "displayed a pattern of acting in violation" of the law or has "failed to comply with a lawful order of the Commissioner or the arbitrator."

*Open Questions:*

- Will the new law's definition for "emergency medical services" without more guidance further exacerbate the long-standing struggle between providers, facilities and insurers as to the scope of emergency medical services for purposes of reimbursement?
- How will the new law's arbitration mechanism for provider/facility-insurer reimbursement disputes work in practice? Critical questions are likely to center on what a provider or facility must show to establish that the "complexity and circumstances" of services entitle the provider or facility to reimbursement from the insurer in an amount greater than the typical in-network rate for those same services.
- What constitutes a "pattern of acting in violation" of the new law that can subject providers and facilities to heightened enforcement authority under the new law?
- What policies and protocols will providers and facilities need to implement to ensure compliance with the new law and, in particular, the patient consent requirements in non-emergency circumstances with respect to referrals?

Parker Hudson continues to monitor the law and its effects on providers and facilities. Should you need additional information, please do not hesitate to contact us.