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Georgia Surprise Bill Legislation

Surprise billing legislation was already experiencing a substantial amount of activity and interest prior to COVID-19 in Georgia, but as of the past few months, this legislation has only received more attention from legislators. "Balance Billing" refers to the difference charged by an Out-of-Network (OON) (non-contracted) provider and the amount paid by the insurer less standard patient responsibility. "Surprise Billing" generally comes in when a patient receives non-elective care at an in-network facility, but from an OON provider. In either context, the patient is typically responsible for the remaining balance between what the bill is for services rendered and how much the patient's insurance will cover.

Georgia has become the latest state to adopt full protection Surprise Billing Legislation. On Thursday July 16th, 2020, Georgia Governor Brian Kemp signed into law House Bill 888 which effectively adds a new chapter to Title 33 of the Official Code of Georgia Annotated, relating to insurance, to be known as the "Surprise Billing Consumer Protection Act." Effective January 1, 2021, the Act:

- provides for certain consumer protections against surprise billing
- requires the department to provide for the maintenance of an all-payer health claims database
- establishes an arbitration process to resolve payment disputes between insurers and OON providers or facilities

Surprise Billing High Points

Regarding emergency services, the Act states that an insurer who provides emergency care benefits for its covered subscribers shall pay for emergency services regardless of whether the provider or facility furnishing those services is participating with the insurer with respect to emergency services, without need for prior authorization and without any retrospective denial for medically necessary services.

Specific to non-emergency services, the Act states that an insurer who provides any benefits to covered persons for non-emergency medical services shall pay for such services in the event that the services resulted in a surprise bill regardless of whether the rendering healthcare provider is a participating provider with respect to those services. This does not apply when the covered individual chooses to receive non-emergency medical services from an OON provider as long as that choice is documented in advance of the service and after he/she has been provided with an estimate of the potential charges.

In the event a covered person receives emergency or non-emergency medical services from a non-participating medical provider, the provider shall collect or bill no more that the person's deductible, coinsurance, copayment or other cost-sharing amount determined by his/her policy.

- The insurer shall treat such services as if they were provided by a participating provider and apply the patient's cost-sharing responsibilities accordingly
- The insurer shall directly pay the provider the greater of:
    - The verifiable contracted amount paid by all eligible insurers subject to the Act for the same/similar services;

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- The most recent verifiable amount agreed to by the insurer and non-participating provider for the same services when the provider is in-network with the insurer; or
- A higher amount that the insurer may deem appropriate for the complexity and circumstances of the services provided

All Payer Health Claims Database High Points
For insurers to meet their obligations in adjudicating "surprise billing" claims according to the provisions of the Act, the department will provide for an all-payer health claims database and maintain records of insurer payments for tracking over a wide variety of healthcare services and geographic areas of the state.

Arbitration Process High Points
If an OON provider or facility deems payment received from an insurer to be insufficient due to the complexity and circumstances of the services provided, the provider or facility can initiate a request for arbitration with the Commissioner; the request must be made within 30 days of receipt of the payment. Prior to proceeding with the requested arbitration, the Commissioner will allow the parties 30 days to negotiate a settlement.

The arbitration process is not limited to individual claims and may be extended to multiple patients and/or multiple substantially similar healthcare services.

The department is expected to contract with one or more resolution organizations by July 1, 2021 to carry out the arbitration process.

Non-participating providers are prohibited from reporting to credit agencies any covered persons who receive their surprise bills and don't pay an amount beyond what their cost-sharing amount would have been if the provider had been participating.

If you have any questions or need further information on this topic, please contact your APS Practice Manager.