House Bill 888
Surprise Billing Consumer Protection Act
Summary of Legislation

Act Effective date - January 1, 2021

Emergency Services

- Insurers must pay for emergency medical services regardless of whether the individual healthcare provider or facility is in- or out-of-network.
- Insurers must pay for emergency medical services without prior authorization and without any retrospective denial for medically necessary services.
- If a patient receives emergency medical services from an out-of-network provider or facility:
    - the patient's cost-sharing is the same as if he or she had received services from an in-network provider or facility;
    - the insurer must apply the patient's cost-sharing to his or her deductible and out-of-pocket maximum in the same manner as if the services were provided by an in-network provider or facility; and
    - the provider or facility may not bill the patient more than the patient's deductible, co-insurance, co-payment or other cost-sharing amount.
- Payment to out-of-network individual providers (*e.g.*, physicians or midlevel providers) for emergency medical services is the greater of:
    - the verifiable contracted amount paid by insurers for the same or similar services;
    - the most recent verifiable amount agreed to by the insurer and the out-of-network provider for the provision of the same or similar services during the time the provider was in-network; or
    - a higher amount the insurer deems appropriate given the complexity and circumstances of the services provided.

Non-Emergency Services – Surprise Bills from Out-of-Network Providers

- Insurers must pay for non-emergency medical services provided by an out-of-network healthcare provider at an in-network facility. The term "facility" is defined to include hospitals as well as ambulatory surgery centers, imaging centers and similar institutions.
- Payment to out-of-network individual providers (e.g., physicians and midlevel providers) for non-emergency medical services at an in-network facility is the greater of:
    - the verifiable contract amount paid by all insurers for the provision of the same or similar services;
    - the most recent verifiable amount agreed to by the insurer and the out-of-network provider for the provision of the same or similar services during the time the provider was in-network; or

    - a higher amount the insurer deems appropriate given the complexity and circumstances of the services provided.
- Insurer payments made to an out-of-network provider at an in-network facility shall be made in accordance with Georgia's prompt payment law and include a notification disclosing whether the insurer is subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974 (ERISA).
- If a patient receives non-emergency medical services from an out-of-network provider at an in-network facility:
    - the patient's cost-sharing is the same as if he or she had received services from an in-network provider; and
    - the patient's cost-sharing must be applied to his or her deductible and out-of-pocket maximum in the same manner as if the services were provided by an in-network provider.

Non-Emergency Services – Patient Chooses an Out-of-Network Provider

- A patient may still receive a balance bill for non-emergency medical services if he or she chooses to receive such services from an out-of-network provider and the choice is:
    - documented through written and oral consent in advance of the services; and
    - occurs only after the patient receives an estimate of the potential charges.
- An out-of-network provider does not have to meet the above requirements if during the provision of non-emergency services, the patient requests the attending provider refer him or her to an out-of-network provider for additional non-emergency services and:
    - the referring provider advises the patient that the referred provider may be out-of-network and may charge higher fees than an in-network provider;
    - the patient provides an oral and written acknowledgement that he or she is aware that the referred provider may be out-of-network and may charge higher fees than an in-network provider;
    - the written acknowledgement is documented on a separate form from other documents provided by the referring provider and includes language specified by the Commissioner of Insurance; and
    - the referring provider documents the satisfaction of these requirements in the patient's medical record.

All-Payer Claims Data Base – When funding is appropriated, Commissioner of Insurance must establish and maintain an all-payer healthcare claims database.

Arbitration

- If an out-of-network provider or facility concludes that payment from an insurer is not sufficient given the complexity and circumstances of the services provided, the provider may request arbitration through the Commissioner of Insurance.
    - Arbitration is not available in situations where the patient has chosen to see an out-of-network provider in accordance with the requirements above.
- The Commissioner of Insurance will promulgate rules and regulations establishing an arbitration process utilizing an independent dispute resolution organization. The process is not subject to the Georgia Administrative Procedures Act or Civil Procedure Act.

- The provider and insurer each submit a proposed amount of payment to the arbitrator along with any initial arguments supporting documents.
- The arbitrator selects one of the two proposed payment amounts, considering the complexity and circumstances of the case, including, but not limited to:
    - the level of training, education and experience of the provider; and
    - other factors as determined by the Commissioner of Insurance.
- The decision of the arbitrator is not subject to appeal.
- The party whose proposed payment amount was not selected by the arbitrator is responsible for the arbitration expenses.
- The Commissioner of Insurance will post information on its website regarding the number and outcomes of arbitration claims for each calendar year.

Credit Reporting – Out-of-network providers are prohibited from submitting a report to any credit reporting agency regarding a patient that receives a surprise bill and does not pay any amount beyond what the patient would have paid if the provider had been in-network.

Enforcement

- The Commissioner of Insurance may refer an arbitration decision to the appropriate state agency or governing board of the provider or facility if the Commissioner concludes that the provider has:
    - displayed a pattern of acting in violation of the Act; or
    - failed to comply with a lawful order of the Commissioner or arbitrator.
- Failure of an insurer to comply with the Act is considered an unfair claims settlement practice and subject to penalty by the Commissioner of Insurance.