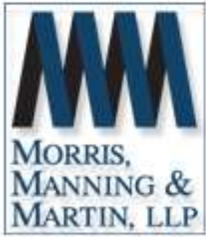
Surprise Billing – Strategic Healthcare Partners

May 5, 2021



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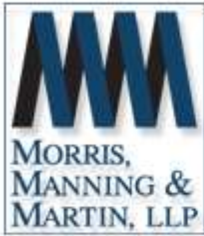
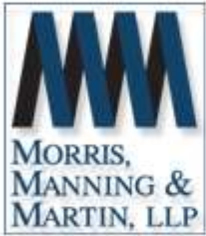
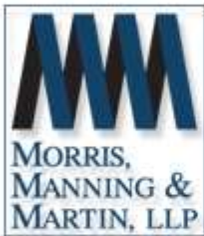


State of Georgia Surprise Billing Law and Regulations



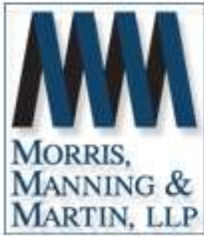
Georgia Surprise Billing Overview

- The Georgia Surprise Billing Consumer Protection Act went into effect January 1, 2021, along with its implementing regulations.
- The Act is designed to protect consumers from surprise medical bills, many of which result from services provided by out-of-network providers at in-network facilities.
- The Act and regulations address medical bills for emergency and non-emergency services.
- The Act does not apply to ERISA Exempt Plans subject to the exclusive jurisdiction of federal are not eligible for review under the Act.



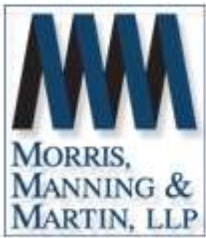
Georgia Surprise Billing – Emergency Medical Services

- "Emergency Medical Services" are medical services rendered after the recent onset of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of severity, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:
    - Placing the patient's health in serious jeopardy;
    - Serious impairment to bodily function;
    - Serious dysfunction of any bodily organ or part."



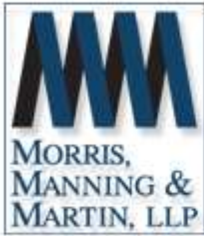
Georgia Surprise Billing - Payment for Out-of-Network Emergency Services

- Insurers must pay for Emergency Medical Services regardless of whether the facility or provider is out-of-network and without prior authorization and without retrospective payment denial.
- The patient's liability for Emergency Medical Services is limited to the patient's cost-sharing obligations (e.g., co-pay, deductible, etc.)
- The insurer must pay the out-of-network provider of Emergency Medical Services is the *greater of*:
  - The verifiable contracted amount paid by all eligible insurers for the provision of the same or similar services;
  - The most recent verifiable amount agreed to by the insurer and the nonparticipating provider for the provision of the same services during the time the provider was in-network; or
  - A higher amount that the insurer deems appropriate given the complexity and circumstances.



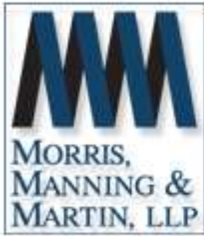
Georgia Surprise Billing – Non-Emergency Medical Services

- Insurers must pay for non-emergency medical services that result in a “Surprise Bill.”
- A “Surprise Bill” is a bill that results from charges where the patient receives services from an out-of-network provider at an in-network facility. (e.g., the hospital is in-network but the radiology group is out-of-network).
- The patient’s liability for a Surprise Bill for non-emergency medical Services is limited to the patient’s cost sharing obligations (e.g., co-pay, deductible, etc.)



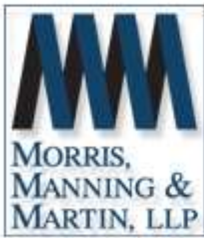
Georgia Surprise Billing – Payment for Non-Emergency Medical Services

- Insurers must pay out-of-network providers for Surprise Bills for non-emergency medical services the ***greater of***:
  - The verifiable contracted amount paid by all eligible insurers for the provision of the same or similar services;
  - The most recent verifiable amount agreed to by the insurer and the nonparticipating provider for the provision of the same services during the time the provider was in-network with the insurer; or
  - A higher amount that the insurer deems appropriate given the complexity and circumstances.



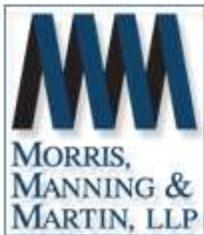
Georgia Surprise Billing – Non-Emergency Medical Services Based on Patient Choice

- Patients remain liable for charges associated with out-of-network non-emergency medical services if the patient elects to receive the services.
- The patient's choice to receive non-emergency medical services from an out-of-network provider:
  - Must be documented through the patient's written and oral consent in advance of the provision of services; and
  - Consent must occur only after an estimate of charges has been provided.

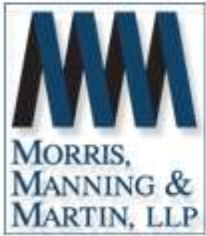


Georgia Surprise Billing – Arbitration

- Out-of-network providers or out-of-network facilities determining that payment for emergency or non-emergency medical services is not sufficient because of the complexity or circumstances of the services may pursue relief through arbitration.
- Arbitration requests must be submitted to the Administrative Procedure Division of the Office of Insurance and Safety Fire Commissioner.
- A request for arbitration must be made within 30 days of the receipt of payment and a copy of the arbitration request must be provided to the insurer.
- The Act requires “baseball-style” arbitration, meaning that the arbitrator must select either the amount proposed by the insurer or the amount proposed by the provider/facility.
- The losing party must pay certain expenses associated with arbitration, including the arbitrator’s fees and expenses.

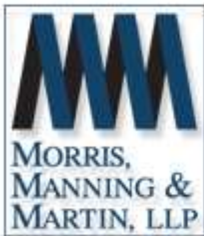


Federal No Surprises Act



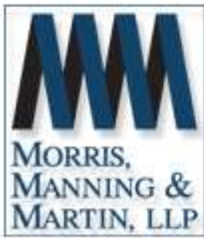
Federal No Surprises Act

- Passed as part of the omnibus spending bill in late December 2020
- Many of the implementing regulations are set to be published later in 2021 – so more insight and guidance should be forthcoming.
- The federal law has many similarities to the Georgia Surprise Billing Law.
- While further guidance may be forthcoming, the federal law would likely apply only to health plans not subject to the Georgia Surprise Billing Consumer Protection Act.



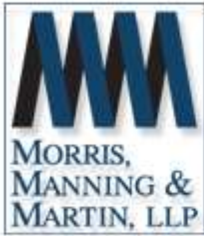
Federal No Surprises Act – Emergency Treatment

- Coverage for emergency services must be provided to patients without the requirement of any prior authorization from the insurer and regardless of whether the provider or facility participates in the plan.
- The federal statute limits a patient's payment obligations for emergency services to cost sharing obligations (co-pays, deductibles, etc.) that would apply in connection with services provided by an in-network provider or facility.
- A patient's cost-sharing obligations are based on a "recognized amount."
- The health plan or insurer must submit an initial payment to the provider or facility within 30 days of transmission of a bill for services.
- The health plan or insurer must make a total payment (taking into account the initial payment) equal to the amount by which the "out-of-network" rate exceeds the patient's cost sharing obligations.



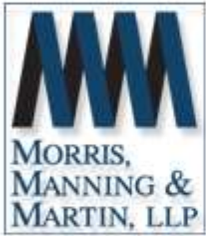
Federal No Surprises Act – Non-Emergency Treatment

- Provides protection from surprise bills by out-of-network providers at in-network facilities.
- The patient's liability is limited to cost sharing obligations (similar to the obligations for emergency services).
- Patient may not be billed or held liable for amounts beyond cost sharing obligations.
- The health plan or insurer must submit an initial payment to the provider or facility within 30 days of transmission of a bill for services.
- The health plan or insurer must make a total payment (taking into account the initial payment) equal to the amount by which the "out-of-network" rate exceeds the patient's cost-sharing obligations.



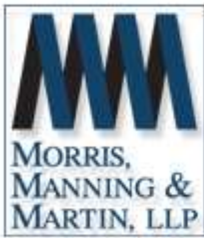
Federal No Surprises Act – Non-Emergency Treatment

- The patient may voluntarily consent to receive services from an out-of-network provider and assume financial responsibility.
- The out-of-network provider must provide the patient with written notice and obtain the patient's written consent.
- The out-of-network provider must provide written notice to a patient at least 72 hours prior to the scheduled services, or, if services are scheduled within 72 hours, at the time services are scheduled.
- Consent may not be obtained for ancillary services that a patient typically does not select (e.g., anesthesiology, radiology, pathology, emergency services and neonatology).



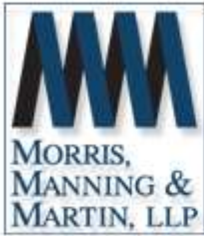
Federal No Surprises Act – Dispute Resolution

- Insurers and providers have 30 days from the initial payment or denial to initiate voluntary negotiations to settle a disputed payment. The negotiation period lasts for 30 days from initiation.
- If the insurer and provider fail to reach a resolution, then either may request arbitration within four days of the end of the negotiation period.
- Like the Georgia law, the federal law requires "baseball- style" arbitration.
- Like the Georgia law, the losing party is obligated to pay the administrative costs of arbitration.
- If the parties settle, costs are shared equally.
- A party that initiates arbitration may not pursue arbitration against another for the same item or service for 90 days following a decision.



Federal No Surprises Act – Dispute Resolution

- Each party submits its offer for a payment amount and supporting documentation within 10 days of the selection of an arbitrator.
- In reaching a decision, the arbitrator may not consider "usual and customary" charges or the Medicare and Medicaid rates.
- The arbitrator is required to consider certain circumstances applicable to the disputed amount, including:
    - Training, experience and quality of the facility or provider
    - Acuity of the patient or complexity of the item or service
    - The plan's or insurers rates for similar services in the same geographic region
    - Good faith efforts of the parties to enter into network agreements during the last 4 years



Federal No Surprises Act – Notice of Balance Billing Requirements

- Health care providers and facilities are required to provide and post on their websites a one-page notice relating to balance billing.
- The notice must describe the following:
  - The federal prohibitions on balance billing;
  - State laws relating to balance billing and cost sharing obligations; and
  - Contact information for state or federal agencies if the provider or facility violates the balance billing requirements.

State and Federal Surprise Billing

QUESTIONS?