

120-2-106 Surprise Billing

120-2-106-.01 Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority set forth in O.C.G.A. §§ 33-2-9 and O.C.G.A §§ 33-20E.

120-2-106-.02 Scope and Purpose

This Regulation is made pursuant to the “Surprise Billing Consumer Protection Act,” which was passed to provide a mechanism to resolve billing and payment disputes between insurers and out-of-network providers. It will also establish a fair and equitable arbitration process to handle such disputes. This Regulation applies only to “healthcare plans” and “state healthcare plans,” as defined in this Regulation. Nothing in this Regulation shall reduce a covered person’s financial responsibilities concerning ground ambulance transportation. Failure of an insurer to comply with the provisions of Chapter 20E of Title 33 shall be deemed an unfair trade practice as defined in 33-6-4.

120.2-106-.03 Definitions

For the purposes of this Regulation, the following definitions apply:

- (1) “Balance bill” means the amount that a non-participating provider charges for services provided to a covered person. Such amount equals the difference between the amount paid or offered by the insurer and the amount of the non-participating provider’s bill charge, but shall not include any amount for coinsurance, copayments, or deductibles due by the covered person.
- (2) “Contracted amount” means the median in-network 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 Department shall annually adjust such amount for inflation, which may be based on the Consumer Price Index, and shall not include Medicare or Medicaid rates.
- (3) “Covered person” means an individual who is insured under a healthcare plan.
- (4) “Emergency medical provider” means any physician licensed by the Georgia Composite Medical Board who provides emergency medical services and any other healthcare provider licensed or otherwise authorized in this state to render emergency medical services.
- (5) “Emergency medical services” means medical services rendered after the recent onset of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of sufficient 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:

- (a) Placing the patient's health in serious jeopardy;
- (b) Serious impairment to bodily functions;
- (c) Serious dysfunction of any bodily organ or part.

- (6) "Facility" means a hospital, an ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution.
- (7) "Geographic area" is defined as one of 16 Geo Rating Areas established for ACA purposes by use of Georgia Standardized Metropolitan Statistical Areas, expanded by contiguous counties and which has been in required use by Georgia insurers since 2014.
- (8) "Healthcare plan" means any hospital or medical insurance policy or certificate, healthcare plan contract or certificate, qualified higher deductible health plan, health maintenance organization or other managed care subscriber contract, or state healthcare plan. This term shall not include limited benefit insurance policies or plans listed under paragraph (3) of Code Section 33-1-2, air ambulance insurance, or policies issued in accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating to workers' compensation, Part A, B, C, or D of Title XVIII of the Social Security Act (Medicare), or any plan or program not described in this paragraph over which the Commissioner does not have regulatory authority. Notwithstanding paragraph (3) of Code Section 33-1-2 and any other provision of this title, this chapter this term shall include stand-alone dental insurance and stand-alone vision insurance for purposes of this chapter.
- (9) "Healthcare provider" or "provider" means 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, athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist, speech-language pathologist, audiologist, dietitian, or physician assistant.
- (10) "Healthcare services" means emergency or non-emergency medical services.
- (11) "Insurer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including those of an accident and sickness insurance company, a health maintenance organization, a healthcare plan, a

managed care plan, or any other entity providing a health insurance plan, a health benefit plan, or healthcare services.

- (12) “Median” means the middle number of a sorted list of reimbursement amounts paid to in-network providers or facilities with respect to a specific emergency or non-emergency medical service, with each paid claim amount separately represented on the list, arranged in order from least to greatest. If there is an even number of items in the sorted list of paid claim amounts, the median is found by taking the average of the two middlemost numbers. The calculated median paid amount shall include copayment, coinsurance, and deductible as applicable and shall exclude claims in which the insurer is not the primary payer.
- (13) “Most recent contracted amount” means a participating provider agreement in-force within the six (6) months preceding the claim date of service.
- (14) “Non-emergency medical services” means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from an illness, injury, or other human physical problem which does not qualify as an emergency medical service and includes, but is not limited to:
- (a) Hospital services which include the general and usual care, services, supplies, and equipment furnished by hospitals;
 - (b) Medical services which include the general and usual care and services rendered and administered by doctors of medicine, dentistry, optometry, and other providers; and
 - (c) Other medical services which, by way of illustration only and without limiting the scope of this chapter, include the provision of appliances and supplies; nursing care by a registered nurse; institutional services, including the general and usual care, services, supplies, and equipment furnished by healthcare institutions and agencies or entities other than hospitals; physiotherapy; drugs and medications; therapeutic services and equipment, including oxygen and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and appliances, including wheelchairs, trusses, braces, crutches, and prosthetic devices, including artificial limbs and eyes; and any other appliance, supply, or service related to healthcare which does not qualify as an emergency medical service.
- (15) “Out-of-network” refers to healthcare services provided to a covered person by providers or facilities who do not belong to the provider network in the healthcare plan

(16) “Non-participating provider” means a healthcare provider who has not entered into a contract with a healthcare plan for the delivery of medical services

(17) “Participating provider” means a healthcare provider that has entered into a contract with an insurer for the delivery of healthcare services to covered persons under a healthcare plan.

(18) “Resolution organization” means a qualified, independent, third-party claim dispute resolution entity selected by and contracted with the Department.

(19) “State healthcare plan” means:

(A) The state employees’ health insurance plan established pursuant to Article 1 of Chapter 18 of Title 45;

(B) The health insurance plan for public school teachers established pursuant to Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20;

(C) The health insurance plan for public school employees established pursuant to Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20; and

(D) The Regents Health Plan established pursuant to authority granted to the board pursuant to Code Sections 20-3-31, 20-3-51, and 31-2-4.

(20) “Surprise bill” means a bill resulting from an occurrence in which charges arise from a covered person receiving healthcare services from an out-of-network provider at an in-network facility.

120-2-106-.04 ERISA Exempt Plans

ERISA Exempt Plans subject to the exclusive jurisdiction of federal law and rules are not eligible for review under the “Surprise Billing Consumer Protection Act.”

120-2-106-.05 Emergency Services

(1) Insurers shall pay covered emergency medical services for covered persons regardless of whether the provider or facility is participating or non-participating in their network according to this Regulation. Such an insurer shall make such payment without prior authorization and without retrospective payment denial for emergency medical services deemed to be medically necessary.

(2) If a covered person receives emergency medical services from a non-participating provider, such person shall not be liable to the non-participating provider or facility for any amount exceeding such person’s deductible, coinsurance, copayment, or other cost-sharing amount as determined by such person’s policy. The amount payable by an insurer for emergency medical services paid directly to the provider shall be the greater of:

(a) The verifiable median contracted amount paid by all eligible insurers for similar services calculated by a vendor utilized and chosen by the Commissioner;

(b) The most recent verifiable amount agreed to by the insurer and the non-participating emergency medical provider for the same services during which time the provider was in-network with the insurer; (if applicable)

(c) A higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

Any amount payable by an insurer under this section for emergency medical services shall not include any amount of coinsurance, copayment, or deductible owed by the covered person or already paid by such person.

(3) Insurers shall not deny benefits or emergency medical services rendered based on a covered person's failure to provide subsequent notification where the insured's medical condition prevented timely notification.

(4) Emergency medical services received from non-participating providers and/or facilities shall count toward the deductible and any maximum out of pocket policy provisions as if the services were obtained from a participating provider.

(5) In cases of emergency medical services received from a non-participating facility, the facility shall bill the covered person no more than deductible, coinsurance, copayment, or other cost-sharing as determined by such person's policy.

(6) Insurer payments made to providers in this Code section shall be in accord with prompt payment requirements under 33-24-59.14. Notification should reflect whether coverage is subject to the exclusive jurisdiction of ERISA (1974), U.S.C. Sec 1001.

120-2-106-.06 Non-emergency Medical Services

(1) If the provisions of 120-2-106.08 are met, an insurer that provides any benefits to covered persons with respect to non-emergency medical services shall pay for such services in the event that such services resulted in a surprise bill regardless of whether the healthcare provider furnishing non-emergency medical services is a participating provider with respect to non-emergency medical services.

(2) In the event a covered person receives care in a facility that generates a surprise bill for non-emergency medical services from a non-participating medical provider, the non-participating provider shall collect or bill the covered person no more than such person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such person's policy. The insurer shall directly pay such provider the greater of:

(a) The verifiable median contracted amount paid by all eligible insurers for similar services calculated by a vendor utilized and chosen by the Commissioner;

(b) The most recent verifiable amount agreed to by the insurer and the non-participating emergency medical provider for the same services during which time the provider was in-network with the insurer; (if applicable)

(c) A higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

Any amount that the insurer pays the non-participating provider under this subsection shall not be required to include any amount of coinsurance, copayment, or deductible owed by the covered person or already paid by such person.

(3) Non-emergency medical services received from non-participating providers and/or facilities shall count toward the deductible and any maximum out of pocket policy provisions as if the services were obtained from a participating provider.

(4) In cases of non-emergency medical services received from a non-participating facility, the facility shall bill the covered person no more than deductible, coinsurance, copayment, or other cost-sharing as determined by such person's policy.

(5) All insurer payments made to providers pursuant to this Code section shall be in accord with Code Section 33-24-59.14. Such payments shall accompany notification to the provider from the insurer disclosing whether the healthcare plan is subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C.202 Sec. 1001, et seq.

120-2-106-.07 Balance Billing provision for covered benefits from non-participating providers

No healthcare plan shall deny or restrict covered benefits from a participating provider to a covered person solely because the covered person obtained treatment from a non-participating provider leading to a balance bill. Notice of such protection shall be provided in writing to the covered person by the insurer.

120-2-106-.08 Covered Person Choosing to receive Non-emergency medical Services from a non-participating provider, Referrals and Procedures

(1) Nothing in this chapter shall reduce a covered person's financial responsibilities in the event that such covered person chose to receive non-emergency medical services from an out-of-network provider. Such services shall not be considered a surprise bill for the purpose of this chapter.

(2) The covered person's choice described in subsection (1) of this Code section must:

- (a) Be documented through such covered person's written and oral consent in advance of the provision of such services; and
- (b) Occur only after such person has been provided with an estimate of the potential charges.

(3) If during the provision of non-emergency medical services, a covered person requests that the attending provider refer such covered person to another provider for the immediate provision of additional non-emergency medical services, such referred provider shall be exempt from the requirements in subsection (b) of this Code section if the following requirements are satisfied:

- (a) The referring provider advises the covered person that the referred provider may be a non-participating provider and may charge higher fees than a participating provider;
- (b) The covered person orally and in writing acknowledges that he or she is aware that the referred provider may be a non-participating provider and may charge higher fees than a participating provider;
- (c) The written acknowledgment referenced in paragraph (2) of this subsection shall be on a document separate from other documents provided by the referring provider and shall include language to be determined by the Commissioner (Appendix A) and Regulation; and
- (d) The referring provider records the satisfaction of the requirements in paragraphs (1), (2), and (3) of this subsection in the covered person's medical file.

120-2-106-.09 Claims Database

Pursuant to O.C.G.A 33-20E-8 (a) appropriations for an all claims database were not provided, and subsection (b) of O.C.G.A 33-20E-8 will be triggered. The Department will utilize a verifiable median contracted amount paid by all eligible insurers for similar services calculated by a vendor utilized and chosen by the Commissioner.

120-2-106-.10 Arbitration

- (1) If an out-of-network provider concludes that payment received from an insurer pursuant to regulation 120-2-xxx-.05 or 120-2-xxx-.06 is not sufficient given the complexity and circumstances of the services provided. Or if an out-of-network facility concludes that payment received from an insurer pursuant to Regulation 120-2-xxx-.05 concludes the same, a request for arbitration with the Commissioner may be initiated. A request for arbitration must be submitted within 30 days of receipt of payment for the claim and concurrently provide the insurer with a copy of such request.
- (2) All arbitration requests must be submitted to the Administrative Procedure Division of the Office of Insurance and Safety Fire Commissioner.
- (3) Within 30 days of the insurer's receipt of a provider's or facility's request for arbitration, the insurer must submit to the Administrative Procedure Division

all data necessary to determine whether the insurer's payment to such provider or facility complied with regulations 120-2-106-.05 or 120-2-106-.06.

- (4) The Commissioner will dismiss specific arbitration requests if the disputed claim meets certain criteria laid out in O.C.G.A. § 33-20E-10. Should an insurer believe one of these criteria is present, they should submit the appropriate data they believe supports this contention. Should the Commissioner dismiss a claim for meeting one of the criteria in O.C.G.A. § 33-20E-10, the provider or facility may request a hearing under the rules contained in Regulation 120-2-2.
- (5) Before proceeding with arbitration, the parties will be permitted 30 days from the date the request was received to negotiate a settlement. The parties must notify the Administrative Procedure Division of the result of such negotiation. If the Administrative Procedure Division has not been notified within 30 days of the settlement negotiation's result, 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, they will be responsible for splitting any costs incurred by the resolution organization due to the referral.
- (6) Disputes are to be reviewed by independent resolution organizations with whom the Department will contract. The disputes will be decided pursuant to the rules as laid out in O.C.G.A. 33-20E *et. seq.*
- (7) A list of the selected organizations and their approved fee schedules will be kept by the Administrative Procedure Division and available for review upon request. In contracting with each dispute resolution organization, the Department will ensure that appropriate safeguards are put in place, so that information subject to trade secret protection laws is duly protected.
- (8) Upon the Commissioner's referral of a dispute to a resolution organization, the parties will have five days to select an arbitrator by mutual agreement. If the parties have not notified the resolution organization of their mutual selection before the fifth day, the resolution organization shall select an arbitrator from among its members. Should the parties not agree to the resolution organization's choice of arbitrator, the Commissioner will select one for the parties; this decision will be final.
- (9) 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.
- (10) In addition to the factors found in O.C.G.A. § 33-20E-15, in deciding a claim, arbitrators should also consider the following factors:

- 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.
- (11) Following the resolution of arbitration, the Commissioner is permitted to refer the decision of the arbitrator to the appropriate state agency or the governing entity with governing authority over such provider or facility if the Commissioner concludes that a provider or facility has either displayed a pattern of acting in violation of this chapter or has failed to comply with a lawful order of the Commissioner or the arbitrator. However if the provider or facility's violations or actions fall under the Commissioner's jurisdiction, the Commissioner may investigate and proceed under the provisions of Title 33.
- (12) Each resolution organization contracted with by the Department should submit its quarterly reports to the Administrative Procedure. In addition to the information required by O.C.G.A. § 33-20E-19, each resolution organization will also submit in its quarterly report: the name of each arbitrator who settled a dispute, and the number of disputes they settled in favor of either the insurer or the provider or facility.

120-2-106-.11 Hospital Surprise Bill Rating

Insurers shall make available online and in print a health benefit plan surprise bill rating for hospitals as required in Chapter 20C, of Title 33. For each hospital, health benefit plans shall clearly display a rating denoting the health benefit plan surprise bill rating factor. This factor shall range from 0 denoting no specialties are in network to 4 which means all specialty groups are in network. For any rating less than 4, the health benefit plan shall display which specialty group is not in network by marking the specialty with a red **X** and any specialty group that is included by a green check mark **X**. If a hospital does not provide one of the qualified hospital based specialties, the absence of that specialty shall be designated by a green N/A. The factor and markings shall be clearly displayed for the covered person or potential covered person to easily understand. Qualified hospital based specialty groups are medical groups that include anesthesiologist, pathologist, radiologists or emergency medicine physicians. Any

changes in the in the hospital rating factor shall be changed by the health benefit plan within 30 days.

120-2-106-.12 Severability

If any section or any portion of a section of this Regulation or the applicability thereof to any waiver or circumstances is held invalid by any court of competent jurisdiction, the remainder of the rules or applicability of such provisions shall not be affected.