America's Health
Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite 500 (Rundle)
Washington, DC 20001

202.778.3200
www.ahip.org

November 12, 2020

Attention: Gregg Conley, Executive Counsel
Office of the Commissioner of Insurance
Administrative Procedure Division
704 West Tower, Floyd Building
2 Martin Luther King Jr. Drive
Atlanta, GA 30334

Email to: gconley@oci.ga.gov

RE: AHIP Comments on Surprise Billing Proposed Regulations 120-2-106

Dear Mr. Conley,

America's Health Insurance Plans (AHIP) appreciates the Office's efforts to protect consumers from arbitrary and inflated surprise medical bills, and wishes to provide comments on Surprise Billing Proposed Regulations 120-2-106. AHIP believes in a balanced approach that protects patients from surprise bills, provides for fair and reasonable payment to non-contracted providers, and provides for a dispute process when providers think they have not been accurately paid. We believe the solution should rely on the reasonable rates negotiated by the free market and ensure networks can continue to play an important role in delivering high quality and lower costs.

We applaud the efforts made in HB 888 to protect consumers by prohibiting OON providers or facilities from balance billing patients for emergency services or non-emergency services. Most surprise bills emanate from a small subset of medical specialists who lack financial incentives to participate in networks since their patient volume is driven by the steady flow of patients coming through hospital doors. This market dynamic has been exacerbated since private equity firms have identified surprise medical bills as a business strategy upon which they can capitalize. Recent studies reveal that firms are purchasing provider practices and driving up health care costs.

AHIP remains concerned about the arbitration approach prescribed in the legislation and regulations. Arbitration can still increase costs and foster uncertainty because it does not address the root cause of surprise bills – highly inflated prices from certain medical specialty providers. It adds administrative costs to the health care system by creating a massive new bureaucratic process – costs to be borne by state government, plans and providers, as well as consumers who

see administrative costs factored into premiums (as required by state financial solvency requirements). In states that have explored arbitration as a solution, it has slowed down the claims process, limited payment predictability, exacerbated patient aggravation, created perverse provider incentives to remain OON, and led to instances where OON providers have gamed the arbitration process in order receive payments that exceed billed charges.

The process for submitting claims for arbitration outlined in statute (§33-20E-9) should be more operationally feasible and include disincentives to abuse the process. We propose implementing a threshold amount (e.g., $2,500) for claims eligible for arbitration, limited batching of claims, and restrictions on repetitive use (e.g., a cooling off period). Placing guardrails around the arbitration process is necessary to mitigate the likelihood that patients will see unnecessarily high costs as a result of this new bureaucratic system.

Additionally, AHIP remains concerned about the vendor selection for calculating verifiable median contracted amounts paid by insurers, with the possibility of benchmarking that could include billed charges in this arbitration determination process. On behalf of health insurance providers and the consumers we serve, we have been working across the states and with Congress to find solutions to alleviate the financial burdens imposed on patients by surprise medical bills, which affect at least one in five Americans annually. Approaches that require insurers to pay OON providers based on methodology that uses billed charges means that payment amounts would have no guardrails and no reasonable parameters and would allow providers to charge whatever fee they choose. A system based on billed charges typically leads to health care purchasers - employers, taxpayers and health insurance providers - paying far more than negotiated rates for care, which increases premiums for everyone.

Reimbursement to OON providers should not be based on a methodology that uses billed charges. We support a benchmark approach which promotes affordable care, reasonable reimbursement and market stability. AHIP believes reasonable reimbursement is based on a market rate or what the market is already paying for services (i.e., accepted rates, contracted rates, or government payment fee schedules). Billed charges are generally higher than the amount paid to providers under negotiated health plan contracts, or Medicare or Medicaid payment rates. A study using Georgia-specific data from FAIR Health revealed average billed charges at up to 1099.2% of Medicare reimbursement rates[1].

Recently, the Texas Department of Insurance selected FAIR Health as the benchmarking database for their arbitration process established by legislation (SB 1264). We understand that FAIR Health has benchmarking modules that include either billed charges or maximum allowed amounts for reimbursement of provider charges. The Department's Six-Month Preliminary Report on the implementation of SB 1264 shows that of the over 8,000 requests submitted for arbitration, those settled through arbitration have an average awarded amount much closer to the average billed charge.

In the absence of an all payer claims database or vendor selection to determine median contracted amounts paid--as provided in Section 120-2-106-.09—it is imperative that an interim

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[1] Charges Billed by Out-of-Network Providers: Implications for Affordability. Page 13. America's Health Insurance Plans. September 2015. Available at https://www.ahip.org/wp-content/uploads/2015/09/OON_Report_11.3.16.pdf.

plan be established regarding the verifiable median contracted amount benchmark. In the absence of an interim plan, we believe the Office will be inundated with requests for review, leading to delays in claims payments, further burdening our already stretched health care system. We recommend that the approach taken be feasible for insurers to implement and configure their business operations to ensure compliance given the quickly approaching effective date.

Thank you for considering our concerns and recommendations as you address surprise medical bills. We hope to continue to work with you towards solutions to alleviate the financial burdens that surprise bills impose on consumers and to improve health care affordability for Georgians. If you have any questions, please do not hesitate to contact me at mosman@ahip.org or 202-861-1474

Sincerely,

Mara Osman
Senior Regional Director

America's Health Insurance Plans (AHIP) *is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers. Visit www.ahip.org for more information.*

Holland & Knight

1180 West Peachtree Street, Suite 1800 | Atlanta, GA 30309 | T | F 404.881.0470
Holland & Knight LLP | www.hklaw.com

Victor Moldovan
+1 404-898-8120
Victor.Moldovan@hklaw.com

November 11, 2020

Via E-mail (gconley@oci.ga.gov)

Mr. Gregg Conley
Administrative Procedure Division
704 West Tower, Floyd Building
2 Martin Luther King Jr. Drive
Atlanta, GA 30334

Re: Proposed Regulation for Surprise Billing Rule 120-2-106

Dear Mr. Conley:

This letter addresses the promulgation of rules by Office of Insurance and Safety Commissioner ("OCI") to implement HB 888, the "Surprise Billing Consumer Protection Act" (the "Act"). We represent the Private Practice Physicians Association, Inc. and their member physician practices (the "Practices") that opposed the passage of the Act and continue to question its legality under the Georgia Constitution and statutes. The State should not set rates for contracts between private parties when no government funds are used. The Practices contend that the Act is unconstitutional under the federal and state constitutions taking clauses, due process and the freedom of speech. (Ga. Const. Article I, Section I, paragraphs I, II, IV; U.S. Constitution, Amendment I, Amendment XIV) However, we recognize that OCI does not have the authority to question the legality of the Act. It must implement the ASC as passed. As a result, the following suggestions focus on the scope of the regulations and language that will help minimize the potential to the Practices.

1. The Practices have significant concerns that the Act effectively renders meaningless the contracts they have with payers today. As you know, the Act is not limited to emergency care. Under Section 33-20E-5, any provider that provides nonemergency services that is out-of-network must accept the "Contracted Amount" (i.e., the Act defines it as the 2017 median in-network payment by the Plan). Plans could simply cancel all of their network contracts that have a higher rate than the Contracted Amount which would result in all of those providers being out-of-network. The regulations should include a prohibition on "Healthcare Plans cancelling or not renewing a network contract with a provider because the Plan wants to use the Contract Amount.

The fact that the Act says that the Healthcare Plan must pay the nonparticipating provider the amount that the Plan paid the provider when it was in-network if its higher than the Contracted Amount does not resolve the concern. (Section 33-20E-5(b)) Healthcare Plans have dozens of

products. The Plans have network contracts with a provider for each product. The products change continuously. Healthcare Plans could take the position that the most recent in-network rate paid to a provider when it was participating was for a specific product and that product is not the same product that covers the patient who was treated when the provider became nonparticipating. Thus, the Plan would argue that because the provider had no prior in-network rate the Plan will pay the "Contracted Amount."

The regulations should prohibit that kind of gamesmanship. Proposed Rule 120-2-106-.05 and 120-2-106-.06 should say that the "most recent verifiable amount paid" when the provider was in network should be defined as the highest amount paid for any product when the provider was in network.

2. The Plans can easily manipulate the payment amount by selecting the information to use when calculating the "Contracted Amount." We continue to be concerned that the Plans will have a race to the bottom on payments. The amount paid by the Plan in 2017 for in-network providers depends entirely on what plans were in place for a geographic service area. The Plan could select the product that had the lowest amount and claim that is the median. The Plan could use a product that has no or limited beneficiaries and use the amount paid under that product as the median. The Plan could take the position that it is using the median payment for all of its products that will result in the Practices actually getting paid less than their current network contract dictates.

Proposed Rules 120-2-106-.05 and 120-2-106-.06 should prohibit (i) the Plans from cancelling or not renewing a network contract in order to allow the Plans to pay a lower amount and (ii) the manipulation of payment data to support a lower payment rate.

3. The Act suggests that the nonparticipating provider should collect the amount of co-pay dictated by the patient's Plan when the provider is out-of-network. That means that the patient will pay a higher co-pay because it is typically higher (sometime significantly higher) than the in-network rate. The Plan, however, is required to pay only the "Contracted Amount" which is a product of in-network payments to providers. The end result is that patient actually pays more and the Plan pays less when the provider is out-of-network. Yet, the premiums paid by the beneficiaries or their employers include out-of-network benefits.

OCI should adopt regulations that require the Payers to pay the out-of-network rate to providers when the provider is required to collect the out-of-network co-payment. That is consistent with the intent of the law.

4. The Act allows patients to choose an out-of-network provider under Section 33-20E-7. The provider is required to obtain written and oral consent and provide an estimate. Plans may use this provision as an excuse to pay only the "Contracted Amount" instead of the out-of-network rate. Proposed Rule 120-2-106-.08 should require the Plans to pay the out-of-network rate if the provider bills for it. The Plans should not have the right to assume the provider has not obtained the consents or provided the estimate. The regulations should require the payment of the out-of-network rate unless the Plan has evidence that the consents were not obtained and the estimate was

not provided. We are concerned that the payers will delay paying the amount billed until it receives what it believes are the appropriate documents required under the Rule. Nothing in the Act gives the payers that authority.

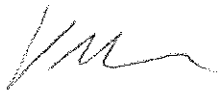
5. The regulations should make clear that the estimate of charges under 33-20E-7 is simply an estimate of charges not payment or final billing. The total bill may include items that have to be addressed during the procedure that were not itemized on the estimate, and the estimate does not represent what the provider may collect from a Plan or patient.

6. The database information requirement in Section 33-20E-8 should be implemented by OCI using transparent methods. Section 120-2-106-.09 says OCI will utilize a vendor to calculate the median contracted amount. The regulation should require OCI to make available to the public (by placing it on the website) the information used by the vendor to calculate the contracted amount to allow the public to verify it.

OCI should not contract with or rely on data submitted by an interested party or an association of interested parties or any vendor affiliated with interested parties. The regulations should allow providers the opportunity to challenge the Contracted Rate and allow them access to the source of the information used by OCI for the database.

Sincerely yours,

HOLLAND & KNIGHT LLP



Victor Moldovan

VM:cmb

National
Multiple Sclerosis
Society

November 12, 2020

Commissioner John F. King
Office of Insurance and Safety Fire Commissioner
Administrative Procedure Division
Two Martin Luther King, Jr. Drive
West Tower, Floyd Building
Atlanta, Georgia 30334

Re: Pharmacy Benefits Managers Regulation

Dear Commissioner King:

Thank you for your efforts to improve health outcomes for every Georgian. I am commenting on behalf of the National Multiple Sclerosis Society (the Society) regarding proposed pharmaceutical benefit manager rules that will impact all Georgians living with medical conditions which require treatment with prescription drugs, especially Georgians living with multiple sclerosis (MS).[1]

During the 2020 Legislative Session, the Society actively supported legislation to update PBM licensure, oversight, and penalties; strengthen existing anti-steering laws; increase transparency requirements added along with new patient protections including copay accumulator; extend protections to other dispensers; and enact a surcharge on PBMs that engage in steering or continue to engage in charging pharmacies point of sale or retroactive fees. As a result of this legislations' passage, it is now necessary for the Department of Insurance's rules reflect the legislative intent and stop PBMs and insurance companies from doing things that harm patients; lack transparency; put barriers between doctors and patients; and drive up the cost of healthcare.

The proposed rules are an important step to protecting Georgians from PBM practices that the General Assembly has determined should cease. We understand that the provisions of HB 946 and SB 313 are sweeping in their scope. These rules accurately address several of the core issues set forth in the new law and provide a mechanism for transparency, investigation, and enforcement. **As such, we thank you and respectfully request that you proceed with adoption and enaction of Proposed Rules 120-2-97-.02; Rule 120-2-97-.03; Rule 120-2-97-.05; Rule 120-2-97-.06; Rule 120-2-97-.07; and Rule 120-2-97-.08.**

We encourage you to consider adding provisions to the rules regarding ensuring that PBMs annually submit

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[1] Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity, and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. Early and ongoing treatment with a disease modifying medication is the best way we know to slow the progression of MS, prevent the buildup of disability, and protect the brain from damage due to MS. While there are approximately 20 DMTs available, they are not interchangeable, and we do not yet know which medication will work best for each person. Only one generic DMT exists and its dosing regimen significantly differs from its brand name counterpart. MS is an expensive disease to live with and treat, impacting the healthcare system, health plans and of course, families affected by MS. The median price for DMTs continues to increase—in 2019 it was $88,853. A recent study showed that MS DMT costs nearly tripled over the last 7 years. The $88,853 number is just for a disease modifying therapy and does not consider the costs of other often used medications to control and treat MS symptoms and comorbidities Disease modifying treatments (DMTs) are approximately 75% of the cost of treating MS.

National
Multiple Sclerosis
Society

information reflecting compliance with Section 3 of the legislation dealing with physicians employed or contracted with pharmacy benefits managers as well as provisions related to copay assistance for patients.

Please require PBMs to provide the necessary records to assist investigators in connection with complaints that a PBM has failed to apply copay assistance when required by law. The copay issue featured prominently during the legislative session with patient groups and providers, including individuals living with MS, emphasizing how harmful copay accumulator practices can be to sick patients who are on specialty medications.

Copay accumulator adjustment programs began from the belief that drug manufacturers' patient assistance programs are discouraging patients and their doctors from choosing generics or less-costly prescription drug alternatives. These programs are used to prohibit prescription drug coupons or other forms of prescription drug manufacturer assistance from applying towards a patient's annual deductible or out-of-pocket maximum amounts. A recent study funded by the Society found that approximately 70% of people living with MS relying on DMTs receive some type of assistance like the patient assistance programs mentioned in the legislation.

With the implementation of copay accumulator adjustment programs, people with MS are experiencing higher cost burdens as they struggle with unexpected expenses during their deductible period. This hardship is made worse by copay accumulator adjustment programs because preventing copay assistance from applying to a person's deductible means it takes them longer to reach the end of the deductible period. Because patients are responsible for 100% of their health care costs until the deductible is satisfied, prolonging the deductible period can put other medical needs—such as doctors' visits, rehabilitation therapies, MRIs, or other medications—financially out-of-reach. Copay accumulator adjustments primarily impact people who need financial assist to obtain their needed medication. According to a recent survey, 40% of people with MS alter or stop taking their disease modifying treatment (DMT) due to cost.

The National Multiple Sclerosis Society has called on all stakeholders in the prescription drug supply chain to come together and find real solutions to escalating price increases, barriers to care and a system too complex to navigate. It is important to note that less than 5% of the Society's annual revenues come from pharmaceutical companies. We do not take any corporate funding tied to our advocacy issues or outcomes.

The National MS Society supports solutions that help Georgians access life-changing medications without getting them caught in the middle of struggles between other stakeholders. We again thank you for your leadership and work in promulgating these rules. If you have any questions, please contact me at heather.breeden@nmss.org or 404-213-6052.

Sincerely,

Heather Breeden, JD
Senior Manager of Advocacy
National Multiple Sclerosis Society

11/12/2020

Gregg Conley
Georgia Department of Insurance
Administrative Procedure Division
704 West Tower, Floyd Building
2 Martin Luther King, Jr. Drive
Atlanta, Georgia 30334

Mr. Conley,

I am writing to provide comment regarding the Georgia Department of Insurance's proposed Surprise Billing Regulation 120-2-106. Specifically, I am looking to address the Department's proposed promulgation of rules under the 120-2-106-.11 Hospital Surprise Billing Rating subsection.

The Georgia General Assembly passed, and Governor Kemp signed into law, House Bill 789 during the 2020 legislative session. House Bill 789 (2020) created a system for insurers to indicate whether certain hospital based specialty groups are in network, out of network, or are not provided by a hospital. This system provides for the use of green check marks, red x marks, and green N/A marks to illustrate the hospital based specialty group's network status or lack of existence.

Lines 32 – 38 of House Bill 789/AP provide the following:

> *"Each checkmark indicates the presence of a in-network particular type of qualified hospital based specialty group. An X-mark indicates the absence of an in-network particular type of qualified hospital based specialty group. 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 mark. Any color advertisement which includes a health benefit plan surprise bill rating shall use green checkmarks, red X-marks, and green N/A marks.".*

Effort was given by the legislature to avoid designing a system that creates an undue negative perception for a hospital that does not provide certain specialties due to the nature of their medical focus. This is evident by looking at the legislative history and the explicit avoidance of that issue through legislative drafting and comments made by legislators during committee hearings.

The Georgia State Senate Health and Human Services Committee considered House Bill 789 during their committee meeting held on 06/17/2020. The Senate video archive of the committee can be found at the following link. https://livestream.com/accounts/26021522/events/8730585/videos/207589656

During the committee hearing, Representative Mark Newton, Chairman of the House Special Committee on Access to Quality Health Care and author of the legislation provided the following commentary.

> *[12:40] "What this does, it establishes a surprise bill rating system, House Bill 789 does. So whenever an insurance company tells you that a hospital is in-network, they have to add one bit of information. Which is, of those four specialties, are they in-network. That's pathology, radiology, E.R., and anesthesiology, the ones you can't pick. And if they're all in-network at this hospital you want to go to, whenever they say this hospital is in-network, they will have this surprise bill rating that will be four (4) checks, if it's in color it will be four (4) green checks."*

> *[13:40] "House Bill 789, if it goes into effect, will require insurance companies, whenever they mention that a hospital is in-network, to also delineate its surprise bill rating, and obviously what you're looking for, we're trying to coax people into looking for four (4) green checks, that's what we want."*
>
> *[14:23] "So what this bill would do, if you look on line 29, it's a health benefit plan surprise bill rating, and that's what you're going to get, you're going to get those four (4) green checks, that's what you're really going to be looking for. If there is a red x, they're going to have to explain, that means emergency medicine is out of network at this hospital.*
>
> *[16:34] "Shepherd Spinal Center* [sic] *doesn't have an operating room, they don't have anesthesiology, so we don't want them to get a red x and have it look bad, even though they're an in-network facility. We have a green N/A if it's not applicable...we're not trying punish anyone, we're trying to encourage."*

We are concerned that the proposed regulations in 120-2-106-.11 creates a system that is inconsistent with the text and intent of the law.

The proposed regulation in 120-2-106-.11 Hospital Surprise Billing Rating subsection provides:

> *"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 proposed regulation creates a numerical system in addition to the green check mark, red x mark, and green N/A mark system described by law. While the legislature explicitly worked to ensure that its system did not negatively impact hospitals for not having a certain hospital based specialty group, the proposed regulatory system does just that. The legislation did not provide for a numerical "health benefit plan surprise bill rating factor." Certain hospitals, due to the type of care they provide, could never achieve a 4 in the scoring system described in the proposed regulation and would thus be subjected to undue negative perceptions.

It is our view that regulatory language that provides for a system of green check marks, red x marks, and green N/A marks without creating an additional new numerical scoring system would be a better fit and in line with the law.

Please let me know if I can address any questions. I appreciate your consideration of this matter.

John T. Smith
Director, Government Relations & Advocacy
Shepherd Center
john.smith@shepherd.org

Emergency Department ED PMA Practice Management Association

November 9, 2020

Via Email
Gregg Conley
Administrative Procedure Division
704 West Tower, Floyd Building
2 Martin Luther King, Jr. Drive
Atlanta, Georgia 30334
gconley@oci.ga.gov

Re: 120-2-106 Surprise Billing

Dear Mr. Conley:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, **EDPMA's members deliver (or directly support) health care for about half of the 146 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

Thank you for requesting stakeholder input on proposed regulations implementing House Bill (HB) 888/Senate Bill (SB) 359. We are pleased that that the law takes patients out of the middle of reimbursement disputes and creates a dispute resolution process. The law took years of negotiation to craft so implementing a law that works for patients is paramount. Therefore, we recommend several important changes to the proposed regulation:

1. Improve the Effectiveness of Arbitration

The Process

The arbitration process is clearly defined in law, however, the rule lacks considerable substance on the actual "process" emergency physicians and their billers intend to use. We recommend adopting timelines, an arbitration website portal model, and other details that are similar to those that were adopted in Texas[1]. We also ask that the rule clarify the time period in which insurers are required to submit their best and final offer for the arbitrator to consider. Further, the

[1] Texas SB 1264 Arbitration FAQ's

arbitration criteria that references "circumstances and complexity of the cases" and the" usual and customary cost" are vague and must be defined. We recommend using the definition of "usual and customary charges" and base this definition on an unbiased, unafflicted database like FAIRHealth. It is important to understand that it would be inappropriate to utilize an algorithm to calculate reimbursement for complicated and complex cases and an algorithm that is based on final diagnosis would actually violate both federal and state laws that incorporate the important patient protection referred to as the prudent layperson standard (PLP). The rules should clarify that decisions related to these cases must be based on the presenting symptoms, so the medical record must be reviewed.

Batching

Fortunately, the law[2] addresses various bundling (batching) scenarios for emergency department (ED) claims. Batching of similar claims should be permitted in order to reduce everyone's costs and improve efficiency. Specifically, the law states that an arbitration request may involve:

1. a single patient and single type of healthcare services,
2. a single patient and multiple type of healthcare services,
3. multiple patients and a single type of healthcare service, or
4. **multiple substantially similar healthcare services in the same specialty on multiple patients.**

By the law excluding a monetary threshold for batching, the dispute process is accessible to emergency physicians. Physicians with the same federal tax identification number (TIN) should be allowed to batch similar claims. Two-thirds of emergency departments are staffed by independent physician groups and those groups collect reimbursement and pay physicians according to their contract. The individual physician is often not involved in collection disputes because they are busy treating patients. In the Medicare program, the emergency physician group is treated as the "billing provider[3]" since it is the entity with the one Tax Identification Number (TIN) that is billing and collecting the physician fee. Following this Medicare precedent makes good sense because it would ensure more providers are reimbursed at a sustainable rate, improve efficiencies, and protect patient access to care.

Other Important Considerations

Further, under Georgia's new law, the party whose final offer is not selected must pay the amount of the verdict, which includes arbitrator expenses and fees. However, the proposed rule confusingly states that the provider is liable for half the arbitration costs. **This language needs to be removed.** It not only conflicts with the statutory language, but it would also allow commercial insurers to significantly under-reimburse emergency physicians with impunity. This, in turn, would likely reduce patient access to timely emergency care.

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[2] GA HB 888, 33-20E-9

[3] CMS 1500 Health Insurance Form, Box 33

2. Amend Reimbursement Discrepancies Between the Rule and Law

Payment

The law[4] is clear on what insurers must reimburse an OON provider. Insurers must pay the greater of (emphasis added):

> 1. The verifiable contracted amount paid **by all eligible insurers** subject to the provisions of this chapter for the provision of the same or similar services as determined by the department;
> 2. The most recent verifiable amount agreed to by the insurer and the nonparticipating emergency medical provider for the provision of the same services during **such time as such provider was in-network with such insurer**; or
> 3. Such higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

The proposed rule limits the term "most recent contracted amount" to the most recent 6 months. This not only conflicts with the clear intent of the law, but it also encourages commercial insurers to cancel current contracts quickly to remove those contracted rates from future calculations. The Texas Department of Insurance (TDI) recently released a six-month report[5] on the effectiveness of the new law[6]. It reports that most arbitrated claims were emergency claims. It also found that, **on average, for the claims that were taken to arbitration, the plans were found to be paying more than five times less than they should have paid.** The average amount billed by providers was $1611, the insurer's average initial payment was $191, and arbitrator found that payment, on average, should have been $1016. **This report illustrates the high likelihood that commercial insurers will significantly underpay emergency providers in Georgia if the important protections provided in the statutory language are weakened through regulation.**

Other Important Considerations

It is important to note that due to the federal mandate to provide emergency medical care to all patients, regardless ability to pay (the Emergency Medical Treatment & Labor Act (EMTALA)[7]), emergency providers have no leverage with which to negotiate a fair network rate. Insurance plans can dictate their "most recent contracted amount" by offering low "take it or leave it" in-network rates. In order to protect against abuse, the rule should reference the median contracted rate in the geographic area and not the individual insurer's rate. Finally, we recommend that the rule use the CPI's medical index instead of CPI because it reflects the true cost to the provider of providing medical care.

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[4] GA HB 888, 33-20E-4 (b)(1-3)
[5] Senate Bill 1264: Six-month preliminary report, Texas Department of Insurance, July 2020.
[6] TX Senate Bill 1264 (2019).
[7] http://www.edpma.org/downloads/2020EMTALA.pdf

3. Protect the Prudent Lay Person Standard

Medically Necessary Services

Insurers continue to implement policies that violate the prudent layperson standard (PLP) by down coding claims based on a diagnosis lists, always pay lists, or other algorithms to deny or pay physicians less (downcoding) for emergency services. **CMS has already provided guidance on this issue (emphasis added). As CMS has clearly stated in the Medicaid Managed Care Rule 2016:**

> *"we prohibit the use of codes (either symptoms or final diagnosis) for denying claims because we believe there is no way a list can capture every scenario that could indicate an emergency medical condition under the BBA provisions. ... The final determination of coverage* ***and payment*** *must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens."* [8].

When EDPMA wrote to CMS on these policies; CMS responded and reiterated:

> *"Whenever a payer (whether an MCO or a State) denies coverage* ***or modifies a claim for payment,*** *the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must make take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional)*[9].
> *This State Medicaid Director letter is still in effect and can be found at:*
> http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html "

Federal law extends this same protection to commercial plans, so it would be wise for the department to include this guidance into the rules, but more importantly enforce federal protections when insurers implement policies that violate PLP. Further, we urge regulators to include financial penalties for implementing algorithms or policies that violate the PLP standard.

4. Alleviate Database Discrepancies

Unavailable All Payers Claim Database (APCD)

The law references that a state shall maintain a database and maintain records of insurer payments. However, we are concerned that appropriations are not available to create an APCD. Eighteen states have passed laws creating APCD's and a few of those states require arbitrators or state regulators to reference the APCD to resolve payment disputes between providers and insurers. However, due to the irregularities in most state APCD's, Georgia and Maine[10] wisely

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[8] *Managed Medicaid Rule 2016*
[9] *3/15/18 CMS Response Letter*
[10] ME LD 2105 (2020), Sec. 3. 24-A MRSA §4303-E, 1C (3).

included provisions in legislation stating if the data in the state APCD is insufficient, state regulators may select an unbiased, unaffiliated alternative database to determine payment standards. **We request the department include a similar provision in the final rule that designates FAIRHealth as an alternative to verify all data submitted by insurers. It is also important to note that FAIRHealth is already being utilized in Alaska, Connecticut, New Mexico, New York, and Texas.** More importantly, the rule lacks the "nuts and bolts" of the state's process of collecting data from insurers. The rules are also silent on the due diligence that will be enacted by the state to ensure that data submitted by insurers is verifiable, not cherry-picked, and HIPAA compliant. We urge you to include financial penalties for bad actors.

5. Expand Plan Transparency

Providers – who are charged with collecting the patient's financial contribution – often do not know what type of plan is covering the claim and, therefore, do not know what patient protections apply to the claim. Many commercial insurers make it very difficult for providers to find out this essential information. A simple fix that would help ensure that patients are not charged too much, is to require all plans in the state to disclose the type of plan to providers in the plan number. For instance, ERISA plans could be identified by adding a "-E" at the end of the policy number. Some plans already encode information in their policy numbers, yet the meaning of these codes is not shared with providers. Transparency improves the efficiency of the process and ensures a level playing field.

Other Important Considerations

We urge you to study the proposed hospital surprise bill rating system before implementing it. The ratings may unnecessarily impact staffing and contracting in the state. The department may want to appoint a stakeholder group, that includes emergency physicians, to study the impact further.

Thank you for considering our comments. Please feel free to reach out with any questions.

Sincerely,

Bing Pao, MD, FACEP, Chair of the Board
Emergency Department Practice Management Association (EDPMA)

cc: John F. King, Georgia Insurance Commissioner

November 12, 2020

Via Email: gconley@oci.ga.gov

John F. King, Commissioner
Office of the Commissioner of Insurance
Administrative Procedure Division
708 West Tower, Floyd Building
Two Martin Luther King, Jr. Drive
Atlanta, Georgia 30334

Re: Proposed Rule 120-2-106 "Surprise Billing"

Dear Commissioner King:

On behalf of our 161 members, the Georgia Hospital Association (GHA) appreciates the opportunity to submit comments on the Office of the Commissioner of Insurance's (OCI's) proposed Rule 120-2-106 regarding surprise billing (the "Proposed Rule"). GHA appreciates the significant work of state policymakers over the last eight plus years which resulted in House Bill 888, the *Surprise Billing Consumer Protection Act* (the "Act" or "HB 888"). We support the Act and are generally supportive of the Proposed Rule implementing its requirements. However, given the complex nature of health care reimbursement and of the surprise billing issue in particular, we offer the following comments and request the following clarifications:

Enforcement and Interpretation Generally

As noted in Section 120-2-106-.02 of the Proposed Rule, HB 888 "was passed to provide a mechanism to resolve billing and payment disputes between insurers and out-of-network providers." It is meant to take the patient out of the middle of these disputes and should, therefore, be interpreted broadly to favor the patient in any coverage or payment determination.

The Act is effective Jan. 1, 2021. However, O.C.G.A. § 33-20E-12 does not require the Commissioner to have a contract in place with a resolution organization until July 1, 2021. It will take time for the Commissioner to identify and contract with a vendor to calculate the verified contracted amounts required by O.C.G.A. §§ 33-20E-4(b) and 5(b).[1] Until the vendor contract is in place, health care providers will not have access to the information necessary to verify whether an insurer has paid a claim in accordance with the requirements of HB 888. Furthermore, if an out-of-network emergency services provider has been paid less than the cost of care, they would have no recourse because O.C.G.A. § 33-20E-4 prohibits the provider from billing the patient anything other than the patient's co-pay, deductible or other cost-sharing amount. Without the ability to

[1] Per Section 120-2-106.09 of the Proposed Rule the Commissioner will contract with a vendor to calculate the median contracted amount because the state has not yet provided funding to establish an all payer claims database.

Georgia Hospital Association
1675 Terrell Mill Road, Marietta, Georgia 30067 / Phone: 770-249-4500 / Fax: 770-955-5801 / http://www.gha.org

request arbitration through a resolution organization, the purpose of the of the Act is frustrated, and there is no incentive for insurers to pay out-of-network claims in a fair and reasonable manner. **GHA respectfully requests enforcement of HB 888 and the Proposed Rule be delayed in the interim until a resolution organization is selected.**[2]

Definitions

Contracted Amount – For purposes of determining the "contracted amount" GHA recommends comparisons be made only between the same specialty or subspecialty. For example, comparing the amount paid to a pediatrician and a neonatologist, which is a subspecialty of pediatrics, would not be appropriate.[3] GHA recommends revising the definition of contracted amount to read:

> "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 <u>or similar specialties and subspecialties where applicable</u>, 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.

Date of Receipt – For purposes of calculating the 30-day timeframe that an out-of-network provider or facility has to initiate a request for arbitration under OCGA § 33-20E-9(a) and Section 120-2-106-.10 of the Proposed Rule, GHA recommends the "date of receipt" of payment for the claim be defined as 30 days from the date the payment is posted to the provider or facility's bank account (if paid electronically) or the date the payment is received by the provider or facility (if mailed).

Most recent contracted amount – When a contract between a group practice of providers and health care plan is in place, it is not uncommon for a delay to occur between the time such practice notifies the plan of the addition of a new provider to the group and the time that provider's information is loaded into the plan's claim system. This can result in some providers' claims being paid as in-network while others are paid as out-of-network even though the contract is between the health plan and the provider group. To protect patients and avoid processing these claims as out-of-network, GHA

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[2] The Commissioner took similar action regarding the implementation of House Bill 789, the *Surprise Bill Transparency Act*. This law became effective Nov. 1, 2020. However, in Bulletin 20-EX-10, the Commissioner used his enforcement discretion to announce he would not initiate any regulatory actions against insurers prior to Jan. 1, 2020.

[3] A list of specialties and subspecialties is available on the Association of Academic Medical Centers website at: https://www.aamc.org/cim/explore-options/specialty-profiles

recommends expanding this definition to require payment at the rate specified in an existing group contract:

> "Most recent contracted amount" means a participating provider agreement in-force within the ~~six (6)~~ twelve (12) months preceding the claim date of service with the individual provider or provider's group practice, as applicable.

Out-of-Network, Non-participating Provider, Participating Provider – GHA recommends clarifying these terms to recognize that a provider may have a contract with a particular health plan, but that does not mean that the provider is in-network or participating in all of the networks associated with the health plan, including the one utilized by a particular covered person.[4] This often occurs with health plans that create new, narrow networks to exclude providers from the network available to covered persons even though those providers have a contract with the health plan. For example, a provider that has a contract with Health Plan A may be a participating provider in Health Plan A's XYZ network, but a non-participating provider in Health Plan A's 123 network.

GHA recommends revising these definitions to read:

> "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 applicable to such covered person.
>
> "Non-participating provider" means a healthcare provider who has not entered into a contract with a healthcare plan for the delivery of medical services in a covered person's provider network.
>
> "Participating provider" means a healthcare provider that has entered into a contract with an insurer, either individually or through a provider group, for the delivery of healthcare

[4] Providers often do not know whether the plan has excluded them from a particular network until they submit a claim. When a provider and a health plan execute a participation agreement, it may contain a list of networks in which the provider will participate. However, the health plan often has the right to add to this list over time or change the name or type of networks in which the provider participates. When a patient presents his or her insurance card, the provider often cannot tell whether they are in-network. O.C.G.A. §§ 33-20E-4 and 5 prohibit providers from billing patients any more than their "deductible, coinsurance, copayment, or other cost-sharing amount *as determined by [the patient's] policy directly*" (emphasis added). These code sections also make clear that for purposes of calculating the patient's cost-sharing amount, the plan shall treat the services as if they were provided by a participating provider or facility, as applicable. To effectively implement these provisions of the Act, health plans will also need to comply with the provisions of O.C.G.A. § 33-20C-1 *et seq.* regarding accurate provider directories.

> services to covered persons under a healthcare plan's provider network applicable to such covered persons.

Emergency and Non-Emergency Medical Services

For providers in a group practice, it is often the group practice that contracts with a health care plan rather than each individual physician. Accordingly, GHA recommends revising Sections 120-2-106-.05(2)(b) and .06(2)(b) to read:

> (b) The most recent verifiable amount agreed to by the insurer and the non-participating [emergency or non-emergency] medical provider for the same services during which time the provider or, as applicable, the provider group that contracts for the provider, was in-network with the insurer; (if applicable)

Section 120-2-106.06(5) of the Proposed Rule covers the provision of non-emergency medical services received from a non-participating facility. However, HB 888 only regulates provider billing of non-emergency medical services in situations where a "surprise bill" may arise. Instances where a patient may unknowingly receive non-emergency hospital services from an out-of-network facility are fairly limited. Typically, patients only receive care at an out-of-network hospital by choice or in an emergency. For this reason, the General Assembly sought to regulate hospitals and other health care facilities under O.C.G.A § 33-20E-4, which covers emergency medical services, but not under O.C.G.A. § 33-20E-5, which covers non-emergency medical services. Therefore, **GHA recommends the Commissioner delete Section 120-2-106.06(5) in its entirety so as to remain consistent with O.C.G.A. § 33-20E-5 and legislative intent.**

Claims Database

Section 120-2-106.09 of the Proposed Rule indicates the Commissioner will contract with a vendor to calculate the median contracted amount because the state has not yet provided funding to establish an all payer claims database. **GHA strongly encourages the Commissioner to choose a vendor completely independent from the insurance industry.** In order for both providers and insurers to trust the accuracy of the median contracted amount, the selected vendor must be transparent and conflict free.[5]

Arbitration

Section 120-2-106-.10(6) indicates the Commissioner will contract with a resolution organization(s) for the claim dispute process as required in O.C.G.A. § 33-20E-12. GHA recommends this organization(s) have experience in handling health care payment

[5] FAIR Health is perhaps the most well-known independent claims database. According to its website, FAIR Health was founded in 2009 as part of a settlement agreement with insurance companies after an investigation into perceived conflicts of interest involving the adjudication of claims.

matters. For example, the American Health Lawyers Association Dispute Resolution Services or JAMS Healthcare Medication, Arbitration and ADR Services.

O.C.G.A. § 33-20E-9(b) allows providers and facilities to request arbitration for claims involving "a single patient and a single type of healthcare service, a single patient and multiple types of healthcare services, multiple patients and a single type of healthcare service, or multiple substantially similar healthcare services in the same specialty on multiple patients." **GHA recommends the Commissioner add a paragraph to Section 120-2-106-.10 of the Proposed Rule to clarify that the deadline to initiate a request for arbitration of claims related to multiple patients or services is based on the date of receipt of payment for the last claim to be paid.**

Section 120-2-106-.10(10) of the Proposed Rule lays out factors to be considered by the arbitrator. In addition to the specific factors provided in Proposed Rule, **GHA recommends the arbitrator also consider the type of space and equipment; amount and type of supplies; level of care; length of care; medical complications; non-payment of the patient's deductible, coinsurance, copayment or other cost sharing amount; and any other factors the arbitrator may deem relevant.**

Under O.C.G.A. § 33-24-59.5, health plans are required to remit payment for electronic claims within15 working days. If the health plan fails to make timely payment, the health plan is required to pay interest to the provider or facility in the amount of 12 percent per annum. Accordingly, **GHA recommends a paragraph be added to Section 120-2-106.10 of the Proposed Rule to clarify that when the arbitrator selects the provider or facility's offer amount, the health plan is required to remit payment to the provider or facility within 15 working days of receipt of the arbitrator's decision in accordance with O.C.G.A. § 33-24-59.5.**

Hospital Surprise Bill Rating

Section 120-2-106-.11 of the Proposed Rule implements House Bill 789, the *Surprise Bill Transparency Act*, the purpose of which is to provide patients and employers an easy way to determine if their in-network hospital-based physicians match up with their in-network hospitals, thereby creating an adequate provider network. To effectively implement this legislation, **GHA recommends health plans be required to list the network participation of qualified hospital-based specialty services at the physician practice or group level versus the individual provider level.** As noted above a physician group practice may be considered in-network by a health plan, but an individual physician in that group practice may not yet be credentialed or uploaded in the plan's systems.

HB 789 requires health plans to display green checkmarks and red x-marks to indicate whether a health plan's in-network hospitals match its in-network qualified hospital-

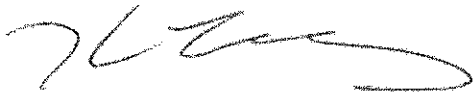
based physician specialty groups[6] and is therefore considered an adequate network. The Proposed Rule takes this one step further by requiring health plans to display a specific number rating of 0 – 4 depending on the number of checkmarks a hospital receives. This has the potential to confuse patients and disadvantage certain specialty or rural hospitals that do not provide all four qualified hospital-based services. If patients or employer-sponsored health plans look at the website and see that a hospital only has a rating of 3 out of 4 without reading the fine print, they may easily confuse this rating with a quality score. This potential confusion with a quality score is the reason HB 789 was amended by the General Assembly to require checkmarks instead of stars. **GHA recommends references to the 0 – 4 rating factor in Section 120-2-106-.11 of the Proposed Rule be deleted and the Section be revised to simply require health plans to post a green checkmark or red x-mark for each qualified hospital-based specialty group. As the Proposed Rule currently states, if a hospital does not provide one or more of the qualified hospital-based specialties, the absence of that specialty shall be designated with a green N/A.**

In addition, some hospitals, especially in rural areas, contract with more than one qualified hospital-based specialty group or even individual physicians to provide services to hospital patients. It is possible that one of these groups participates in a particular health plan network while the other one does not. The health benefit plan surprise bill rating should clarify whether all providers or groups of providers are in- or out-of-network.

****

Thank you for your consideration of GHA's comments. We would be happy to work with the OCI to address any of the requests or recommendations above. Please feel free to contact me at 770-249-4564 or kconley@gha.org with any questions or if you desire to discuss these comments further.

Sincerely,



Keri F. Conley
General Counsel and SVP, Healthcare Policy
Georgia Hospital Association

[6] O.C.G.A. § 33-20C-1(11) defines qualified hospital-based specialty groups as anesthesiologists, pathologists, radiologists, or emergency medicine physicians.

DELTA DENTAL

deltadentalins.com

November 12, 2020

Mr. Gregg Conley
Administrative Procedure Division, Office of Commissioner of Insurance and Fire Safety
2 Martin Luther King Jr. Dr SE Ste 704
Atlanta, Georgia 30334
(404) 463-0240 gconley@oci.ga.gov

RE: Comments on Proposed Regulation – 120-2-106 (Surprise Billing)

Dear Mr. Conley:

On behalf of Delta Dental Insurance Company (Delta Dental), which provides affordable dental benefits to more than 650,000 Georgians, thank you for the opportunity to provide comments on the proposed regulations related to House Bill 888 – the newly enacted law on surprise billing. As the Department of Insurance (Department) works to finalize these regulations, there is one section of the legislation we would appreciate clarification.

Section 120-2-106-.08.
The language in HB 888 (33-20E-7) and in proposed Section 120-2-106-.08 is clearly written with health plans in mind, and not dental plans. The section requires that a form of consent be obtained prior to services being performed by an out-of-network provider, in order to disqualify it as a "surprise bill" situation. This works in a health plan setting because this consent can be obtained by a contracted in-network provider who is making arrangements for services at an in-network facility (i.e., a hospital).

This is not possible in the typical PPO fee-for-service dental plan. Our PPO plans allow enrollees to seek services from either an in-network or out-of-network provider, at their choice and discretion. We encourage in-network services in order to take full advantage of the dental discount for which in-network providers are contractually obligated. But the enrollee is free to choose to seek care from out-of-network providers without prior approval, or even notice. As a result, a dental plan has no contractual leverage to require any form of patient consent by the out-of-network provider. We currently communicate an enrollee's right to a cost estimate prior to service and consider the voluntary choice of an out-of-network provider as consent to the services received. Please consider amending the proposed regulations to clarify the expectations of a dental plan in this regard.

Again, thank you for the opportunity to provide feedback for proposed regulation 120-2-106. Should you have any questions, please feel free to contact me at jalbum@delta.org or our legislative advocate, Bryan Fiveash at 404-223-2946, or bryan@fiveashstanley.com.

Sincerely,

Jeff Album

Jeff Album
Vice President, Public and Government Affairs
Delta Dental Insurance Company

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Telephone: 770-641-5100

KAISER PERMANENTE®

Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305
Writer's Direct Dial – (404)-423-9678

November 12, 2020

Via Email: gconley@oci.ga.gov

Mr. Gregg Conley
Administrative Procedure Division
Office of the Insurance Commissioner
704 West Tower, Floyd Building
2 Martin Luther King Jr. Drive
Atlanta, Georgia 30334

Re: Surprise Billing (HB 888) and PBM (SB 313) Regulations

Dear Mr. Conley:

Kaiser Permanente offers health plan care and coverage as the largest integrated health care system in the United States serving more than 12 million individuals. Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) is a licensed health maintenance organization with more than 300,000 members in its fully insured individual and group health plans. Kaiser Permanente Insurance Company (KPIC) is a licensed insurer with more than 10,400 enrollees in its fully insured group health plans in Georgia. Together, Health Plan and KPIC offer the following comments and recommendations on behalf of themselves and the Kaiser Permanente program to strengthen the protection afforded to Georgia consumers from surprise billing.

As a licensed health maintenance organization, Health Plan issues health plan coverage to individuals and groups that takes advantage of Kaiser Permanente's approach to the delivery of integrated health care services utilizing a dedicated group of providers, The Southeastern Permanente Medical Group (TSPMG), and selected community providers to augment the services rendered by Health Plan and TSPMG providers. To coordinate members' care, Kaiser Permanente providers access medical record information through KP HealthConnect, Kaiser Permanente's proprietary medical record system. Health Plan, itself and through Kaiser Foundation Hospitals, as well as TSPMG strategically contract with community providers, hospitals, physicians and other licensed providers to provide services to individuals enrolled in Kaiser Permanente health plans. This unique approach to the provision and arrangement of covered services means that, with the exception of emergency and urgent care services, very few services are provided through non-contracted (out-of-network) providers. Members who need care from non-contracted providers because, for example, they have a rare medical condition or need

access to services on an expedited basis do receive referrals to non-contracted (out-of-network) providers for non-emergency medical services. Nonetheless, most Health Plan members will receive non-emergency medical services through in-network providers as explained in their coverage documents. We do not read the requirements of H.B. 888 or its implementing regulations to impact this approach which is authorized by the HMO licensing requirements (Chapter 21 of Title 33).

Kaiser Permanente (Health Plan and KPIC) is diligently working to implement new operational policies and procedures to comply with the new payment requirements. The statute and regulations make clear that without an appropriation for the development of an all claims database, the Department must publish a verifiable median contracted amount for each service and item. Those amounts will then be the basis for payment for emergency and non-emergency medical services. To accomplish the necessary work to configure its claims payment systems so that timely payment may happen for 2021 dates of service, Kaiser Permanente and other payors are reliant on the Department to release the verifiable median contracted amount as soon as possible. In addition, we and other payors need direction regarding how to pay for those services and items for which there may be no verifiable median contracted amount. Having Kaiser Permanente's systems configured for dates of service after January 1, 2021, will be difficult unless the Department releases these amounts by the end of the month. Given this timeline, will the Department consider delaying enforcement of the new statutory scheme and/or giving payors 120 days to configure their systems once the Department releases the schedule of verifiable median contracted amounts?

Similarly, the required arbitration process may be invoked early in the first quarter of 2021. If the Department does not identify and contract with resolution organizations soon, then the arbitration process may be delayed. While this may incentivize payors and providers to negotiate more realistically in the first 30 days, it may also lead to a backlog of cases and ultimately to delayed payment. What will happen with disputes that arise prior to the resolution organizations being appointed and ready to consider disputes?

With regard to the requirements regarding non-emergency medical services, the statutory and regulatory scheme appear to differ. It is our understanding that the provisions regarding non-emergency services do not apply to facilities as set forth in subsection (c) of Section 33-20E-5. Therefore, we believe that the wording of subsection (3) of section 120-2-106-.06 should be applicable to non-emergency services received from a non-participating provider in a participating facility.

Finally, SB 313, among other things, establishes a requirement at OCGA 33-64-12 that PBMs and "any other person operating a health plan and licensed under this title that utilizes a contracted pharmacy benefits manager" make certain reports and attestations to the Department of Insurance regarding steering, point of sale fees, and retroactive fees." Thus, the legislation intends to capture only PBMs and those health plans which contract with PBMs. Health plans which do not contract with PBMs are not regulated under SB 313. This distinction was discussed during the bill's consideration and [passage and is purposely included in the legislation.

The Department's proposed Regulation 120-2-97, Pharmacy Benefit Managers, fails to make the distinction intended and passed by the Legislature. The proposed rule, at 120-2-97-.07(7), purports to require reports and attestations from PBMs and any "person operating a health plan under Title 33"— it fails to adopt the limiting phrase "***that utilizes a contracted pharmacy benefits manager***" included in

the legislation. When adopted, the final rule should reflect legislative intent and include the language of SB 313.

Thank you for the opportunity to provide these comments on the implementing regulations. We hope to continue to partner with the Department throughout the implementation of HB 888 and SB 313. Please contact me at Kirkland.A.Mcghee@kp.org or 404-423-9678 with any questions.

Sincerely,

Kirkland A. McGhee

Vice President & Regional Counsel

Georgia Association of Health Plans

November 12, 2020

Gregg Conley
Administrative Procedure Division
704 West Tower, Floyd Building
2 Martin Luther King Jr. Drive
Atlanta, GA 30334

Email to: gconley@oci.ga.gov

GAHP Comments on Proposed Regulation 120-2-106

Dear Mr. Conley:

The Georgia Association of Health Plans (GAHP), the trade association representing Georgia's commercial health insurance industry, was pleased to work with the Governor's Office, Lt. Governor's Office, leaders in the General Assembly, and other industry stakeholders and patient advocates to reach a historic compromise on surprise billing reform during the 2020 session. The Surprise Billing Consumer Protection Act (HB 888) embodies an agreement between the involved parties to take the patient out of the middle of contract disputes between insurance carriers and providers by banning surprise bills in emergency settings, establishing a fair market-based reimbursement rate, limiting patient exposure to inflated charges, and implementing a resolution process for providers to contest instances where remuneration is in dispute. Further, we are appreciative of the flexibility contained in Bulletin 20-EX-10 which will allow insurance carriers time to adapt their provider directories and online assets in order to comply with the provisions of HB 789, which is also addressed in the proposed rule and in our comments below.

GAHP and our member companies are committed to advocating for our policyholders' interest in maintaining access to affordable, quality healthcare and believe that network management is a critical tool in advancing that goal. Surprise bills typically occur in instances where a specialist has an economic incentive to not participate in insurance carrier networks to maximize patient revenue.

HB 888 achieves the goal of removing the patient from being exposed to astronomical charges in emergency settings by limiting the amount a nonparticipating provider may charge a patient who receives emergency medical care. In nonemergency settings, it protects patients from surprise bills where the patient did not choose to receive services from a non-participating provider and allows for the patient to receive a reasonable estimate of their exposure in the event they elect to receive care from a nonparticipating provider. Except where a patient elects to receive nonemergency services from a non-participating provider the patient would not be required to pay more out-of-pocket than would have been the case if their entire care team had been in-network for their plan.

Based upon our understanding of the legislative intent of the Surprise Billing Consumer Protection Act and our experience in other jurisdictions with similar statutes, we would respectfully like to offer the following comments on the proposed rule.

Emergency and Nonemergency Services

The definition of "contracted amount" includes reference to annual adjustment which "may" be based upon the Consumer Price Index, as such we suggest for this purpose that the Department utilize the non-seasonally adjusted Bureau of Labor Statistics CPI-U South Urban series.

The definition of "facility" or "similar institution" was understood to correspond to the term "Institution" as defined in O.C.G.A. 31-7-1, which is limited to entities that are regulated by the Healthcare Facility Regulation Division of the Department of Community Health. We suggest clarifying this by incorporating by reference the definition of "Institution" as defined in O.C.G.A. 31-7-1 into the definition of "Facility" in Proposed Regulation 120-2-106-.03(6). In addition, given that O.C.G.A. 31-7-1 excludes physicians' and dentists' private offices from the definition of "Institution," we suggest adding specific language to the definition of "Facility" to clarify that such places of service are not included in the definition of "Facility" or "similar institution" so that it is clear that the Surprise Billing Consumer Protection Act does not protect patients receiving services at an in-network office setting by an out-of-network provider (e.g., an out-of-network anesthesiologist at an in-network oral surgeon's office).

Additionally, Proposed Regulation 120-2-106-.06 paragraphs (3) and (4) reference both nonparticipating providers and nonparticipating facilities, however the enacting statute specifically defines a "surprise bill" as a charge resulting from a nonparticipating provider at an in-network facility. The General Assembly did not intend for non-participating facilities to be covered under O.C.G.A. 33-20E-5 and the word "facility" does not appear in that Code Section.

GAHP supports the definition of "most recent contracted amount" to be limited to six-months preceding the date of service for the claim. We urge the Department to include within the proposed rule stringent requirements that a patient election made pursuant to O.C.G.A. 33-20E-7 be documented by the nonparticipating provider or referring provider as required by the statute.

Claims Database

The selection of a vendor to assist in the determination of the verifiable median contracted amount paid by all insurers is a critical factor in determining the success of the legislation in protecting patients or the success of providers in locking in above-market reimbursements and therefore driving healthcare costs higher and raising premiums. Any methodology that uses billed charges or maximum allowable amounts as a basis for calculation runs counter to the letter and intent of the legislation, which expressly requires the use of only "paid" amounts, not billed charges in determining the contracted amount.

Prior to the selection of a vendor or the establishment of a Claims Database pursuant to O.C.G.A. 33-20E-8, it is critical that insurers have guidance from the Department on implementation and how to undertake a rate calculation. We reiterate with great emphasis the

need for an interim plan to be established regarding benchmarks so we may proceed with configuring our respective business operations to ensure compliance. Absent such interim plan, we believe the Department will be inundated with requests for review, and claims payments will be delayed, further burdening our already stretched health care system during the COVID-19 pandemic.

Arbitration

Another area of focus and concern for GAHP membership is the proposed dispute resolution process. O.C.G.A. 33-20E-10 stipulates that the Commissioner shall dismiss arbitration requests that meet certain criteria and allows for other circumstances beyond those enumerated in the statute to be considered as grounds for dismissal, however the proposed rule does not contemplate any additional reasons for dismissal.

We urge the Department to include additional reasons for dismissal including: if the disputed claim is not a covered benefit under the insured person's policy; if the provider or facility is not licensed or certified by the State of Georgia or one of its departments, agents, boards, commissions, or instrumentalities; if the provider or facility fails to secure the documentation required in O.C.G.A. 33-20E-7 and this rule; if the request for arbitration is not submitted within 30 days of receipt of payment for the claim; if the contracted amount for emergency or nonemergency medical services was paid by the insurer to the nonparticipating provider or facility; if either party fails to file required documentation within a timely fashion; and if the disputed claim or claims in question amount to less than $1,000. In addition, we urge the department to add language indicating that any arbitration request dismissed by the Commissioner will be dismissed with prejudice.

Additionally, the statute authorizes the arbitrator to weigh other factors in evaluating which of the two submitted amounts to select at the point of rendering a final decision. We applaud the inclusion of language allowing for an assessment of reasonableness based on other contracted rates in the same region.

Reasonable restrictions will inoculate the system from being abused and subject to a deluge of frivolous claims. We also urge the Department to adopt rules of procedure governing the arbitration process so that the parties and the arbitrator will have a clear understanding of the process ex ante.

Greater clarity on patient cost-sharing responsibility would be helpful in situations where due to settlement negotiations with the provider or an award decision by the arbitrator, the physician is paid a greater amount than was paid by the insurer and collected from the patient as copayment, deductible, or other cost-sharing amount on or around the date of service. Is the patient's out of pocket liability variable based upon the result of settlement negotiations or a decision of the arbitrator?

Furthermore, we urge the inclusion of strict confidentiality and non-disclosure requirements on the parties. All pricing information provided by the parties should be confidential and should not be disclosed by the arbitrator or any other party to the arbitration.

Any and all arbitration decisions and related matters, proceedings, etc., whether preceding, concurrent, or subsequent to arbitration, should be strictly bound by a nondisclosure agreement. All parties including the arbitrator should sign such an agreement and it should be included within the arbitrator's written decision.

By incorporating rules of procedure, adopting additional reasons for dismissal, and incorporating confidentiality requirements on all parties, the result will be a dispute resolution mechanism that is fair and predictable, avoids inflationary bias, and will function as a means of "last-resort" rather than a "first-instance" recourse.

Hospital Surprise Bill Rating

The final area of focus and concern for the GAHP membership is the 0-4 rating factor in Proposed Regulation 120-2-106-.11. This section of the Proposed Regulation relates to HB 789, which requires insurers to include a "health benefit plan surprise bill rating" in their print and online provider directories for hospital-based anesthesiology, pathology, radiology, and emergency medicine specialty groups. O.C.G.A. Section 33-20C-1 defines "Health benefit surprise bill rating" as follows:

> "the number of checkmarks and X-marks between zero and four that a health benefit plan's in-network hospital has earned based upon the number of qualified hospital based specialty group types with which such health benefit plan is contracted for the provision of healthcare services. Each checkmark indicates the presence of a in-network particular type of qualified hospital based specialty group. An X-mark indicates the absence of an in-network particular type of qualified hospital based specialty group. 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 mark.... O.C.G.A 33-20C-1(4)."

In addition to the X-mark and checkmark system described above, Proposed Regulation Section 120-2-106-.11 seems to require an additional 0-4 numerical "rating factor" not contemplated by the statute to denote how many of the qualified hospital based specialty groups have in-network participants. According to the proposed regulation, a zero would indicate that none of the four specialties are in-network at that particular hospital, and a four would indicate that all such specialty groups are in-network.

The 0-4 rating factor is unnecessary because it provides no additional information to the insured beyond the X-marks and checkmarks, and in fact, creates a likelihood of member confusion. Insureds can very easily determine how many of the qualified hospital-based specialty groups have in-network participants by counting the checkmarks and X-marks, thereby rendering the 0-4 rating system redundant and unnecessary.

In addition, the rating factor creates a strong likelihood of member confusion because (1) it does not account for N/A designations, which indicate qualified hospital based specialty groups the hospital does not offer; and (2) members may interpret the rating factor as a rating of the quality of the hospital, rather than an indication of the number of qualified hospital based specialty groups that have in-network participants at the hospital. To illustrate the potential for

confusion that may be caused by the N/A designations, consider Hospital A, which offers all four of the specialties in-network and therefore earns four checkmarks and a rating factor of four. Hospital B, however, offers only three specialties in-network. The fourth specialty is not available at the hospital at all, resulting in three checkmarks, a N/A, and a rating factor of three. In the case of Hospital B, members may mistakenly conclude that the rating factor of three means there is a higher likelihood that they will be treated by an out-of-network group or provider within the designated categories of specialties at that hospital, when in fact, all qualified hospital based specialty groups offered by the hospital have in-network participants and the lower rating factor is simply due to the fact that one of the specialties is not offered at that hospital.

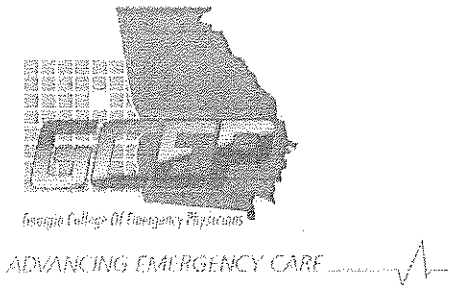
GAHP wholeheartedly supports efforts by the Office of the Commissioner of Insurance to provide additional information to insureds to protect them from surprise bills, and the X-mark and checkmark system does that in a succinct and easily understandable way. The 0-4 rating factor, however, provides no additional benefit to the member and instead, has the potential to cause member confusion. As a result, the significant additional cost that insurers would incur to implement such a requirement is not justified. For these reasons, we urge the Department to remove this requirement from Proposed Rule 120-2-106-.11.

Again, we appreciate the Department's efforts to implement this historic piece of legislation. To date, your office has been tremendously helpful in providing information to the industry as we rush to implement the requirements of these new statutes, and we appreciate it. On behalf of the Board of GAHP and our member companies, thank you for considering the forgoing concerns as you work to address this critical issue. If you have any questions or feel we can be helpful to your efforts in any way, please do not hesitate to contact me at jweathington@totalspectumsga.com or at 770-715-8764.

Respectfully,

Jesse Weathington

Jesse J. Weathington
President & CEO
GAHP



October 29, 2020

Office of the Commissioner of Insurance
Attn: Gregg Conley
Administrative Procedure Division
704 West Tower, Floyd Building
Two Martin Luther King, Jr. Drive
Atlanta, Georgia 30334

HEADQUARTERS
6134 Poplar Bluff Circle
Suite 101
Peachtree Corners, Georgia 30092
770-613-0932
305-422-3327 (FAX)
www.gcep.org

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EXECUTIVE DIRECTOR
Tara M. Morrison, CAE, CMP

Dear Mr. Conley:

The Georgia College of Emergency Physicians (GCEP) is the state affiliate of the American College of Emergency Physicians and represent all emergency physicians and their patients in the great State of Georgia.

We appreciate the opportunity to provide feedback on proposed regulation 'Surprise Billing 120-2-106.' Our comments on these draft regulations follow:

1. DOI's draft regulations emphasize that insurers' failure to comply with HB888 will be deemed an unfair trade practice, per HB888 and we agree. We feel that this emphasis is important and appropriate.

2. The definition of contracted amount in the draft regulations is *per insurer*, and not a calculation from "all eligible insurers" as per the statute. HB888 clearly states that for emergency medical services, "insurer shall directly pay such provider the greater of (1) The verifiable contracted amount paid by all eligible insurers…." As represented to us by the authors of HB888, and as clearly stated in HB888, this means that the contracted amount for out-of-network emergency services is to be a consolidated number for "all eligible insurers" for the contracted amount, and not individual amounts per individual insurers. DOI's proposal for making the contracted amount a variable amount per insurer (instead of per "all eligible insurers" as required in HB888), will make it impossible for physicians to determine if they are being paid fairly. Only individual insurers will have this data. For historic reasons, Georgia's physicians have a long-standing distrust of any data from insurers due to manipulation by insurance-only data and due to the subsequent cries from insurers that their data is protected by trade secret laws. We recommend that the contracted amount be strictly interpreted as per HB888 and represent the median of all commercial insurers per designated area, specialty and service. This data is readily available for low-to-no cost from independent, not-for-profit databases which are not affiliated with any insurers or their agencies.

3. The CPI is capitalized, but it doesn't specify that this is the US Bureau of Labor's CPI, nor which date for the CPI will be annually used. We recommend that this be clarified. Also, we recommend that DOI specify that the USBL's Medical Index (based on hospitals, physicians and insurers) should be used because it more fairly represents this sector's inflation rate.

4. Thank you for reiterating the importance of the Prudent Layperson definition. Our hope is that this signals your intention to enforce PLP laws in Georgia. This area has been of particular concern to us as commercial insurers frequently deny emergency medical services claims by alleging that the services was "unnecessary."

5. It is interesting to us that DOI chose to use the Geo Rating system which rates insurance parameters by county. HB888 states that the geographic areas should be geozips. We request that DOI publicly state why it has specifically deviated from the written law of HB888 in this decision.

6. It is a very serious matter to us that DOI only allows going back 6 months for the most recent contracted amount. HB888 states, "insurer shall directly pay such provider the greater of: ... (2) The most recent verifiable amount agreed to by the insurer and the nonparticipating emergency provider for the provision of the same services during such time as such provider was in-network with such insurer...." This clearly does not limit a look-back period. This element was put in place to protect those who already had in-network contracts with insurers for emergency medical services. In fact, many contracts have actually been cancelled by insurers this year. Physicians and other healthcare providers should not be penalized because insurers have been cancelling contracts in order to nullify the second provision of the payment rules of HB888.

7. We believe that insurers will inappropriately use the phrase, "deemed medically necessary" by refusing payment for services provided in Emergency Departments across Georgia. This is happening now, and we see that it is likely to continue in the future. This behavior is a violation of state and federal prudent layperson statues. We believe, that for emergency medical services, the DOI regulations should clarify the importance of PLP matters by stating in regulation, "Such insurer shall make such payment without prior authorization and without retrospective payment denial for emergency medical services." The term emergency medical services is clearly defined in HB888 and elsewhere in Georgia and in federal law. DOI should take this opportunity to notify insurers that neither insurance company employees nor computer analytics can determine what was the average knowledge of the prudent layperson in seeking treatment in a hospital Emergency Department for a perceived threat to his/her life or health.

8. We appreciate seeing in the draft regulations a reiteration of Georgia's prompt payment law and the statutory mandate that insurers must notify providers of the patient's ERISA status.

9. DOI draft regulations clearly state that DOI will not have its own database (APCD). HB888 states that, in such a case, DOI shall select "verifiable data." These draft regulations state that DOI will "utilize a verifiable median contracted amount by all eligible insurers for similar services calculated by a vendor utilized and chosen by the Commissioner." Unfortunately, this statement leaves plenty of room for doubt as to the source of such data. Insurers must not be trusted with supplying this necessary data. Insurers will not allow a thorough, independent analysis of their products. Insurers have misrepresented healthcare insurance date to DOI in the recent past. Also, insurers will likely hide behind trade secret "protections" when prompted to provide statistically verifiable data assurances. Only a truly independent, robust, transparent, verifiable database which is not affiliated with any insurer or their agencies will suffice for genuinely verifiable data for the purposes of HB888. We request that DOI select a database which is independent, robust, transparent, verifiable and not affiliated with any insurer or its agencies.

10. The DOI draft regulations leave many questions regarding the arbitration process. Will DOI have a website and online forms for requesting arbitration? If not, what will be the process? Will the completed form(s) requesting arbitration be automatically sent to the insurer, and will that fulfill the provider's notification requirement? How will documentation be submitted? How will providers be able to review decisions? Much information remains to be disseminated in order for physicians to feel comfortable regarding this process.

11. We remain very concerned that the insurers will manipulate the arbitration process (just as they are currently manipulating the payment process vis-à-vis cancelling contracts) and will make a practice of attempting to settle after the dispute has been referred to arbitration, but before the hearing. Utilizing this tactic where the arbitration fees must then be equally split between insurer and provider. As a result, providers will be seriously and continuously economically disadvantaged by this frequent splitting of fees between very large and profitable insurance companies and small, not-so-profitable physician practices. Physicians will not be able to withstand the economic power of insurers with this process. We recommend that DOI limit the frequency or pattern of individual insurance companies attempting to settle after referral by the DOI to the arbitrators.

12. We are concerned that the underlying reasons and processes for arbitration decisions will be kept secret based on DOI draft regulations stating, "the Department will ensure that appropriate safeguards are put in place so that information subject to trade secret protection laws is duly protected." This is an untenable situation and will give the upper hand to the insurers in all matters of payment and arbitration. We request that each and every arbitration decision be made public immediately upon decision by the arbitrators.

13. Draft regulations for item "f" under additional factors states "usual and customary cost of service." It is impossible for physicians to determine their costs to deliver individual services. However, the usual and customary charge is readily available and is the long-standing and normal method for identifying information regarding the usual cost to the patient for that physician's particular medical service. We recommend that the draft regulations restate this item as, "usual and customary charges."

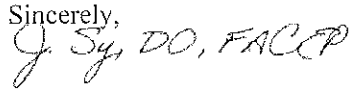
It is our hope that the final DOI regulations for the implementation of HB888 will be fair, reasonable, consistent with HB888 language, and not lead to litigation for purposes of clarification or implementation of duties imposed by HB888.

We thank you for your attention to these urgent matters. It is our hope that the issuance of final regulations will be timely prior to the January 1, 2021 effective date for HB888.

Please feel free to reach out to us if you have any questions regarding our comments. Our point of contact for HB888 issues is

Dr. D. W. "Chip" Pettigrew, III MD, FACEP
Past President, GCEP
(706) 202-3738 (mobile)
chippettigrew@gmail.com.

Sincerely,



John L. Sy, DO, MS, FACEP
President, GCEP

November 11, 2020

Commissioner John King
Georgia Department of Insurance
Two Martin Luther King, Jr., Drive
West Tower, Ste 704
Atlanta, Georgia 30334

Dear Commissioner King:

The Georgia Society of Anesthesiologists (GSA) represents more than 1,300 practicing Physician Anesthesiologists and Anesthesiologist Assistants in Georgia. GSA's mission is to provide world-class continuing education to anesthesia providers and to advocate for the highest quality medical care to assure patient safety and positive health outcomes.

Methodology for computing billing and payments for anesthesia services is unique among all other medical providers. GA strongly urges the Department to recognize this distinction as the elements of anesthesia billing will impact the manner in which future anesthesia payments are made and/or mediated under this regulatory section. We are grateful for the Department's work on proposed rules, "120-2-106 Surprise Billing," and wish to express the following concerns and observations:

GA Surprise Billing Administrative Guidelines

- The provisions of 120-2-106-08 require notification to the patient of the network status of the provider followed by obtaining a signed (written and oral) consent. In anesthesia, this will be very difficult to obtain when a patient presents "day of" surgery. Remember that anesthesia providers do not choose their patients, rather, anesthesia providers care for other physicians' patient during procedures. Typically, the anesthesia provider does not see the patient until just before the procedure. Further, the requirement to provide a true estimate of anesthesia charges will be difficult because payments for anesthesia services are based on time units. The total time under anesthesia in what would be considered similar surgeries can be drastically different. Nationally, anesthesia rates are reimbursable based upon assigned American Society of Anesthesiology (ASA) base units for the procedure + time units (may be 10 or 15 minute increments depending on carrier) + modifiers multiplied by a $conversion factor, not a straight CPT like other physicians/facilities. The most notable variant is time units depending on how long the surgical procedure took for which anesthesia has no control. Influencing factors may include academic/partial academic settings whose cases routinely take longer and robotic vs non-robotic surgery techniques. Will the pricing index take these factors into account? Additionally, will it take into account Care Team Billing when both a physician and CAA

or CRNA are present on the claim; equal 50/50 split or other?

- Definition (13) for "most recent contracted amount" is a new term and not contained in the statute. It is meant to clarify the second payment possibility, whereby the payment amount can be the "most recent verifiable amount agreed to by the insurer and the... provider." First, the Department should fix the language because "most recent contracted amount" is not the language used. Second, the definition purports to limit the most recent amount to network contracts that were effective within the 6 months prior to the date of service. Because the verifiable amounts paid under the statute to in-network providers (another possibility for the "greater of" payment from insurers) are prescribed to be from calendar year 2017, a reasonable ask is that the most recent agreed rate be allowed to go back that far as well. If the three-year time frame receives pushback, the timeframe still should be longer than 6 months. The Department should additionally allow for an exception if the provider can show a significant increase in the cost of providing the specific service since the time of the last effective contract.

- Definition (12) for "median" is new term and not contained in the statute. Because the Department has not been allocated funds to create a payments database, the Department is going to determine "median contracted amounts" for purposes of the first of the three payment amounts to be considered (the contracted amount). In 120-2-106.09, it states a vendor will be chosen by the Commissioner to provide the amounts (this possibility was contemplated by the statute), but it says nothing as to qualifications of the vendor or where it will be sourcing the information. We recommend posing a question asking if the Department can clarify the information source. We also recommend suggesting additional language in this section specifically stating that Medicare- and Medicaid-paid amounts, including amounts paid by Medicare Advantage and Managed Medicaid plans, should not be included in the list of reimbursement amounts. The statute and proposed regulations already define "contracted amount" to exclude Medicare or Medicaid rates, but adding it to this section as well and also specifically mentioning MA and MM plan payments would improve it and make it more clear.

- 120-2-106-.10(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; This highlighted provision is the most concerning to GSA members as we do not want reimbursement set at what health plans pay other out of network providers. The provision promotes gamesmanship by payors as payors will tactically term participation of agreements with reasonable rates to drive down the out of network allowable.

  Note that these additional factors are new in the proposed regulations; they are not contained in the statute. While this is just one factor of several for an arbitrator to consider, the above provision gives an insurer-friendly arbitrator a reason to choose a low reimbursement amount, which may seem "reasonable" just because that insurer and/or others are artificially depressing out-of-network payments (which they control). Some large insurers already pursue a strategy of unreasonably low out-of-network payments across the board and use their large market share to shift market payment rates in their favor.

- The Arbitration provision (120-2-106.10) does not address the Statute's requirement of 33-20E-8(b). The ability to bundle claims is imperative for a physician provider. To seek arbitration on a single
  claim basis is administratively cumbersome and more importantly cost prohibitive for the average physician practice. The specific language from 33-20E-8(b) must be specifically mentioned in the administrative guidelines.

  > Per, 33-20E-8(b) "A request for arbitration may involve a single patient and a single type of healthcare service, a single patient and multiple types of healthcare services, multiple patients and a single type of healthcare service, or multiple substantially similar healthcare services in the same specialty on multiple patients."

- The wording of the arbitration provision in the statute could potentially lend itself to a narrow reading, and now so could the regulation. The statute reads: "If an out-of-network provider concludes that payment received from an insurer pursuant to Code Section 33–20E–4 or 33–20E–5 or if an out-of-network facility concludes that payment received from an insurer pursuant to Code Section 3–20E–4 is not sufficient *given the complexity and circumstances of the services provided*, the provider or facility may initiate a request for arbitration with the Commissioner." The regulation, at 120-2-106-.10, similarly reads as though arbitration could possibly be limited to instances where the complexity of the services provided is what makes payment insufficient (not simply because the insurer did not comply with paying at the "greater of" the 3 options): "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."

  We can't imagine that the state legislature set up an entire arbitration procedure just for that limited subset of cases, as opposed to all cases where insurers violate the law. The statute later says, for example, that insurers are to submit data necessary "to determine whether such insurer's payment to such provider or facility was in compliance with Code Section 33–20E–4 or 33–20E–5"—it does not specify any particular portion of those sections. This is echoed in the proposed regulations at 120-2-106-.10(3).

  We suggest the regulation on arbitration be edited to remove "given the complexity and circumstances of the services provided," or "or otherwise" could be added after that phrase.

- The regulations use the same language as the statute indicating that the statutory requirements are triggered "in the event of a surprise bill"—this is phrased a few different ways, but the language sometimes suggests that a surprise bill must actually be generated and sent to a patient. This seems very odd, when at the same time balance billing is prohibited (for example, the statute says "the facility shall bill the covered person no more than deductible, coinsurance, copayment, or other cost- sharing as determined by such person's policy.") We would recommend proposing that the statute more clearly be triggered upon the potential liability of a patient for a surprise bill, not the actual generation of a surprise bill.

- We also wanted to note that both the statute and the proposed regulations say that the Commissioner can refer to the appropriate state agency any provider or facility that displays a pattern of failing to comply with the law or violates an order of the Commissioner. Presumably,

this would be facilities and providers who consistently send surprise bills to patients. There is not a parallel provision for *insurers* who consistently violate the statute, but that may just be because the Commissioner of Insurance already has jurisdiction to regulate those entities, so no referral would be required.

- There is an error in the final sentence of Definition #8, which currently reads "Notwithstanding paragraph (3) of Code Section 33-1-2 and any other provision of this title, ~~*this chapter*~~ *this term* shall include...." Strike "this chapter".

- In 120-2-106-.06(1), we found the first phrase "If the provisions of 120-2-106-.08 are met..." confusing. It would seem to make more sense to us if the language was: "if the provisions of 120-2-106-.08 are ***not*** met...." At the end of the day, this probably will not be a big deal, but the Department should consider the question.

- The regulation sets up 120-2-106-.06(2) with "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," while the statute says "In the event a covered person receives a surprise bill for the provision of nonemergency medical services from a nonparticipating medical provider." The regulation's "in a facility that generates a surprise bill" language could be read potentially to mean that the *facility* is the one with a balance bill. Out of an abundance of caution, we suggest that the regulation language track the statute (though see comment above—patients really should not be receiving surprise bills at all).

- In 120-2-106-.06(2)(b), the words "emergency medical" should be struck (or at least "emergency"), and it should be "during such time as," not "during which time," for consistency with prior provisions and the statute.

- The reference in 120-2-106-.08(3) to "subsection (b)" should be to "subsection (2)," and the reference in 120-2-106-.08(3)(d) to "paragraphs (1), (2), and (3)" should be to "paragraphs (a), (b), and (c)."

Submitted by:
James E. "Jet" Toney
Executive Secretary
Georgia Society of Anesthesiologists
404-580-7353 cell
Jet.toney@politics.org

Georgia Dental ASSOCIATION
7000 Peachtree Dunwoody Rd, Building 17, Suite 200, Atlanta, GA 30328

November 12, 2020

Gregg Conley
Administrative Procedure Division
704 West Tower, Floyd Building
2 Martin Luther King, Jr. Drive
Atlanta, GA 30334
Submitted via email to: gconley@oci.ga.gov

RE: GDA Comments Regarding "Promulgating Regulation 120-2-106 entitled 'Surprise Billing'"

Dear Mr. Conley:

On behalf of over 3,600 member dentists licensed in the state of Georgia, the Georgia Dental Association ("GDA") respectfully submits the following comments for Commissioner King's consideration with regard to Proposed Rule 120-2-106 (the "Proposed Rule") associated with House Bill 888 (the "Surprise Billing Bill"):

- **"120.2-106-.08 Covered Persons Choosing to receive Non-Emergency medical services from a non-participating provider, referrals and procedures"**

GDA Comments:

In 120.2-106-.08(2)(a), there should no time requirement for when the patient's oral and written consent must be obtained by an out-of-network provider in advance of providing treatment. A previous draft of HB 888 included such a requirement, but it was removed by the Georgia General Assembly in the final version of the bill. The GDA respectfully requests that the language of the administrative rule regarding this issue remain consistent with the final draft of the bill.

The estimate required pursuant to 120.2-106.08(2)(b) should be non-binding on the out-of-network provider.

Thank you for allowing the GDA to submit comments on this critical issue for our patients and the citizens of Georgia. Please feel free to contact me if you have any questions or concerns. I can be reached via email at scott@gadental.org; office phone: (404) 636-7553; cell: (540) 529-3953.

Respectfully,

Scott V. Lofranco
General Counsel and VP of Government Affairs, Georgia Dental Association

cc: State Representative Lee Hawkins
Richard Weinman, DMD
Annette Rainge, DMD
Frank J. Capaldo

1849 The Exchange
Suite 200
Atlanta, GA 30339
678.303.9290
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Fax 678.303.3732
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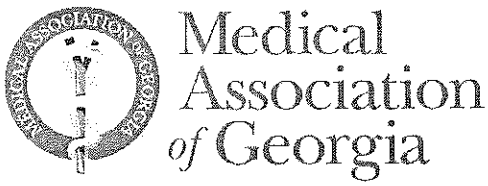


Building a Better State of Health Since 1849

November 11, 2020

Commissioner John King
Georgia Department of Insurance
Two Martin Luther King, Jr., Drive
West Tower, Ste 704
Atlanta, Georgia 30334

Dear Commissioner King:

The Medical Association of Georgia (MAG) has over 8,400 physician members across all specialties and practice settings. Our mission is to "Enhance patient care and the health of the public by advancing the art and science of medicine and by representing physicians and patients in the policy making process." To this end, addressing the issue of surprise billing in Georgia is vitally important to MAG. We are grateful for the Department's work on proposed rules, "120-2-106 Surprise Billing," but have the following concerns…

1. 120-2-106-.03(13) limits "most recent contracted amount" to contracts that have been in place within the six months preceding the date of service. This limitation did not exist in H.B. 888, and it is incongruent with the rationale for including the most recent contracted amount one of the potential reimbursements under this law. The cancellation of physician contracts has been a serious issue during the years surprise billing legislation has been discussed, and the clause in H.B. 888 was designed to protect physicians and other health care professionals from having their contracts cancelled by insurers because the median contracted amount is less than the current contracted rate.

2. In addition to the concerns above related to the "most recent contracted amount," we would like to see the rules address a common issue where an insurer will significantly reduce the reimbursement to a physician and the physician's only recourse is to terminate the contract. In this situation, the contracted amount will be significantly less for the period of time between the unilateral reduction in reimbursement and when the physician can legally terminate the contract due to required notice periods. The most recent contracted amount would consequently be lower than the amount that both parties agreed to that was in place for some time. As an alternative, MAG suggests using "the highest contracted amount that was in effect between 2017 and the termination of the contract." This would prevent insurers from circumventing the intent of the H.B. 888 requirement.

3. H.B. 888 and 120-2-106-.05(1) state that payment for emergency medical services should be made without "retrospective payment denial for emergency medical services deemed to be medically necessary." Insurers currently deny emergency medical care on a retroactive basis if they determine that it was not "medically necessary." MAG believes that patients would be better protected if the rules reiterated the crucial need for insurers to follow the "prudent layperson standard" in making these determinations.

4. Under 120-2-106-.03(2), the Consumer Price Index would be used to adjust the contracted amount on an annual basis. However, it is not clear which date would be used or whether that is a reference to the

U.S. Bureau of Labor's CPI index. MAG recommends using the USBL's Medical Index, which is based on hospital, physician, and insurer data, and which more accurately accounts for inflation in this industry.

5. The rationale for using the Geo Rating system instead of the geozips system that is included in H.B. 888 is not clear.

6. Under the proposed rules, the Department would select a vendor to provide the verifiable data that is necessary to calculate the median contracted rate – keeping in mind that there is no all-payer claims database in Georgia. But the proposed rules do not address the process or parameters that the Department would use to select this vendor. Relying on insurers to provide this data is problematic, as they routinely cite "trade secrets" as a reason they cannot release payment information. It is also worth noting that insurer-supplied data has proven unreliable in the past. Therefore, MAG suggests that the Department selects a database vendor that uses a system that is robust, transparent, and verifiable and which is not affiliated with any insurer or their agencies.

7. MAG believes that the proposed rules should be more specific about the arbitration process, including the documents that will need to be filed. We are also concerned about the following language: "The Department will ensure that appropriate safeguards are put in place so that information subject to trade secret protection laws is duly protected." Because this may limit physicians' access to key information that the insurer will have, they would be at a disadvantage in the arbitration process. MAG consequently believes that the proposed rule should be revised to ensure that physicians have access to as much information as is legally permissible as soon as the arbitration process is completed.

8. Under 120-2-106-.10(10)(f), one of the factors that the arbitrator would consider is the "usual and customary cost of the service." But determining these costs for each individual procedure or service would be untenable for most physicians (e.g., calculating general overhead). The "usual and customary charge" is readily available and easily calculated for each episode of care, and it is the long-standing and normal method for identifying information regarding the usual cost to the patient for that physician's particular medical service and would be a better factor to include in this list.

9. MAG requests that the proposed rules be revised to emphasize that they do not apply to self-funded plans and that they do not apply to physicians when they care for a patient who is covered by such a plan.

10. 120-2-106-.10(1) would require that requests for arbitration would have to be filed within "30 days of receipt of payment for the claim." This could represent a significant hurdle for physicians who provide services that result in lower cost charges and payments because any issues/problems would not become apparent until multiple claims are paid. These services are the reason H.B. 888 allows for bundling of claims for arbitration as there may not be enough claims to adequately arbitrate until it has been more than 30 days from the first payment in a series.

11. MAG would like to see the following language from H.B. 888 included in the rules: "A request for arbitration may involve a single patient and a single type of healthcare service, a single patient and multiple types of healthcare services, or multiple patients and a single type of healthcare service."

12. MAG would like to see the proposed rule modified to address what will happen when an insurer or a patient provides inaccurate information that results in the physician submitting a bill to the patient or insurer that violates these rules.

13. Two of 120-2-106-.08(2)'s requirements address 1) oral and written consent and 2) an estimate of potential charges. It may be difficult for some physicians to fulfill the consent requirement (when the care cannot be consented before the day it is received. For example, an anesthesiologist might not see a patient until just before they perform a procedure. The estimate required may also be difficult for anesthesia providers and other similarly situated providers due to the nature of the services they provide and the way

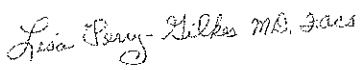
their charges are calculated. MAG would also like to see language clarifying that the estimates provided are not legally binding. Finally, the proposed rule is not clear on whether each individual physician or provider who is involved in the patient's care must fulfill the consent requirement or whether they must each provide the patient with a separate estimate (e.g., a surgical procedure may involve a surgeon, an anesthesiologist, and a pathologist and/or radiologist).

14. MAG would like additional information on the process that the Department will use to select the resolution organization.

MAG genuinely appreciates the opportunity to comment on these proposed rules, and we look forward to working with the Department throughout the implementation process.

Please contact MAG Director of Government Relations Derek Norton at 404.274.4210 or dnorton@mag.org with any questions.

Thank you for your consideration,



Lisa Perry-Gilkes, M.D.
President
Medical Association of Georgia

Quest Diagnostics

November 11, 2020

Office of the Commissioner of Insurance
Attn: Gregg Conley
Administrative Procedure Division
704 West Tower, Floyd Building
Two Martin Luther King, Jr. Drive
Atlanta, Georgia 30334

Dear Mr. Conley,

On behalf of Quest Diagnostics, we appreciate the opportunity to offer comments on Proposed Rule 120-2-106 regarding surprise billing. Quest Diagnostics is the world's leading provider of diagnostic information services and serves one in three adult Americans and half the physicians and hospitals in the United States annually. We are particularly proud of our presence in Georgia, which is the home to our Southeast Region headquarters, and includes over 1,800 employees, 3 labs, and 36 patient service centers. With our robust infrastructure in Georgia, we service nearly 18,000 physicians and 94 hospitals, and handle 36,000 patient specimens daily.

Quest's commitment to Georgia has only strengthened in response to the COVID-19 pandemic. To date, we have already conducted over 487,000 viral COVID-19 tests and over 356,000 serology tests to detect COVID-19 antibodies.

We applaud the State's focus on the important issue of surprise billing. However, we propose minor amendments to these regulations to make them even stronger and effective in addressing the unique situation of clinical laboratory services. Pursuant to these regulations, 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." By limiting the application of these rules to services performed at an "in-network facility," this definition significantly limits the scope of the surprise billing protections in the context of labs. In fact, this will do little to curb surprise bills for most out-of-network lab services because those services are typically not performed in an in-network facility. Patients are often unaware that their ordering practitioner has utilized an out-of-network lab. In fact, for specimens drawn in the provider's office, the patient typically has no knowledge of what lab will be providing the testing. We recommend that the regulation be amended to also provide protections from surprise billing where any in-network provider orders covered laboratory services to be performed by an out-of-network laboratory.

Quest Diagnostics

Thank you for the opportunity to comment on these regulations, and please feel free to reach out if we can answer any questions.

Sincerely,

David M. Reiner

David M. Reiner
Senior Director, State Government Affairs
David.M.Reiner@QuestDiagnostics.com

Womack, Pennie

From: Lewis Massey <Lewis@impactpublic.com>
Sent: Monday, November 2, 2020 3:30 PM
To: Conley, Gregg
Subject: RE: Surprise Billing Regulations

Thank you Gregg. I sent this to Martin also but this is some suggested language to ensure that no conflicts of interest arise with an IRO. Please let me know if you need more info.

Conflict of Interest:

The independent resolution organization, any arbitrators it designates to conduct an arbitration, or any officer, director, or employee of the independent resolution organization shall not have any material professional, familial, or financial affiliation, as determined by the Commissioner, with any of the following:

(1) The health plan issuer.

(2) Any officer, director, or employee of the health plan issuer.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which the proposed health care service was provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy in dispute.

(6) The covered person or the covered person's immediate family.

Lewis A. Massey
Impact Public Affairs
www.impactpublic.com
404-783-9362

From: Conley, Gregg <GConley@oci.ga.gov>
Sent: Monday, November 2, 2020 2:59 PM
To: Lewis Massey <Lewis@impactpublic.com>
Subject: Surprise Billing Regulations

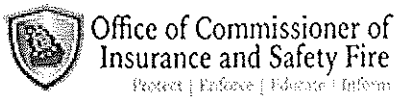
Mr. Massey,

Martin told me you have some official comments to submit concerning the proposed regulations to complement the new Suprise Billing law. You can send those to me if you'd like to have them made part of the record at the regulatory hearing. Please let me know if you have any questions.

Best,
Gregg

Gregg Conley

Executive Counsel
Office of Commissioner John F. King
Two Martin Luther King Jr Drive SE
Suite 704 West Tower
Atlanta, Georgia 30334
O: 404.463.0240 C: 470.725.4428
gconley@oci.ga.gov



November 12, 2020

VIA ELECTRONIC SUBMISSION

Gregg Conley
Administrative Procedure Division
704 West Tower, Floyd Building
2 Martin Luther King, Jr. Drive
Atlanta, Georgia 30334

Re: Comments on surprise billing regulations 120-2-106

Dear Mr. Conley:

Thank you for the opportunity to provide input on the rules and regulations governing Georgia's new surprise billing protection law. The undersigned organizations appreciate the attention that the Georgia General Assembly, Governor Kemp, and the Office of Insurance and Safety Fire Commissioner ("DOI") has given to this issue.

Collectively our organizations believe that cost should not stand in the way of access to health care for Georgians. That is why we worked with state leaders to pass the Surprise Billing Consumer Protection Act to protect Georgia families from unfair and costly surprise out-of-network medical bills.

Our primary purpose in offering comments is to guarantee that the intent of the law—to protect consumers to the fullest extent possible from surprise out-of-network medical bills—is upheld. To that end, we offer these recommendations to your agency in an effort to strengthen and add further detail to the proposed rules and regulations on behalf of Georgia consumers.

33-20E-7

This section allows consumers to waive their lawful protections against being balance billed by an out of network (OON) provider, but only if they are fully informed that they are making such a selection. We believe that this section of the law must be tightly regulated and strictly enforced to ensure that the letter and spirit of the law are retained and to avoid the creation a consequential loophole to be exploited by health care providers and facilities.

In order for a consumer's consent to be meaningful, it must be solicited in a way that is understandable, transparent, and provides the consumer with enough information and time to facilitate an informed decision. Without a consent process that meets these standards, the law will fail to protect consumers' access to care and financial wellbeing. Because this process is so important for consumers, we urge DOI to consider the consent process in these ways:

The content and design of the notice/consent process

We urge DOI to develop a uniform written consent form and verbal process for use by health care providers across the state. Texas adopted a similar approach after the state's initial notice and consent rules were found to be insufficient, and consumers were being taken advantage of.

The consent process must be designed in a way that takes into account the diversity of Georgia's population and their health care needs. Many Georgia consumers have reading skills below a 6th grade level, low health literacy skills (written and verbal), do not speak English as a first language, or have cognitive differences that are not readily apparent even to health care providers. In order to ensure that all Georgians are provided a truly informed choice about whether to seek care OON, it is imperative that both the written consent forms and verbal consent prompt:

- Make clear the full estimated costs of the OON care episode
- Abide by best practices of health literacy and universal design (e.g. lots of white space, short sentences, everyday language/terms, among other guidelines);
- Be available in the patient's preferred language;
- Be made available in formats that meet the Americans with Disability Act standards (e.g. screen readable pdfs, Braille); and
- Include prominent notice that consumers do not have to waive their rights and may be offered other options for care if they so choose.

While Texas did not require verbal consent from consumers, their written materials provide a good example of what Georgia's could look like, as they follow many readability, usability, and accessibility best practices. DOI can find the Texas consumer consent form here along with the form's instructions for providers. The Michigan Department of Health and Human Services published these content and design standards for the state's public assistance application following a two-year study period; these standards may also be useful for DOI's purposes.

The staff at Georgians for a Healthy Future (one of the undersigned organizations) maintain expertise in the areas of health literacy, accessibility, and readability for health forms. We would be pleased to help DOI in its efforts to provide consumers with a clear and understandable consent process.

The timing of the consumer consent process

The law mentions two time periods related to consumer consent to go OON for their care. The first stipulates that in nonemergency medical situations, consumers can only make an informed choice after they are provided with an estimate of potential charges. Georgia consumers will be best able to make an informed decision about their care if:

1. They receive this cost estimate as far ahead of any scheduled health services as possible; and
2. The cost estimate is detailed and understandable to lay people.

Informed decisions by consumers can only take place if they have the time and space needed to review the cost estimate provided by an OON provider, call their health insurer to explore

their IN options, and consider all of the available information on their own or in consultation with other decision makers in their households. To that end, GHF urges DOI to require that health care providers:

- Provide a written estimate that includes the date of service; service code and name for all expected services/supplies; the amount the provider bills for each item; and the amount that the consumer may need to pay for each item and in total. The Texas consent form builds in an easy-to-understand cost estimate structure that we believe would provide Georgia consumers with the information needed to check with their insurer about IN provider options and/or comparison shop with other providers.

- Provide the estimate of OON services at the time that the appointment is made; or as soon as possible ahead of the appointment. Almost as a rule, health care providers collect consumers' health insurance information at the time that a health appointment is made. This allows the provider to check their network status with the consumers' plan immediately or very soon afterwards. Providers should be required to check their network status while booking appointments, or within two business days following the booking of the appointment. Upon finding that they are OON for a consumers' plan, providers should be required to notify the consumer and provide a written cost estimate of services within one business day. If the booked appointment would occur within the three-business day window, the network determination and written cost estimate should be provided to consumers at least 24 hours ahead of their appointment.

The second time period detailed by this section of the law refers to situations in which a provider is asked by a patient who needs more or different care from another provider for a referral with a short-enough turnaround time that it would make the above process unworkable. GHF urges that DOI define the time period referred to as "immediate" in 33-20E-7(c) as shorter than two business days. For referrals taking place more than two business days in the future, health care providers should be able to reasonably notify consumers of their network status and the estimated costs of care.

The notice provided to the consumer in these same-day, next-day, or otherwise short-turnaround referrals are especially consequential as consumers will feel as though they have less time to check with their insurer about in-network provider options and/or comparison shop with other providers. The written and verbal notice provided to consumers in this situation should mirror as much as possible the notice provisions described in the above *Content and design of the notice/consent process* section. Because this part of the law does not require that consumers are provided with a cost estimate, the referring provider should be required to at least provide the consumer with the contact information of the referred provider so that the consumer can easily request an estimate.

Documentation of the consumer consent process

So that consumers have complete records and files with which to document their health care and out of pocket costs, providers should be required to provide copies of all written OON consent forms and other documentation of all verbal consents to consumers during the consumer's health appointment or in a reasonably timely manner following the appointment. This will maintain transparency for consumers and accountability on the part of providers.

33-20E-8

We look forward to engaging with the Georgia All Payer Claims Database Advisory Committee on the establishment of the APCD, upon appropriations.

33-20E-17

We encourage the DOI to be proactive in referring providers and facilities to the appropriate governing bodies following a pattern of behavior that violates this law. We further urge DOI to make these referrals public in an annual report. This report could be coordinated with the annual publication of the arbitration results report to the House and Senate Insurance Committees.

The Surprise Billing Consumer Protection Act is incredibly significant for Georgia consumers. If proactively implemented and meaningfully enforced, it could protect the financial security and access to care for thousands of Georgians each year. We look forward to working with DOI to promote this law and protect Georgia consumers from surprise out of network medical bills.

Thank you for the consideration of our comments. If you have any questions, please contact Laura Colbert, Executive Director of Georgians for a Healthy Future, at 404-890-5804 or lcolbert@healthyfuturega.org.

Sincerely,

Laura Colbert
Executive Director
Georgians for a Healthy Future

Kelly Barta
State Advocacy Project Manager
Allergy & Asthma Network

Kristen Crawford
Advocacy Director
Arthritis Foundation

Carole Maddux
Executive Director
Georgia Interfaith Public Policy Center

Liz Coyle
Executive Director
Georgia Watch

Edith A. Rosato R.Ph., IOM
CEO
Hemophilia of Georgia

Sarah Balog
Regional Director of Government Affairs
The Leukemia & Lymphoma Society

Heather Breeden
Senior Manager of Advocacy
National Multiple Sclerosis Society

Kristen Stiffler, J.D.
State Government Relations Manager
National Psoriasis Foundation

Dr. Marissa Lapedis & Dr. Angeline Ti
Georgia Cluster Co-leaders
Reproductive Health Access Project

Dorothy Leone Glasser
Executive Director
Rx within Reach & Advocates for Responsible Care

Stacey Ramirez
State Director
The Arc Georgia

August 31, 2020

Commissioner John King
Office of Insurance and Safety Fire Commissioner
Two Martin Luther King, Jr. Drive
West Tower, Suite 704
Atlanta, Georgia 30334

Re: Input for rules and regulations regarding Georgia's new surprise billing legislation

Dear Commissioner King:

We write regarding Georgia's new surprise billing legislation. We are pleased that the Office of Insurance and Safety Fire Commissioner ("DOI") is accepting stakeholder input about how to best implement this law for the benefit of Georgia consumers. We urge DOI to promulgate proactive and consequential rules and regulations in order to protect consumers from surprise out-of-network medical bills.

Our primary purpose in offering comments is to guarantee that the intent of the law—to protect consumers to the fullest extent possible from surprise out-of-network medical bills—is upheld. To that end, we offer these recommendations to inform your work on Georgia's new surprise billing legislation:

33-20E-7
This section allows for consumers to waive their protections under this law, but only if they are fully informed that they are making such a selection. We believe that this section of the law must be tightly regulated and strictly enforced to ensure that the letter and spirit of the law are retained and to avoid the creation a consequential loophole to be exploited by health care providers and facilities.

In order for a consumer's consent to be meaningful, it must be solicited in a way that is understandable, transparent, and provides the consumer with enough information and time to facilitate an informed decision. Without a consent process that meets these standards, the law will fail to protect consumers' access to care and financial wellbeing. Because this process is so important for consumers, we urge DOI to consider the consent process in these ways:

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We urge DOI to develop a uniform written consent form and verbal process for use by health care providers across the state. Texas adopted a similar approach

after the state's initial consent rules were found to be insufficient, and consumers were being taken advantage of.

The consent process must be designed in a way that takes into account the diversity of Georgia's population and their health care needs. Many Georgia consumers have reading skills below a 6th grade level, low health literacy skills (written and verbal), do not speak English as a first language, or have cognitive differences that are not readily apparent even to health care providers. In order to ensure that all Georgians are provided a truly informed choice about whether to seek care out-of-network, it is imperative that both the written consent forms and verbal consent prompt:

- Make clear the full estimated costs of the out-of-network care episode
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Georgians for a Healthy Future staff maintain expertise in the areas of health literacy, accessibility, and readability for health forms. We would be pleased to help DOI in its efforts to provide consumers with a clear and understandable consent process.

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The law mentions two time periods related to consumer consent go out-of-network for their care. The first stipulates that in nonemergency medical situations, consumers can only make an informed choice after they are provided with an estimate of potential charges. Georgia consumers will be best able to make an informed decision about their care if:

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- Provide a written estimate that includes the date of service; service code and name for all expected services/supplies; the amount the provider bills for each item; and the amount that the consumer may need to pay for each item and in total. The Texas consent form builds in an easy-to-understand cost estimate structure that we believe would provide Georgia consumers with the information needed to check with their insurer about IN provider options and/or comparison shop with other providers.
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The second time period detailed by this section of the law refers to situations in which a provider is asked by a patient who needs more or different care from another provider for a referral with a short-enough turnaround time that it would make the above process unworkable. GHF urges that DOI define the time period referred to as "immediate" in 33-20E-7(c) as shorter than 2 business days. For referrals taking place more than 2 business days in the future, health care provider should be able to reasonably notify consumers of their network status and the estimated costs of care.

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So that consumers have complete records and files with which to document their health care and expenditures, providers should provide copies of all written OON consent forms and other documentation of all verbal consents to consumers. This will maintain transparency for consumers and accountability on the part of providers.

33-20E-8

We look forward to engaging with the Georgia All Payer Claims Database Advisory Committee on the establishment of the APCD, upon appropriations.

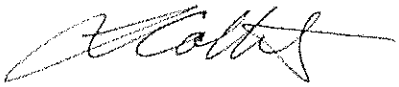
33-20E-17

We encourage the DOI to be proactive in referring providers and facilities to the appropriate governing bodies following a pattern of behavior that violates this law. We further urge DOI to make these referrals public on in an annual report. This report could be coordinated with the publication of the annual arbitration results report to the House and Senate Insurance Committees.

This new law is incredibly significant for Georgia consumers. If proactively implemented and meaningfully enforced, it could mean financial security and access to care is maintained for thousands of Georgians each year. We look forward to working with DOI to promulgate rules and regulations that promote what is best for Georgia consumers, especially consumers who have historically had little or no access to care and/or insurance coverage.

We would be happy to address any of the points raised here. Please do not hesitate to contact me with any questions.

Sincerely,



Laura Colbert
Executive Director
Georgians for a Healthy Future