No More Surprises: An Overview of Georgia's Latest Effort to Resolve Balance Billing Disputes

by Douglas J. Witten[1]

Introduction

On July 16, 2020, Governor Brian P. Kemp signed into law Georgia HB 888, the state's Surprise Billing Consumer Protection Act (the "Act").[2] The Act, which became effective on January 1, 2021, is designed to limit patient responsibility for unexpected medical bills from out-of-network providers and facilities. Through the Act, the Georgia legislature follows the lead of many other states, and recently also the federal government,[3] and installs a mechanism to address the lingering challenges of "surprise," or "balance," billing.

This article highlights some of the key features of the Act, with a particular focus on the Act's dispute resolution and arbitration provisions.

Balance Billing Prohibition and Basic Provisions

At its core, the Act is designed to resolve billing and payment disputes between insurers and out-of-network providers.[4] So-called surprise medical bills result when patients covered by health insurance receive out-of-network care from healthcare providers or facilities, and then those patients become subject to unexpectedly high balance billing. When a patient receives emergency care, or non-emergency care at an in-network facility but from a non-network provider, the patient might be charged hundreds or thousands of dollars – despite having health insurance – for the out-of-network services.

To curb this growing problem, the Act brings certain consumer protections against balance billing and limits the amounts patients can be required to pay in these instances. The Act also directs the Office of Commissioner of Insurance and Fire Safety (the "Commissioner") to maintain an all-payer health claims database and, significantly, establish an arbitration process to resolve billing disputes between out-of-network providers or facilities and insurers.

The Act defines "balance bill" as "the amount that a nonparticipating provider charges for services provided to a covered person . . . [equal to] the difference between the amount paid or offered by the insurer and the amount of the nonparticipating provider's bill charge, but shall not include any amount for coinsurance, copayments, or deductibles due by the covered person."[5] A "surprise bill," in turn, is defined as "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."[6]

The Act prohibits balance billing under certain defined circumstances. When an insured patient receives emergency care[7] from a network or non-network provider[8] or facility,[9] balance billing is prohibited, and the provider may not collect or bill the patient more than the applicable deductible, coinsurance, copayment, or other cost-sharing amount as determined by the person's insurance policy. Additionally, the insurer in such instance shall directly pay to the provider the greater of: (1) the verifiable contracted amount[10] paid by all eligible insurers for the provision of the same or similar services; (2) the most recent verifiable amount agreed to by the insurer and the non-participating emergency medical provider for the provision of the same services during such time as such provider was in-network with the insurer; or (3) such higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.[11]

Similarly, the Act also prohibits balance billing whenever an out-of-network provider furnishes non-emergency medical services to an insured patient at an in-network facility, if that patient has not first consented to receive that care from out-of-network providers at the in-network facility.[12] That is, an

insurer that provides any benefits to covered persons with respect to non-emergency medical services shall pay for such services that result in a surprise bill, regardless of whether the healthcare provider furnishing those services is a participating provider with respect to non-emergency medical services.[13] As in its prohibition of balance billing in the context of emergency services, the Act restricts out-of-network providers rendering non-emergency services to billing patients for only cost-sharing amounts pursuant to the applicable insurance policy.[14]

Note, however, that the Act explicitly excludes from its balance billing prohibition, and from its definition of "surprise bill," a covered person's financial responsibilities when such a person chooses to receive non-emergency medical services from an out-of-network provider.[15] The Act sets forth a number of notice and consent requirements associated with a patient's valid choice to receive such non-network services.[16]

Dispute Resolution Mechanism: Independent Arbitration

The Act establishes an arbitration process as a mechanism to resolve disputes between providers, facilities, and insurers over payments for services the Act implicates. If an out-of-network provider or facility concludes that it receives insufficient payment from an insurer for certain emergency or non-emergency services under the Act, as applicable, given the complexity and circumstances of the services provided, the provider or facility may initiate an arbitration request with the Commissioner.[17] In such an instance, the provider or facility is to submit the request within thirty (30) days of receipt of payment for the claim, concurrently providing a copy to the insurer.[18]

Within thirty (30) days of receipt of a request for arbitration, the insurer shall submit to the Commissioner "all data necessary for the Commissioner to determine" whether the insurer's payment to the provider or facility was in compliance with the Act.[19] From the date of receiving the request, the Commissioner shall allow the parties thirty (30) days to negotiate a settlement and notify the Commissioner of the result of negotiations.[20] Then, should the parties not notify the Commissioner of their result within such thirty (30) days, the Commissioner shall refer the dispute to a dispute resolution organization within five (5) days.[21]

The Act further directs the Commissioner to promulgate rules[22] implementing the arbitration process requiring the Commissioner to select one or more resolution organizations[23] "to arbitrate certain claim disputes between insurers and out-of-network providers or facilities."[24] The Commissioner shall contract with one or more resolution organizations by July 1, 2021, to review and consider claim disputes between insurers and out-of-network providers or facilities as the Commissioner might refer.[25]

Upon the Commissioner's referral of a dispute to a resolution organization, the parties have five (5) days to select an arbitrator by mutual agreement.[26] If before the fifth (5th) day the parties have not notified the resolution organization of their selection, the resolution organization shall select an arbitrator from among its members.[27] The Act specifies that any selected arbitrator shall be independent and free of conflict with any party and shall have experience or knowledge in healthcare billing and reimbursement rates.[28]

The Act sets forth additional direction as to the mechanics of the enacted arbitration process. Each party has ten (10) days after arbitrator selection to submit to the resolution organization, in writing, its final offer and supporting argument.[29] Initial arguments are limited to twenty (20) written pages per party, and parties may submit supporting documents and an additional written submission as the arbitrator may deem necessary.[30]

"Baseball-Style" Arbitration Format

Notably, the Act also provides detail describing its "baseball-style" arbitration format. For disputants under the Act, each party is to submit one proposed payment amount to the arbitrator, and the arbitrator must choose one of the two amounts in making a decision.[31] Considering "the complexity and circumstances of each case, including, but not limited to, the level of training, education, and experience of the relevant physicians or other individuals at the facility who are licensed or otherwise authorized . . . to furnish healthcare services and other factors as

determined by the Commissioner through rule," the arbitrator must select a submitted amount without modification.[32]

The arbitrator's final decision must be issued in writing, describing its basis and including citations to relied-upon documents, within thirty (30) days of the Commissioner's referral.[33] Furthermore, importantly, any default or final arbitrator decision "shall be binding upon the parties and is not appealable through the court system."[34] The party whose final offer amount is not selected by the arbitrator, or a defaulting party, shall pay to the resolution organization the amount of the verdict, the arbitrator's expenses and fees, and any other fees assessed by the resolution organization.[35] Moneys due under these provisions shall be paid in full to the resolution organization within fifteen (15) days of the arbitrator's final decision.[36] Within three (3) days of receipt of such payment, the resolution organization shall distribute moneys due to the party whose final offer was selected.[37]

Once a request for arbitration has been filed by a provider or facility under the Act, neither such provider or facility, nor the insurer involved in the dispute, shall file a lawsuit regarding the disputed claim.[38] Besides precluding court action on a claim in arbitration, the Act also clarifies that neither the Georgia Administrative Procedure Act nor the Georgia Civil Practice Act is applicable to an arbitration conducted pursuant to the Act.[39]

Database, Reporting, and Other Provisions

The Act directs the Commissioner to maintain an all-payer health claims database and records of insurance payments that track them by healthcare services and geographic areas.[40] The Commissioner is to update database information at least annually and also maintain the information on its website.[41]

The Act imposes reporting requirements upon resolution organizations and upon the Commissioner. Such requirements relate to the number of arbitrations filed under the Act, the number of such arbitrations settled, arbitrated, defaulted, and dismissed, and whether the arbitration decisions were in favor of the insurer or the provider or facility.[42] Finally, the Act authorizes the Commissioner to refer an arbitrator decision to the appropriate state agency or governing entity if the Commissioner concludes that a provider or facility "has either displayed a pattern of acting in violation of . . . [the Act] or has failed to comply with a lawful order of the Commissioner or the arbitrator."[43]

Endnotes

1. Douglas J. Witten, principal of Innovative ADR International LLC, is a mediator and arbitrator who offers dispute resolution services with a focus on healthcare, workplace injuries, insurance and commercial matters. He is a panel neutral for the American Health Law Association and for BAY Mediation & Arbitration Services. Doug's latest publications include *The Stoic Negotiator and Mediation Essentials Toolkit: A Practitioner's Emergency Survival Guide* (2021).
2. O.C.G.A. §§ 33-20E-1 to 33-20E-23.
3. The federal "No Surprises Act," amending Title XXVII of the Public Health Service Act (42 U.S.C. § 300gg-11, *et seq.*), adopted as part of the Consolidated Appropriations Act, 2021 (H.R. 133; Division BB – Private Health Insurance and Public Health Provisions), was signed into law on December 27, 2020 and is effective January 1, 2022. *See* https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf. Note that Georgia's Act by its terms is not applicable to healthcare plans subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* (ERISA). O.C.G.A. § 33-20E-3(a). *See also* O.C.G.A. § 33-20E-10(4). The Act's definition of "healthcare plan" excludes certain limited benefit insurance policies or plans, air ambulance insurance, Georgia's workers' compensation program, Medicare, Medicaid and other plans over which the Commissioner lacks authority. *See* O.C.G.A. § 33-20E-2(b)(8). An analysis of the interplay between the new federal and Georgia statutes is beyond the scope of this article. Nonetheless, it bears noting that implementation of parallel arbitration mechanisms could become administratively complex, and perhaps federal rulemaking will provide useful guidance (current rulemaking deadline is July 1, 2021).
4. *See* Ga. Comp. R. & Regs. 120-2-106-.02.
5. O.C.G.A. § 33-20E-2(b)(1).
6. O.C.G.A. § 33-20E-2(b)(18).
7. The Act defines "emergency medical services" tied to those "that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part." O.C.G.A. § 33-20E-2(b)(5). The Act does not operate to reduce covered persons' financial responsibilities for ground ambulance transportation. O.C.G.A. § 33-20E-23.
8. "Healthcare provider" or "provider," under the Act, "means any physician, other individual, or facility other than a hospital licensed or otherwise authorized in this state to furnish healthcare services, including, but not limited to, any dentist, podiatrist, optometrist, psychologist, clinical social worker, advanced practice registered nurse, registered optician, licensed professional counselor, physical therapist,

marriage and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist, speech-language pathologist, audiologist, dietician, or physician assistant." O.C.G.A. § 33-20E-2(b)(9).

9. "Facility" is defined as "a hospital, an ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution." O.C.G.A. § 33-20E-2(b)(6).
10. The "contracted amount" is the median in-network amount paid during the 2017 calendar year by an insurer for the services provided by similarly situated in-network providers in the same or nearby geographic area, adjusted annually for inflation and excluding Medicare or Medicaid rates. *See* O.C.G.A. § 33-20E-2(b)(2).
11. *See* O.C.G.A. § 33-20E-4.
12. O.C.G.A. § 33-20E-5(a).
13. *Id*.
14. *See* O.C.G.A. § 33-20E-5(b). The Act also prohibits a non-participating provider from reporting "to any credit agency any covered person who receives a surprise bill . . . and does not pay such provider any copay, coinsurance, deductible, or other cost-sharing amount beyond what such covered person would pay if such nonparticipating provider had been a participating provider."
15. O.C.G.A. § 33-20E-22.
16. O.C.G.A. § 33-20E-7(a).
17. *See* O.C.G.A. § 33-20E-7(b) & (c).
18. O.C.G.A. § 33-20E-9(a).
19. *Id.* A request for arbitration may involve a single patient and single or 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. O.C.G.A. § 33-20E-9(b).
20. O.C.G.A. § 33-20E-11. The Commissioner need not make such compliance determination prior to referring the dispute for arbitration. *Id*.
21. O.C.G.A. § 33-20E-12.
22. *Id*.
23. *See* Ga. Comp. R. & Regs. 120-2-106.01 to 120-2-106.12. "Resolution organization" is defined as "a qualified, independent, third-party claim dispute resolution entity selected by and contracted with the [Commissioner] . . . ." O.C.G.A. § 33-20E-2(b)(16).
24. O.C.G.A. § 33-20E-12.
25. *Id*. The Commissioner's Administrative Procedure Division will keep a list of the selected organizations and their approved fee schedules, available for review on request. Ga. Comp. R. & Regs. 120-2-106-.10(7).
26. O.C.G.A. § 33-20E-13.
27. *Id*.
28. *See id*.
29. O.C.G.A. § 33-20E-14.
30. *See id*. Additional written argument shall be limited to no more than ten (10) pages per party. O.C.G.A. § 33-20E-14. Failure of either party to submit timely supportive documentation may result in a default against that party. *Id*.
31. *See* O.C.G.A. § 33-20E-15.
32. *Id*. Regulations also set forth additional factors an arbitrator should consider in deciding a claim. See Ga. Comp. R. & Regs. 120-2-106-.10(10).
33. O.C.G.A. § 33-20E-15.
34. *Id*.
35. O.C.G.A. § 33-20E-16.
36. *Id*.
37. *See id*.
38. O.C.G.A. § 33-20E-18.
39. O.C.G.A. § 33-20E-21.
40. O.C.G.A. § 33-20E-8. On December 30, 2020, the Commissioner posted on its website that it has contracted with FAIR Health, an independent nonprofit, to provide the "contracted amount" as referenced in the Act and regulations (available at https://oci.georgia.gov/news/2020-12-30/office-commissioner-insurance-and-safety-fire-posts-final-surprise-billing).
41. O.C.G.A. § 33-20E-8.
42. *See* O.C.G.A. §§ 33-20E-19 & 33-20E-20. O.C.G.A. § 33-20E-17. The state agency or governing entity shall then initiate an investigation within thirty (30) days and conclude the investigation within ninety (90) days of receiving such a referral. *Id*. Regulations also detail insurers' responsibility to make available, online and in print, a health benefit plan "surprise bill rating" for hospitals. See Ga. Comp. R. & Regs. 120-2-106.11.