Georgia H.B. 888 protects patients from balance billing. It goes into effect on January 1, 2021. Under H.B. 888...

- Payment for emergency and non-emergency out-of-network services is the greatest of the following...
  - The median in-network amount paid during the 2017 calendar year by an insurer for the emergency or non-emergency services provided by in-network providers engaged in the same or similar specialties and provided in the same or nearest geographical area and annually adjusted for inflation or
  - The most recent verifiable amount agreed to by the insurer and the non-participating emergency medical provider for the provision of the same services when the provider was in-network with the insurer or
  - A higher amount that the insurer deems appropriate given the complexity and circumstances of the services

- Payment for emergency services must be made without the need for any prior authorization and without any retrospective payment denial for medically necessary services.

- The above payment for non-emergency services applies where an insured patient receives health care services from an out-of-network provider at an in-network facility.

- The patient is only responsible for their in-network copay, coinsurance, or deductible, and the insurer must apply the patient’s cost-sharing to the patient’s deductible and maximum out-of-pocket limit as if the services were provided in-network.

- Payments from the insurer must include a notice that specifies whether the health care plan is subject to the exclusive jurisdiction of the ‘Employee Retirement Income Security Act’ of 1974 (29 U.S.C. Sec. 1001, et seq.).

- These payment provisions do not apply if a patient chooses to receive care from an out-of-network provider, and the patient’s choice must be documented by the practice in both written and oral form before any services are rendered and after they have received an estimate of the charges.
• The Georgia Department of Insurance (DOI) is required to create an “all-payer health claims data base” to track payments by health care services and geographic areas once the funding is appropriated. Until then, DOI will use an interim system to publish the “median in-network rate.”

• If the physician or another provider or a facility concludes that the payment they receive for a particular service is not sufficient given the complexity and circumstances of the services provided, they can 1) submit a “request for arbitration” form to DOI within 30 days of receipt of the payment for the claim and 2) send a copy of this form to the insurer at the same time.

• The request for arbitration may involve a single patient and a single type of health care service, a single patient and multiple types of health care services, multiple patients and a single type of health care service, or multiple substantially similar health care services in the same specialty on multiple patients.

• Under the arbitration process, the parties have 30 days to negotiate a payment that is mutually acceptable. If they do not, the DOI will refer the claim to a third-party resolution organization. After an arbitrator is selected, each party has 10 days to submit their final offer and the rationale for their offer. Each party shall submit a proposed payment amount to the arbitrator. And within 30 days of referral, the arbitrator shall pick one of the two amounts – which will be revealed in their final decision. The arbitrator must consider 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 in this state to furnish health care services and other factors as determined by DOI through the rulemaking process.

• An arbitrator’s default or final decision is binding and not appealable in the court system.

• The losing party shall pay the amount of the verdict, the arbitrator’s expenses and fees, and any other fees assessed by the resolution organization – directly to the resolution organization within 15 days of the arbitrator’s decision.

• If DOI concludes that a physician has displayed a pattern of violating this law or fails to comply with a lawful DOI or arbitrator order, DOI can refer the arbitrator’s decision to the Georgia Composite Medical Board.

• Non-participating providers cannot report a patient to any credit reporting agency that does not pay the provider a copay, coinsurance, a deductible, or other cost-sharing amount beyond what a covered person would pay if the non-participating provider had been a participating provider.

MAG members can contact Bethany Sherrer at bsherrer@mag.org with questions about H.B. 888. With more than 8,400 members, MAG is the leading voice for physicians in Georgia. MAG represents physicians in every specialty and practice setting. Go to www.mag.org for additional information.