CRC BENEFITS | THRIVE Workplace Benefits
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GEORGIA

Regulatory Compliance and Resources by State

STATE CONTINUATION

Covered Employees: Employers with fewer than 20 employees

Qualified Beneficiaries: Employees and dependents covered under the plan for 6 months prior to termination

Qualifying Events:

- Any event that results in loss of coverage, except termination for cause

COBRA Duration: 3 months starting after month in which coverage was lost

Maximum premium amount: Not specified

PAID SICK LEAVE

On May 8, 2017, Georgia Governor Nathan Deal signed into law the Family Care Act, a new statute requiring certain employers to allow their employees to use up to five days of their available paid sick leave to care for immediate family members. This new law takes effect on July 1, 2017. What follows are several important questions and answers regarding the Family Care Act's requirements, as well as a number of key takeaways for employers.

Q: Which employers are covered?

A: The new law applies to employers with 25 or more employees, as well as to state government employees. Importantly, the law applies only to employers that already provide paid sick leave in addition to short-term or long-term disability plans.

Q: Which employees are covered?

A: Employees who work for salaries, wages, or other remuneration for at least 30 hours per week are eligible to use sick leave for the care of an immediate family member.

Q: Are employers required to provide paid sick leave benefits?

A: No. Unlike other states with paid sick leave laws, Georgia's statute does not obligate employers to provide sick days. The law only requires that if an employer already provides workers with paid sick leave, then that employer is also required to allow employees to use a certain amount of their leave allowance to care for immediate family members.

Q: How much paid time is required?

A: Covered employers must allow eligible employees to use up to five days of paid sick leave for the care of an immediate family member. Again, this would apply only if the employer already has a paid sick leave policy. The statute also specifically provides that an employer is not required to allow an employee to use more than five days of earned sick leave per calendar year for the care of an immediate family member.

Q: When can an employee use the leave?

A: The statute does not entitle an employee to use sick leave until that leave has been earned, and an employee wishing to use such sick leave must comply with the terms of the employer's sick leave policy.

Q: Who is an "immediate family member"?

A: The law defines "immediate family member" as "an employee's child, spouse, grandchild, grandparent, or parent or any dependents as shown in the employee's most recent tax return."

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Q: How does this affect an employer's obligations under the federal Family and Medical Leave Act (FMLA)?

A: Georgia employers that are also covered by the FMLA will still be required to provide unpaid federal FMLA leave for eligible employees. How this new law and the FMLA will interact remains to be seen, but employers should remain cognizant of the potential interplay between these two statutes and keep themselves apprised of any related advancements.

Q: What are the law's enforcement provisions?

A: The new law does not contain any enforcement or penalty provisions. The law is therefore more bark than bite. In fact, the law specifically states that it shall not be construed to create a new cause of action against an employer.

This does not mean, however, that employers can ignore the Family Care Act. Employers should consider taking affirmative steps to ensure that any paid sick leave plan is compliant with this law, and ensure that all human resources personnel and management employees understand its implications.

Paid Family Leave: None, FMLA

SURPRISE BILLING

When Balance Billing is Prohibited:

Under the new law, balance billing is prohibited in the following circumstances:

1. **Emergency Care:** Whenever any out-of-network provider or out-of-network facility furnishes emergency medical services to an insured patient, regardless of whether the patient has advance notice of a provider's or facility's out-of-network status; and
2. **Non-Emergency Care:** Whenever any 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.

When Balance Billing is Not Prohibited:

The new law does not prohibit balance billing when an insured patient receives non-emergency medical services at an out-of-network facility, whether furnished by the out-of-network facility or an out-of-network provider.

What Constitutes Emergency Medical Services:

"Emergency medical services" are defined based on what would lead "a prudent layperson possessing an average knowledge of medicine and health to believe" that immediate medical care is necessary so as to avoid (a) "serious jeopardy" to the patient's health, (b) "serious impairment to bodily functions," or (c) "serious dysfunction of any bodily organ or part." "Non-emergency medical services" by contrast are defined broadly and generally include anything that does not qualify as "emergency medical services."

What Facilities and Providers are Covered by the New Law:

A "facility" means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice facility, or a "similar institution." A "provider" in turn is defined more broadly and generally includes provider types not falling within the definition of "facility." "Provider" expressly includes "facilities other than a hospital licensed or otherwise authorized in this state to furnish healthcare services" as well as a variety of healthcare professionals such as physicians, physician assistants, advanced practice registered nurses, licensed professional counselors and other therapists, physical therapists and related professionals, clinical social workers, and even athletic trainers.

What Out-of-Network Providers May Collect Under the New Law:

When the new law prohibits balance billing, an out-of-network provider may bill a patient only for the cost-sharing amount (e.g., deductible, coinsurance, copayment, etc.) that the patient is ordinarily responsible for under the terms of his or her insurance policy. The insurer will then be required to pay the out-of-network provider the greater of (i) the verifiable "contracted amount" paid by all eligible insurers for the same or similar services4; (ii) the most recent verifiable amount agreed to by the insurer and the out-of-network provider for the provision of the same services during the time the provider was in-network; or (iii) a higher amount that the insurer deems appropriate given the complexity and circumstances.

The new law contains a formula for calculating the "contracted amount" and whether the out-of-network provider was previously included in the applicable insurer's provider network. The new law also establishes an arbitration process for out-of-network providers and out-of-network facilities who believe they should be entitled to additional

funds under certain provisions of the new law. Providers and facilities would have 30 days from receipt of payment to request arbitration, and the arbitration requests may involve a single or multiple patients and healthcare services.

Patient Consent Required to Balance Bill for Non-Emergency Care Provided by Out-of-Network Provider in In-Network Facility:

The new law allows out-of-network providers furnishing non-emergency medical services at in-network facilities to issue balance bills upon compliance with pre-service patient notice and consent procedures. Such out-of-network providers must:

1. Provide the patient with an estimate of the potential charges associated with receiving the out-of-network services; and
2. Document the patient's informed choice to receive the out-of-network services by obtaining the patient's oral and written consent prior to administering the services.

Notably, if a patient requests an attending provider to refer the patient to another provider for the immediate provision of additional non-emergency medical services, the referred provider can only balance bill the referred patient for non-emergency medical services if the referring provider:

1. Advises the patient that the referred provider may be a "nonparticipating" or out-of-network provider and may charge higher fees than a participating provider;
2. Obtains the patient's oral and written acknowledgement of that fact;
3. Ensures that the written acknowledgement includes statutorily required language and is a separate document from other documents furnished by the referring provider; and
4. Records in the patient's medical file that the first three of these requirements have been satisfied.

Interestingly, the new law puts the burden on the referring provider—rather than on the referred provider—for fulfilling the notice and consent requirements. The referred provider, however, should confirm that the notice and consent requirements were satisfied by the referring provider prior to balance billing.

Exemptions and Limitations of the New Law:

While the new law applies to a variety of State and private health insurance plans regulated by Georgia's Commissioner of Insurance, the law does not apply to Medicare, Medicaid, the State's workers' compensation program, or limited benefit insurance policies designed to supplement major health insurance plans (with the exception that stand-alone dental and vision policies are included). The new law also does not apply to plans exclusively subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). Finally, the new law does not apply to air ambulance insurance plans or any ground ambulance transportation services, regardless of insurer.

Other Notable Features:

- Gives the Commissioner of Insurance jurisdiction in administering the new law, including limited rulemaking powers;
- Authorizes the creation of a publicly available all-payer health claims database;
- Creates a detailed arbitration system for providers to resolve reimbursement disputes with insurers; and
- Authorizes the Commissioner of Insurance to refer arbitration decisions to agencies or entities having governing authority over providers or facilities if the Commissioner finds that a provider or facility has "displayed a pattern of acting in violation" of the law or has "failed to comply with a lawful order of the Commissioner or the arbitrator."

Department of Insurance website: https://oci.georgia.gov/