House Bill 1151

By: Representative Schofield of the 60th

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to increase consumer access to health care by improving network adequacy; to provide for a short title; to provide for definitions; to provide for confidentiality; to provide for the inclusion of a consumer hold harmless provision; to provide that under certain circumstances, health carriers shall charge for out-of-network services at in-network rates; to provide for a requirement that carriers file network adequacy plans with the department; to provide for a requirement that health carriers notify providers on an ongoing basis of the specific covered health care services for which the provider is responsible; to provide for a standard continuity of care authorization form proscribed by the Commissioner; to provide for an advisory committee for advising on standard continuity of care; to provide for notice of contract termination requirements between health insurers and providers; to provide for establishment of a mediation process; to provide to provide for effective dates; to provide for applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new chapter to read as follows:

″CHAPTER 20E

33-20E-1.

This Act shall be known and may be cited as the 'Health Benefit Plan Network Access and Adequacy Act.'

33-20E-2.

As used in this chapter, the term:

(a) 'Authorized representative' means:

(1) A person to whom a covered person has given express written consent to represent the covered person;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) The covered person's treating health care professional only when the covered person is unable to provide consent or a family member of the covered person.

(b) 'Balance billing' means the practice of a health care provider billing for the difference between the provider's charge and the health carrier's allowed amount.

(c) 'Commissioner' means the insurance Commissioner of this state.

(d) 'Covered benefit' or 'benefit' means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(e) 'Covered person' means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

(f) 'Emergency medical condition' means a physical, mental, or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(1) Placing the individual's physical, mental, or behavioral health or, with respect to a pregnant woman, the health of the woman or the fetus in serious jeopardy;

(2) Serious impairment to a bodily function;

(3) Serious impairment of any bodily organ or part; or

(4) With respect to a pregnant woman who is having contractions:

(A) Inadequate time to effect a safe transfer to another hospital before delivery; or

(B) Transfer to another hospital, which may pose a threat to the health or safety of the woman or the fetus.

(g) 'Emergency medical services' means medical services after the recent onset of a medical or traumatic condition, manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing his or her health in serious jeopardy or causing serious impairment to bodily functions or serious dysfunction of any bodily organ or part, and services for the first 24 hours after the covered person's emergency condition has stabilized, as determined by the treating health care provider, regardless of whether the emergency services and services after stabilization occur in an emergency department. Such term shall include care for an emergency condition that continues once a patient is admitted to the hospital from its emergency department and could include other specialists and providers.

(h) 'Essential community provider' or 'ECP' means a provider that:

(1) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA); or

(2) Is described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by Section 221 of Pub.L.111-8.

(i) 'Facility' means an institution providing physical, mental, or behavioral health care services, or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(j) 'Health benefit plan' means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of physical, mental, or behavioral health care services.

(k) 'Health care professional' means a physician or other health care practitioner licensed, accredited, or certified to perform specified physical, mental, or behavioral health care services consistent with their scope of practice under state law.

(l) 'Health care provider' or 'provider' means a health care professional, a pharmacy, or a facility.

(m) 'Health care services' means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental, or behavioral health condition, illness, injury, or disease, including mental health and substance use disorders.

(n) 'Health carrier' or 'carrier' means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a health insurance company, a health maintenance organization, a hospital and health care corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

(o) 'Intermediary' means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

(p) 'Limited scope dental plan' means a plan that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

(q) 'Limited scope vision plan' means a plan that provides coverage substantially all of which is for treatment of the eye that is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

(r) 'Network plan' means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

(s) 'Participating provider' means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(t) 'Person' means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(u) 'Primary care' means health care services for a range of common physical, mental or behavioral health conditions provided by a physician or nonphysician primary care professional.

(v) 'Primary care professional' means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(w)(1) 'Specialist' means a physician or nonphysician health care professional who:

(A) Focuses on a specific area of physical, mental, or behavioral health or a group of patients; and

(B) Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

(2) Such term includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

(x) 'Specialty care' means advanced medically necessary care and treatment of specific physical, mental, or behavioral health conditions or those health conditions which may manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

(y) 'Telemedicine' means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

(z) 'Tiered network' means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing, or provider access requirements, or any combination thereof, apply for the same services.

(aa) 'To stabilize' means with respect to an emergency medical condition, as defined in subsection (f), to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth with no complications resulting in a continued emergency, to deliver the child and the placenta.

(bb) 'Transfer' means, for purposes of subsection (bb), the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(1) Has been declared dead; or

(2) Leaves the facility without the permission of any such person.

33-20E-3.

(a) Except as provided in subsection (b), this chapter applies to all health carriers that offer network plans.

(b) The following provisions of this chapter shall not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) Code Section 33-20E-4(a)(2);

(2) Code Sections 33-20E-4(f)(7)(E), 33-20E-4(f)(8)(B), and 33-20E-4(f)(11);

(3) Code Section 33-20E-5(l)(2)(A)(i)(I) and (III), and Code Section 33-20E-5(C)(iii)(III);

(4) Code Section 33-20E-7;

(5) Code Section 33-20E-8(b)(2) and (3); and

(6) Code Section 33-20E-8(c)(1)(A) and (B), and (2) and (3).

33-20E-4.

(a)(1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) Covered persons shall have access to emergency services 24 hours per day, seven days per week.

(b) The Commissioner shall determine sufficiency in accordance with the requirements of this Code section, and may establish sufficiency by reference to any reasonable criteria, which may include, but shall not be limited to:

(1) Provider covered person ratios by specialty;

(2) Primary care professional covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency;

(8) Other health care service delivery system options, such as telehealth, mobile clinics, centers of excellence and other ways of delivering care; and

(9) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

(c) Notwithstanding subsection (b) of this Code section, the Commissioner shall adopt following specific criteria for patient wait times:

(1) For nonemergency primary care, patient wait times shall be no more than ten business days;

(2) For nonemergency specialists care, patient waits time shall be no more than 15 business days;

(3) For nonemergency mental health care by a health care provider other than a physician, patient wait times shall be no longer than 15 business days; and

(4) For other nonemergency care, patient wait times shall be no more than 15 business days.

(d) Notwithstanding subsection (b) of this Code section, the Commissioner shall adopt following specific criteria for patient travel:

(1) For primary care, OB-GYN, and general hospital care in urban settings, patients shall not have to travel greater than 30 minutes or 30 miles;

(2) For primary care, OB-GYN, and general hospital care in rural settings, patients shall not have to travel greater than 45 minutes or 45 miles;

(3) For specialist care in urban settings, patients shall not have to travel greater than 45 minutes or 45 miles; and

(4) For specialist care in rural settings, patients shall not have to travel greater than 60 minutes or 60 miles.

(e)(1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a nonparticipating provider, or shall make other arrangements acceptable to the Commissioner when:

(A) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(B) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a nonparticipating provider as provided in paragraph (1) of this subsection when:

(A) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and

(B) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health carrier shall treat the health care services the covered person receives from a nonparticipating provider pursuant to paragraph (2) of this subsection as if the services were provided by a participating provider, including applying cost-sharing no greater than the covered person's in-network cost-sharing and counting the covered person's cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described under paragraphs (1) and (2) of this subsection shall ensure that requests to obtain a covered benefit from a nonparticipating provider are addressed in a timely fashion appropriate to the covered person's condition.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider under this subsection and shall provide this information to the Commissioner upon request.

(6) The process established in this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in

accordance with the provisions of this chapter nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this subsection prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

(d)(1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the Commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.

(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

(e)(1) Beginning July 1, 2021, a health carrier shall file with the Commissioner for approval prior to or at the time it files a newly offered network, in a manner and form defined by rule of the Commissioner, an access plan meeting the requirements of this Act.

(2)(A) The health carrier may request the Commissioner to deem sections of the access plan as trade secret information that shall not be made public. The health carrier shall make the access plans, absent trade secret information, available online, at its business premises, and to any person upon request.

(B) For the purposes of this subsection, information is trade secret if the information qualifies as a trade secret pursuant to paragraph (4) of Code Section 10-1-761.

(3) The health carrier shall prepare an access plan prior to offering a new network plan, and shall notify the Commissioner of any material change to any existing network plan within 15 business days after the change occurs. The carrier shall include in the notice to the Commissioner a reasonable timeframe within which it will submit to the Commissioner for approval or file with the Commissioner, as appropriate, an update to an existing access plan.

(f) The access plan shall describe or contain at least the following:

(1) The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;

(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select providers;

(5) The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, diverse gender identities and sexual orientation, physical or mental disabilities, and serious, chronic, or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;

(6) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(7) The health carrier's method of informing covered persons of the plan's covered services and features, including but not limited to:

(A) The plan's grievance and appeals procedures;

(B) Its process for choosing and changing providers;

(C) Its process for updating its provider directories for each of its network plans;

(D) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and

(E) Its procedures for covering and approving emergency, urgent and specialty care, if applicable.

(8) The health carrier's system for ensuring the coordination and continuity of care:

(A) For covered persons referred to specialty physicians; and

(B) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

(10) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner. Such plan shall provide that covered persons who have been approved for continuity of care will be responsible for cost-sharing at no greater amount than that for which they would be responsible when receiving service from an in-network provider;

(11) The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitality care, and pathology and laboratory services at the carrier's participating hospitals; and

(12) Any other information required by the Commissioner to determine compliance with the provisions of this chapter.

(g) The department shall certify or disapprove of network adequacy of all health carriers on an annual basis.

33-20E-5.

(a) A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services.

(b) Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

'Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person. Such agreement shall:

(1) Be documented through the covered person's written and oral consent;

(2) Be documented at least 48 hours in advance of services received by the covered person from the provider; and

(3) Take place afer such covered person has been provided with an estimate of the potential charges. Such covered person may only waive protections against balanced billing from the provider if an in-network provider is available. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.'

(c) Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue until the earlier of:

(1) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled; or

(2) The date the contract between the carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the carrier or intermediary had remained in operation.

(d) The contract provisions that satisfy the requirements of subsections (b) and (c) shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by subsections (b) and (c) of this Code section.

(e) In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

(f)(1) Health carrier selection standards for selecting and tiering, as applicable, of participating providers shall be developed for providers and each health care professional specialty.

(2)(A) The standards shall be used in determining the selection and tiering of participating providers by the health carrier and its intermediaries with which it contracts.

(B) The standards shall meet the requirements of the Georgia Composite Medical Board or other appropriate governing authority.

(3)(A) Selection and tiering criteria shall not be established in a manner:

(i) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses, or health care services utilization; or

(ii) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses, or health care services utilization.

(B)(i) In addition to subparagraph (A) of this paragraph, a health carrier's selection criteria may not discriminate with respect to participation under the health benefit

plan against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

(ii) The provisions of subparagraph (B)(i) of this paragraph may not be construed to require a health carrier to contract with any provider willing to abide by the terms and conditions for participation established by the carrier.

(4) Paragraph (3) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this chapter.

(5) The provisions of this chapter do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 4 of this Act.

(g) A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review and approval by the Commissioner. A description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, shall be easily available to the public on the carrier's website and shall be provided in writing to anyone requesting such information.

(h) A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including, but not limited to, payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

(i) A health carrier shall not offer an inducement to a provider that would encourage or otherwise incent the provider to deliver less than medically necessary services to a covered person.

(j) A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier or in accordance with any rights or remedies available under applicable state or federal law.

(k) Every contract between a health carrier and a participating provider shall require the provider to make health records available to appropriate state and federal authorities

involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their of medical and health records.

(l)(1)(A) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause.

(B) The health carrier shall make a good faith effort to provide verbal and written notice of a provider's removal or leaving the network within thirty (30) days of receipt or issuance of a notice provided in accordance with subparagraph (A) of this paragraph to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause.

(C) When the provider being removed or leaving the network is a primary care professional, all covered persons who are patients of that primary care professional shall also be notified verbally and in writing. When the provider either gives or receives the notice in accordance with subparagraph (l)(1)(A) of this Code section, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier within 30 days.

(2)(A) As used in this paragraph, the term:

(i) 'Active course of treatment' means:

(I) An ongoing course of treatment for a life-threatening condition;

(II) An ongoing course of treatment for a serious acute condition;

(III) The second or third trimester of pregnancy; or

(IV) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) 'Life-threatening health condition' means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(iii) 'Serious acute condition' means a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, postoperative visits, or radiation therapy.

(B) For purposes of subparagraph (A) of this paragraph, a covered person shall have been treated by the provider being removed or leaving the network on a regular basis to be considered in an active course of treatment.

(C)(i) When a covered person's provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

(ii) The health carrier shall provide the notice required under paragraph (1) of this subsection, and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered person may request continuity of care, including a copy of a continuity of care authorization forms as provided under this paragraph.

(iii) The procedures shall provide that:

(I) Any request for continuity of care shall be made to the health carrier by the covered person or the covered person's authorized representative;

(II) Requests for continuity of care shall be reviewed by the health carrier's medical director after consultation with the treating provider for patients who meet the criteria listed in paragraph (2) of this subsection and are under the care of a provider who has not been removed or is leaving the network for cause. Any decisions made with respect to a request for continuity of care shall be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;

(III) The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and

(IV) The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:

(aa) The termination of the course of treatment by the covered person or the treating provider;

(bb) Ninety days, unless the medical director determines that a longer period is necessary;

(cc) The date that care is successfully transitioned to a participating provider; or

(dd) Care is not medically necessary.

(V) In addition to the provisions of subdivision (IV)(iii)(i) of this paragraph, a continuity of care request may only be granted when:

(aa) The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract; and

(bb) The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

(m) The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by either party without the prior written consent of the other party.

(n) A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

(o) A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for noncovered services.

(p) A health carrier shall not penalize a provider when the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

(q) A health carrier shall establish a mechanism by which participating providers may determine in a timely manner at the time services are provided whether or not an individual is a covered person or is within a grace period for payment of a premium during which time the carrier may hold a claim for services, pending receipt of payment of the premium.

(r) A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

(s) A contract between a health carrier and a provider shall not contain provisions that conflict with the provisions contained in the network plan or the requirements of this Act.

(t)(1)(A) At the time the contract is signed, a health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract.

(B) While the contract is in force, the carrier shall timely notify a participating provider of any changes to those provisions or documents that would result in material changes in the contract.

(C) For purposes of this paragraph, the contract shall define what is to be considered timely notice and what is to be considered a material change.

(2) A health carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

33-20E-6.

(a) The Commissioner shall promulgate rules and regulations by October 1, 2020, which:

(1) Prescribe a single, standard form for requesting continuity of care that shall not exceed two pages in length;

(2) Require that the department and all carriers make such form available electronically on the websites of:

(A) The department; and

(B) The carriers;

(3) Require that all carriers accept the standard continuity of care authorization form; and

(4) Require that all carriers deem a fully populated, standard continuity of care authorization form as a complete continuity of care request, for which no additional or supplemental information shall be required.

(b) The Commissioner shall:

(1) Appoint an advisory committee for advice on technical, operational, and practical aspects of developing the required single, standard continuity of care authorization form;

(2) Develop the form proscribed in subsection (a) of this Code section with input from the advisory committee; and

(3) Take into consideration:

(A) Any form for requesting continuity of care that is widely used in this state; and

(B) National standards, or draft standards, pertaining to electronic continuity of care authorization.

(c) The advisory committee shall be composed of the Commissioner or the Commissioner's designee and an equal number of members from each of the following groups:

(1) Physicians;

(2) Consumers or consumer representatives experienced with continuity of care requests; and

(3) Insurers.

(d) Members of the committee shall serve without compensation. The committee shall recommend to the Commissioner a single, standard form for requesting continuity of care.

(e) Within two days of receiving the standard continuity of care authorization form, carriers shall communicate and acknowledge receipt of such form to the covered person or his or her authorized representative.

(f) No later than 10 days after notification that the form has been received, carriers shall communicate to the covered person and the provider a status of either approved, denied, or incomplete.

(g) Each violation of this Code section by a carrier shall constitute a tort under the laws of this state. Any individual who has been injured by such carrier's failure to comply with any portion of this Code section shall have the right to bring a private action for damages.

33-20E-7.

(a) A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this Code section. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Code Section 33-20E-5.

(b) A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

(c) A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

(d) A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon 20 days prior written notice from the health carrier.

(e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

(f) If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for at least ten years in a manner that facilitates regulatory review.

(g) An intermediary shall allow the Commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this chapter.

(h) A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier shall remain obligated to pay the provider for furnishing

covered services under the same terms and conditions as the intermediary prior to the insolvency.

(i) Notwithstanding any other provision of this section, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall retain full responsibility for the intermediary's compliance with the requirements of this chapter.

33-20E-8.

(a) At the time a health carrier files its access plan, the health carrier shall file for approval with the Commissioner sample contract forms proposed for use with its participating providers and intermediaries.

(b) A health carrier shall submit material changes to a contract that would affect a provision required under this chapter or implementing regulations to the Commissioner for approval at least 60 days prior to use.

(c) If the Commissioner takes no action within 60 days after submission of a contract or material change to a contract by a health carrier, the contract or change is deemed approved.

(d) The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon 20 days prior notice from the Commissioner.

22-20E-9.

(a) The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

(b) All contracts shall be in writing and subject to review.

(c) All contracts shall comply with applicable requirements in the laws of the state and applicable regulations.

33-20E-10.

(a) The Commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, if he or she determines that a health carrier:

(1) Has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area;

(2) Has a network access plan that does not assure reasonable access to covered benefits;

(3) Has entered into a contract that does not comply with this chapter; or

(4) Has not complied with a provision of this chapter.

Additionally, if there is lack of compliance with the plan, the Commissioner may use other enforcement powers to obtain the health carrier's compliance with this chapter.

(b) The Commissioner will not act to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a network plan or provider network or regarding any other dispute between a health carrier, its intermediaries, or one or more providers arising under or by reason of a provider contract or its termination.

33-20E-11.

All consumers may file complaints with the department with regard to such consumers' access to an adequate network plan. Such complaints may appeal the department's certification of such network plan. The Commissioner shall establish processes for the department to address such complaints.

33-20E-12.

If any provision of this chapter or the application of any provision to any person or circumstance shall be held invalid, the remainder of the chapter and the application of the provision, other than to persons or circumstances to which it is held invalid, shall not be affected.

33-20E-13.

(a) All provider and intermediary contracts in effect on the effective date of this chapter shall comply with this chapter no later than 12 months after such effective date. The Commissioner may extend the 12 months for an additional period not to exceed six months if the health carrier demonstrates good cause for such extension.

(b) A new provider or intermediary contract that is issued on or after six months after the effective date of this chapter shall comply with this chapter.

(c) A provider contract or intermediary contract not described in subsection (a) or subsection (b) of this Code section shall comply with this chapter no later than 18 months after the effective date of this chapter.

(d) No later than 12 months after the effective date of chapter, each health carrier offering or renewing network plans in this state shall file access plans consistent with Code Section 33-20E-4 of this chapter for all in-force network plans.″

SECTION 2.

All laws and parts of laws in conflict with this Act are repealed.