The House Committee on Public Health offers the following substitute to SB 109:

A BILL TO BE ENTITLED
AN ACT

To amend Chapter 24 of Title 33 and Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to insurance generally and medical assistance generally, respectively, so as to increase access to certain drugs for patients; to prohibit insurers from discriminating against certain healthcare facilities and providers in connection with the procurement, delivery, and administration of provider administered drugs; to provide for definitions; to provide for violation; to provide for construction; to provide for penalties; to require the Department of Community Health to include continuous glucose monitors as a benefit for Medicaid recipients via the most cost-effective benefit delivery channel; to provide for coverage criteria; to provide for certain consultations by treating practitioners; to provide for related matters; to provide for effective dates and applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, is amended by adding a new Code section to read as follows:

"33-24-59.33.

(a) As used in this Code section, the term:

(1) 'Cost-sharing amount' means coinsurance, deductibles, and any other amounts imposed on an enrollee for a covered healthcare service under the covered person's health benefit plan.

(2) 'Covered person' means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan.

(3) 'Enrollee' means an individual who has elected to contract for or participate in a health benefit plan for such individual or for such individual and such individual's eligible dependents.

(4) 'Health benefit plan' means any hospital or medical insurance policy or certificate, healthcare plan contract or certificate, plan contract or certificate qualified higher deductible health plan, health maintenance organization or other managed care plan or subscriber contract, any health benefit plan established pursuant to Part 6 of Article 17 of Chapter 2 of Title 20 or Article 1 of Chapter 18 of Title 45, or a similar plan.

(5) 'Healthcare facility' means a hospital, ambulatory surgical center, birthing center, diagnostic and treatment center, hospice, outpatient clinic, healthcare provider's office, or similar institution.

(6) 'Healthcare provider' or 'provider' means any person, corporation, or healthcare facility licensed pursuant to Chapter 7 of Title 31 or Title 43 to provide healthcare services, including the administration of prescription medications, or otherwise lawfully administering prescription medications.

(7) 'Healthcare 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 abuse disorder.

(8) 'Insurer' means an accident and sickness insurer, fraternal benefit society, healthcare corporation, health maintenance organization, managed care entity, provider sponsored

healthcare corporation, or any similar entity regulated by the Commissioner or subject to the insurance laws and regulations of this state that provides, delivers, arranges for, finances, pays for, or reimburses any healthcare services through a health benefit plan, a plan administrator of any health benefit plan, a pharmacy benefits manager of any health benefit plan, a plan administrator of a health benefit plan established pursuant to Part 6 of Article 17 of Chapter 2 of Title 20 or Article 1 of Chapter 18 of Title 45, or other administrator as defined in paragraph (1) of subsection (a) of Code Section 33-23-100.

(9) 'Network participation contract' means a contract between a healthcare provider and an insurer providing the terms and conditions under which the healthcare provider agrees to provide healthcare services to the insurer's covered persons.

(10) 'Participating healthcare provider' means a healthcare provider that has a network participation contract in effect with an insurer for any healthcare services.

(11) 'Provider administered drug' means a prescription medication that is typically administered and billed by a healthcare provider and that the treating healthcare provider determines cannot be reasonably or safely self-administered by the patient to whom the medication is prescribed or by any individual, other than a healthcare provider, assisting the patient with the self-administration.

(b) An insurer that refuses to authorize, approve, or appropriately pay a participating healthcare provider for provider administered drugs or the administration of provider administered drugs and related services shall be in violation of this Code section.

(c) No insurer shall deny, restrict, refuse to authorize or approve, fail to cover, or reduce payment to a participating healthcare provider for a provider administered drug or the administration of a provider administered drug because the provider administered drug is:

(1) Procured or administered by a participating healthcare provider that is not identified or selected by the insurer;

(2) Dispensed by or procured or obtained from a pharmacy, manufacturer, or supplier that is not identified or selected by the insurer; or

(3) Obtained by the participating healthcare provider from a pharmacy, manufacturer, or supplier that does not have a network participation contract with the insurer, provided the drug supplied by such pharmacy, manufacturer, or supplier meets the requirements set forth in the federal Drug Supply Chain Security Act, Pub. L.113-54, as amended.

(d) No insurer shall require a covered person to pay a higher cost-sharing amount or any other additional amounts for a provider administered drug because the provider administered drug is:

(1) Procured or administered by a participating healthcare provider that is not identified or selected by the insurer;

(2) Dispensed by or procured or obtained from a pharmacy, manufacturer, or supplier that is not identified or selected by the insurer; or

(3) Obtained from a pharmacy, manufacturer, or supplier that does not have a network participation contract with the insurer.

(e) No insurer shall require provider administered drugs to be dispensed by a pharmacy selected by the health benefit plan.

(f) No insurer shall limit or exclude coverage for a provider administered drug when not dispensed by a pharmacy selected by the health benefit plan if such provider administered drug would otherwise be covered under the health benefit plan.

(g) No insurer shall consider, as part of a health benefit plan's medical necessity criteria, the source from which a provider administered drug is procured or the site of delivery or administration of a provider administered drug.

(h) No insurer shall authorize or permit another person or entity acting on its behalf, including a pharmacy benefits manager, to administer claims or benefits under a network participation contract in violation of this Code section.

(i) No insurer shall interfere with the patient's right to choose to obtain a provider administered drug from his or her provider or pharmacy of choice, including interference through inducement, steering, or the offering of financial or other incentives.

(j) An insurer shall not require a specialty pharmacy to dispense a provider administered medication directly to a patient for the purpose of having the patient transport such medication to a healthcare provider for administration to the patient.

(k) An insurer may offer, but shall not require:

(1) The use of a home infusion pharmacy to dispense provider administered drugs to a patient for administration in his or her home; or

(2) The use of an infusion site external to a patient's healthcare provider office or clinic.

(l) Nothing in this Code section shall prohibit an insurer from establishing differing copayments or other cost-sharing amounts within the health benefit plan for provider administered drugs procured from or through, or for the administration of provider administered drugs by a healthcare provider that is not a participating healthcare provider.

(m) Except as provided in this Code section, nothing herein shall prohibit an insurer from refusing to authorize or approve, or from denying coverage for, a provider administered drug based upon failure to satisfy the required terms of coverage in the health benefit plan, including medical necessity criteria, provided that such criteria comply with subsection (g) of this Code section.

(n) Without limiting any other remedies or state laws that may apply, noncompliance with this Code section by an insurer may result in the imposition of penalties set forth in Code Section 33-2-24."

SECTION 2.

Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, is amended by adding a new Code section to read as follows:

"49-4-159.2.

(a) On and after July 1, 2023, the department shall include coverage for continuous glucose monitors as a benefit under Medicaid via the most cost-effective benefit delivery channel. The criteria for such coverage shall be updated to align with current standards of care and shall include, but shall not be limited to, requirements that:

(1) The recipient has been diagnosed with diabetes mellitus by a treating practitioner;

(2) The recipient's treating practitioner has concluded that the recipient or the recipient's caregiver has had sufficient training in using a continuous glucose monitor as evidenced by the provision of a prescription therefor; and

(3) The recipient:

(A) Is treated with at least one daily administration of insulin; or

(B) Has a history of problematic hypoglycemia with documentation of at least one of the following:

(i) Recurrent level 2 hypoglycemic events (glucose less than 54 mg/dL (3.0 mmol/L)) that persist despite two or more attempts to adjust medication, modify the diabetes treatment plan, or both; or

(ii) A history of a level 3 hypoglycemic event (glucose less than 54 mg/dL (3.0 mmol/L)) characterized by altered mental or physical state requiring third-party assistance for treatment for hypoglycemia.

(b) Within six months prior to prescribing a continuous glucose monitor for a recipient, the treating practitioner shall have had an in-person or telehealth visit with the recipient to evaluate the recipient's diabetes control and shall have concluded that the recipient meets the criteria set forth in subsection (a) of this Code section.

(c) Every six months following the initial prescription of a continuous glucose monitor, the treating practitioner shall have an in-person or telehealth visit with the recipient to assess adherence to his or her continuous glucose monitor regimen and diabetes treatment plan."

SECTION 3.

(a) Except as otherwise provided in subsection (b) of this section, this Act shall become effective on July 1, 2023.

(b) Section 1 of this Act shall become effective on January 1, 2024, and shall apply to all health benefit plans issued, delivered, issued for delivery, or renewed in this state on or after such date and all provider administered drugs procured or administered on or after such date.

SECTION 4.

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