Senate Bill 158

By: Senators Burke of the 11th, Kirk of the 13th, Watson of the 1st, Hill of the 6th and McKoon of the 29th

A BILL TO BE ENTITLED
AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide certain consumer and provider protections regarding health insurance; to provide for definitions; to provide for short titles; to provide for health insurer transparency; to provide for health care providers' right to choose; to provide for health care provider stability; to provide for consumer right to access; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

This Act shall be known and may be referred to as the "Consumer and Provider Protection Act."

SECTION 2.

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

"CHAPTER 20C

ARTICLE 1

33-20C-1.

As used in this chapter, the term:

(1) 'Affiliate' means an entity owned or controlled, either directly or through a parent or subsidiary entity, by a contracting entity that accesses the rates, terms, or conditions of health care services.

(2) 'Contracting entity' means any person or entity that enters into direct contracts with health care providers for the delivery of health care services in the ordinary course of business, including a health care organization or hospital organization when leasing or renting the health care organization's or hospital organization's network to a third party.

(3) 'Covered person' means an individual who is covered under a health insurance plan.

(4) 'Enrollee' means a policyholder, subscriber, covered person, or other individual participating in a health benefit plan.

(5) 'Health benefit plan' means any managed care plan, hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy; but health benefit plan does not include policies issued in accordance with Chapter 31 of this title; disability income policies; or Chapter 9 of Title 34, relating to workers' compensation.

(6) 'Health care provider' or 'provider' means any physician, dentist, podiatrist, pharmacist, 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, dietitian, or physician assistant.

(7) 'Health care services' means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from illness, injury, or other human physical problem and includes, but is not limited to:

(A) Hospital services which include the general and usual care, services, supplies, and equipment furnished by hospitals;

(B) Medical services which include the general and usual services and care rendered and administered by doctors of medicine, doctors of dental surgery, and doctors of podiatry; and

(C) Other health care services which include appliances and supplies; nursing care by a registered nurse or a licensed practical nurse; care furnished by such other licensed practitioners as may be expressly approved by the board of directors from time to time; institutional services, including the general and usual care, services, supplies, and equipment furnished by health care institutions and agencies or entities other than hospitals; physiotherapy; ambulance services; drugs and medications; therapeutic services and equipment, including oxygen and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and appliances, including wheelchairs, trusses, braces, crutches, and prosthetic devices, including artificial limbs and eyes; and any other appliance, supply, or service related to health care.

(8) 'Health insurer' means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health

maintenance organization, provider sponsored health care corporation, or any similar entity.

(9) 'Material change' means a change regarding: decreases in fees or payment methodologies in excess of 7 percent, coding guidelines, payment rules, including but not limited to a multiple procedure payment reduction rules, claim payment procedures, or any other elements that the third-party payor utilizes to determine payment or reimbursement amounts. This term does not include any revision to the enrollee's benefit package.

(10) 'Network' means the group of participating providers providing services under a health benefit plan.

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

(12) 'Provider network contract' means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and provider for the delivery of and payment for health care services to covered persons.

(13) 'Rental preferred provider network' means a preferred provider network that contracts with a health insurer or other payor or with another preferred provider network to grant access to the terms and conditions of its contract with medical physicians. Such contracts are often referred to as 'renting' or 'leasing' the network. The term 'rental preferred provider network' does not refer to a proprietary network of a licensed insurer or to arrangements providing for access to the proprietary network of a licensed insurer by affiliates of the licensed insurer or by entities receiving administrative services from the licensed insurer or its affiliates.

(14) 'Third party' means an organization that enters into a contract with a contracting entity or with another third party to gain access to a provider network contract. 'Third party' shall not include the contracting entity's subsidiaries and affiliates. 'Third party' shall also not include any self-funded, employer sponsored health insurance plan regulated under the Employee Retirement Income Security Act of 1974, as codified and amended at 29 U.S.C. Section 1001, et seq.

ARTICLE 2

33-20C-10.

This article shall be known and may be cited as the 'Insurer Transparency Act.'

33-20C-11.

(a) Any person who commences business as a rental preferred provider network shall register with the Commissioner within 30 days of commencing business in this state unless such person is licensed by the Commissioner as a health insurer. Each rental preferred provider network not licensed by the Commissioner on July 1, 2015, shall be required to register with the Commissioner no later than September 30, 2015, and shall be placed on an approved list maintained by the Commissioner.

(b) Registration shall consist of the submission of the following information:

(1) The official name of the rental preferred provider network, including any d/b/a designations used in this state;

(2) The mailing address and main telephone number for the rental preferred provider network's main headquarters; and

(3) The name and telephone number of the rental preferred provider network representative who shall serve as the primary contact with the department.

(c) The information required by this Code section shall be submitted in written or electronic format, as prescribed by the Commissioner by rule or regulation.

(d) The Commissioner may, pursuant to rule or regulation, collect a reasonable fee for the purpose of administering the registration process.

(e) The Commissioner shall maintain an approved list of rental preferred provider networks.

33-20C-12.

It shall be grounds for the Commissioner to remove a rental preferred provider network from the approved list and thereby revoke the registration of such rental preferred provider network if the Commissioner finds that the person has:

(1) Knowingly accessed or utilized a provider's contractual discount pursuant to a provider network contract without a contractual relationship with the provider, rental preferred provider network, or third party; or

(2) Leased, rented, or otherwise granted to a third party access to a provider network contract unless the third party accessing the health care contract is:

(A) A payor or third-party administrator or another entity that administers or processes claims on behalf of the payor;

(B) A preferred provider organization or preferred provider network, including a physician organization or physician-hospital organization; or

(C) An entity engaged in the electronic claims transport between the preferred provider network and the payor that does not provide access to the provider's services and discount to any other third party.

33-20C-13.

This article shall not apply:

(1) To provider network contracts for services provided to Medicaid, Medicare, or State Children's Health Insurance Program (SCHIP) beneficiaries;

(2) To employers, church plans, or government plans receiving administrative services from a rental preferred provider network or its affiliates, or pharmacy benefits managers;

(3) In circumstances where access to the provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity;

(4) To the provision of any medical services for injuries covered by workers' compensation; or

(5) To health insurance plans.

ARTICLE 3

33-20C-20.

This article shall be known and may be cited as the 'Providers' Right to Choose Act.'

33-20C-21.

(a) No health insurer shall require, as a condition of contracting with the health insurer, that a health care provider must provide health care services under all health plans offered or sponsored by, or affiliated with, the health insurer, or to participate in all provider network arrangements offered or sponsored by, or affiliated with, the health insurer. A health insurer may not terminate any contractual relationship with a health care provider on the grounds that the health care provider did not agree to participate in a provider network arrangement pursuant to this Code section.

(b) This Code section shall not be construed to prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health care services under all of the contracting entity's products.

ARTICLE 4

33-20C-30.

This article shall be known and may be cited as the 'Provider Stability Act.'

33-20C-31.

(a) A health insurer may not effect a unilateral material change to a contract under which a health care provider is paid for providing items or services without the express agreement

of the health care provider during either the first year of the contract or the initial term of the contract, whichever is longer.

(b) After the initial term or first year of the contract in which a health care provider is paid, the health insurer may only effect a unilateral material change with the express agreement of the health care provider on the stipulated renewal date of the contract or the anniversary of the effective date of the contract, whichever is longer.

(c) A health insurer may not effect a unilateral material change to a contract with a health care provider pursuant to subsection (b) of this Code section, unless the health insurer provides a calculation that estimates any reduction in the provider's cumulative allowed amount based on 12 months, or an annualized shorter look back period, of actual data.

33-20C-32.

A person who violates or causes a violation of this article shall be liable for a civil penalty of not less than $500.00 or more than $2,000.00 for each violation.

33-20C-33.

A health care provider may maintain an action to enforce any provision of this article. The court may also award attorneys' fees and costs to the prevailing party. Such action shall not be contingent on the health care provider commencing or completing any administrative appeal process provided for in the contract between the health insurer and the health care provider.

33-20C-34.

(a) None of the provisions of this article may be waived by contract, and any such purported waiver is void.

(b) None of the provisions of this article obviates a health insurer's obligation to comply with any and all legal requirements to which such payor must comply with respect to participating or nonparticipating health care providers.

ARTICLE 5

33-20C-40.

This article shall be known and may be cited as the 'Consumer Right to Access Act.'

33-20C-41.

Each health insurer shall:

(1) Maintain a network that is sufficient in numbers and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access 24 hours per day, seven days per week;

(2) Report annually to the Commissioner for each of its policies or plans the number of enrollees and the number of participating in-network health care providers; and

(3) Maintain a network directory via Internet website, mobile applications or other electronic means through which a provider or enrollee may obtain a current listing, updated at least every 30 days, of all participating providers within each network.

33-20C-42.

(a) The Commissioner shall assess the provider network adequacy of each such health insurer. Such assessment shall be done annually at the time of license renewal or at the time of initial licensure and annually thereafter.

(b) In assessing provider network adequacy, the Commissioner shall consider, but is not limited to:

(1) Provider-covered person ratios by specialty;

(2) Primary care provider-covered person ratios;

(3) Geographic accessibility;

(4) Geographic population dispersion;

(5) Waiting times for visits with participating providers;

(6) Hours of operation;

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

(8) The availability and accessibility of appropriate and timely care provided to disabled enrollees in accordance with the Americans with Disabilities Act of 1990, 42 U.S.C. Section 12101, et seq., as amended from time to time.

(c) No health insurer shall exclude from its provider network any appropriately licensed type of health care provider as a class.

(d) Each provider network shall be adequate to meet the comprehensive needs of the enrollees of the health insurer and provide an appropriate choice of health care providers sufficient to provide the services covered under the policies or plans of such health insurer.

33-20C-43.

(a) Within 60 days after the submission by a health insurer to the Commissioner, the Commissioner shall notify the health insurer whether the plan is adequate, in the judgment of the Commissioner, or unsatisfactory. If the Commissioner determines the plan is

unsatisfactory, the notification to the health insurer shall set forth the reasons for the determination and may set forth proposed revisions which will render the plan satisfactory in the judgment of the Commissioner. Upon notification from the Commissioner, the health insurer shall prepare a revised plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised plan to the Commissioner within 45 days after the notification from the Commissioner.

(b) If the revised plan is rejected, the health insurer shall have the right to request a hearing within 45 days after notification pursuant to Code Section 33-2-17.

33-20C-44.

The Commissioner may promulgate necessary rules and regulations to effectuate the provisions of this article.

33-20C-45.

A health insurer examined under this article shall pay the cost of the examination in an amount determined by the Commissioner."

SECTION 3.

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