HOUSE SUBSTITUTE TO SENATE BILL 325

A BILL TO BE ENTITLED
AN ACT

To amend Chapter 2 of Title 31 and Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to the Department of Community Health and insurance generally, respectively, so as to provide for certain coverage under the state health benefit plan and other health benefit plans; to reinstate a pilot program to provide coverage for bariatric surgical procedures for the treatment and management of obesity and related conditions; to provide for automatic repeal; to require health benefit plans to establish step therapy protocols; to provide for a step therapy exception process; to provide for definitions; to provide for statutory construction; to provide for rules and regulations; to provide for applicability; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 2 of Title 31 of the Official Code of Georgia Annotated, relating to the Department of Community Health, is amended by revising Code Section 31-2-12, relating to a pilot program to provide coverage for bariatric surgical procedures for treatment of obesity and related conditions, definitions, eligibility, requirements, and an evaluation report, as follows:

"31-2-12.

(a) As used in this Code section, the term 'state health insurance plan' means:

(1) The state employees' health insurance plan established pursuant to Article 1 of Chapter 18 of Title 45;

(2) The health insurance plan for public school teachers established pursuant to Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20; and

(3) The health insurance plan for public school employees established pursuant to Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20.

(b) ~~Beginning January 1, 2016, the~~ The department shall conduct a ~~two-year~~ three-year pilot program beginning January 1, 2019, to provide coverage for the treatment and

management of obesity and related conditions under a state health insurance plan. The department shall be authorized to enter into an agreement with a postsecondary institution in this state for pilot program management, data collection, patient engagement, and other activities related to the pilot program. The pilot program will provide benefits for medically necessary bariatric procedures for participants selected for inclusion in the pilot program.

(c) Participation in the pilot program shall be limited to no more than ~~75~~ 100 individuals per year, to be selected in a manner determined by the department. Any person who has elected coverage under a state health insurance plan shall be eligible to be selected to participate in the pilot program in accordance with criteria established by the department which shall include, but not be limited to:

(1) Participation in a state health insurance plan for at least 12 months;

(2) Completion of a health risk assessment through a state health insurance plan;

(3) A body mass index of:

(A) Greater than 40; or

(B) Greater than 35 with one or more ~~co-morbidities~~ comorbidities such as diabetes, hypertension, ~~gastro-esophageal~~ gastroesophageal reflux disease, sleep apnea, or asthma;

(4) Consent to provide personal and medical information to a state health insurance plan;

(5) Non-tobacco user;

(6) No other primary group health coverage or primary coverage with Medicare; and

(7) Must have been covered under a state health insurance plan for two years immediately prior to the pilot program and must express an intent to continue coverage under such state health insurance plan for two years following the approved surgical procedure date.

(d) Eligible individuals must apply to participate in the pilot program. The individual and his or her physician shall complete and submit an obesity treatment program application to the department no later than February 1 for each year of the pilot program. The department's contracted health insurance carrier shall review the criteria contained in subsection (c) of this Code section to determine qualified applicants for the pilot program.

(e) The selected participants shall be eligible to receive a ~~multi-disciplinary~~ multidisciplinary health evaluation at a facility located within the State of Georgia which is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence. The bariatric surgical procedures covered in the pilot program are:

(1) Gastric band;

(2) Laparoscopic sleeve gastrectomy; and

(3) ~~Rouen-Y~~ Roux-en-Y gastric bypass.

The participants shall use the department's contracted health insurance carrier to enroll in a case management program and to receive prior authorization for a surgical procedure provided pursuant to the pilot program. The health insurance carrier shall provide case management and patient follow-up services. Benefits for a bariatric surgical procedure under the pilot program shall be provided only when the surgical procedure is performed at a Center of Excellence within the State of Georgia.

(f) All health care services provided pursuant to the pilot program shall be subject to the health insurance carrier's plan of benefits and policy provisions. Complications that arise after the discharge date are subject to the health insurance carrier's plan of benefits and policy provisions.

(g) Participants must agree to comply with any and all terms and conditions of the pilot program including, but not limited to, participation and reporting requirements. Participation requirements shall include a 12 month postsurgery case management program. Each participant must also agree to comply with any and all requests by the department for postsurgical medical and productivity information, and such agreement shall survive his or her participation in a state health insurance plan.

(h) A panel shall review the results and outcomes of the pilot program beginning six months after program initiation and shall conduct subsequent reviews every six months for the remainder of the pilot program. The panel shall be composed of the following members, appointed by the Governor:

(1) A representative of a state health insurance plan;

(2) A representative of the state contracted health insurance carrier or carriers providing coverage under the pilot program; and

(3) At least two physicians who carry a certification by the American Society for Metabolic and Bariatric Surgery.

(i) The department shall provide a final report by ~~December 15 of the last year of the pilot program~~ June 30, 2022, to the chairpersons of the House Committee on Health and Human Services, the Senate Health and Human Services Committee, the House Committee on Appropriations, and the Senate Appropriations Committee. The report shall include, at a minimum:

(1) Whether patients in the pilot program have experienced:

(A) A reduction in body mass index, and if so, the average amount of reduction; or

(B) The reduction or elimination of ~~co-morbidities~~ comorbidities, and if so, which ~~co-morbidities~~ comorbidities were reduced or eliminated;

(2) The total number of individuals who applied to participate in the pilot program;

(3) The total number of participants who enrolled in the pilot program;

(4) The average cost of each procedure conducted under the pilot program, including gastric band, laparoscopic sleeve gastrectomy, and ~~Rouen-Y~~ Roux-en-Y gastric bypass;

(5) The total cost of each participant's annual health care costs prior to the surgical procedure and for each of the subsequent post-procedure years for the three years following the surgical procedure; and

(6) The percentage of participants still employed by the state 12 months following the surgical procedure and 24 months following the surgical procedure~~, respectively~~.

(j) This Code section shall stand repealed on ~~December 31, 2018~~ June 30, 2022.″

SECTION 2.

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:

″33-24-59.23.

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

(1) 'Health benefit plan' means any hospital, health, or medical expense insurance policy; hospital or medical service contract; employee welfare benefit plan; contract or agreement with a health maintenance organization; subscriber contract or agreement; contract or agreement with a preferred provider organization; accident and sickness insurance benefit plan; or other insurance contract under any other name. The term shall include any health insurance plan established under Article 1 of Chapter 18 of Title 45, the 'State Employees' Health Insurance Plan and Post-employment Health Benefit Fund.'

(2) 'Practitioner' means a physician, dentist, podiatrist, or optometrist and shall include any other person licensed under the laws of this state to use, mix, prepare, dispense, prescribe, and administer drugs in connection with medical treatment for individuals to the extent provided by the laws of this state.

(3) 'Step therapy exception' means that a step therapy protocol should be overridden in favor of immediate coverage of the practitioner's selected prescription drug, provided that the drug is covered under the health benefit plan.

(4) 'Step therapy protocol' means an evidence based and updated protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are deemed medically appropriate for a particular patient, including self-administered and physician-administered drugs, and are covered by an insurer or health benefit plan.

(b) A step therapy exception shall be granted by a health benefit plan if the prescribing practitioner's submitted justification and supporting clinical documentation, if needed, is completed and determined to support such practitioner's statement that:

(1) The required prescription drug is contraindicated or will cause an adverse reaction or physical or mental harm to the patient;

(2) The required prescription drug is expected to be ineffective based on the known clinical condition of the patient and the known characteristics of the prescription drug regimen;

(3) The patient has tried the required prescription drug while under his or her current or previous health insurance or health benefit plan and such prescription drug was discontinued due to lack of efficacy, diminished effect, or an adverse event; or

(4) The patient's condition is stable on a prescription drug previously selected by his or her practitioner for the medical condition under consideration whether on his or her current or previous health benefit plan.

(c) Drug samples shall not be considered trial and failure of a preferred prescription drug in lieu of trying the step therapy required prescription drug.

(d) A health benefit plan shall grant or deny a step therapy exception or appeal of a step therapy exception within:

(1) Twenty-four hours in an urgent health care situation; and

(2) Three business days from the date such request or appeal is submitted in a nonurgent health care situation.

If the health benefit plan fails to respond in accordance with the established time frame, such step therapy exception or an appeal shall be deemed approved.

(e) Upon the granting of a step therapy exception, the health benefit plan shall immediately authorize coverage for the prescription drug prescribed by the patient's practitioner, provided that the drug is covered under the health benefit plan. Any step therapy exception denial shall be eligible for a physician's or a patient's appeal in accordance with the health benefit plan's existing appeal procedures.

(f) This Code section shall not be construed to prevent:

(1) A health benefit plan from requiring a patient to try an AB-rated generic equivalent prior to providing coverage for the equivalent-branded prescription drug;

(2) A health benefit plan from requiring a patient to try an interchangeable biological product prior to providing coverage for the biological product; or

(3) A practitioner from prescribing a prescription drug that is determined by such practitioner to be medically necessary.

(g) This Code section shall not be construed to impact a health benefit plan's ability to substitute a generic drug for a brand name drug.

(h) The Commissioner shall adopt rules and regulations to implement the provisions of this Code section.

(i) This Code section shall not apply to the provision of health care services pursuant to a contract entered into by an insurer and the Department of Community Health for recipients of Medicaid or PeachCare for Kids.

(j) This Code section shall apply only to health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2019.″

SECTION 3.

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