Senate Bill 348

By: Senators Kirkpatrick of the 32nd, Burke of the 11th, Watson of the 1st, Harbin of the 16th, Gooch of the 51st and others

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 for certain insurer requirements concerning provider network classification; to require the Department of Insurance to assess provider network adequacy on an annual basis; to provide health insurers with the right to request a hearing when network adequacy plans are refused; to provide for definitions; to provide for a short title; to provide for legislative findings; to provide for related matters; to provide an effective date; 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 cited as the "Consumer Right to Access Act."

SECTION 2.

The General Assembly finds:

(1) In an effort to reduce costs, some health insurers have implemented narrow provider networks which has reduced the number of available health care providers;

(2) Narrow networks often result in patients having difficulty finding physicians within their network, especially in rural areas and for patients with rare and complex diseases;

(3) Patients forced to seek care outside of their network may be faced with high costs for medically necessary care; and

(4) Narrow provider networks may also result in patients not receiving medically necessary care or being subjected to lengthy delays to receive such care.

SECTION 3.

Title 33 of the Official Code of Georgia Annotated, relating to accurate provider directories, is amended by adding a new Code section to read as follows:

″33-20C-2.1.

If an insurer's provider directory includes a particular provider as a participating provider at such time as an enrollee selects his or her insurance plan, such insurer shall cover such provider's charges at in-network rates for no less than 90 days following the departure of the provider from the network during the contract year of such enrollee. This Code section shall not apply if the provider's contract is terminated by such provider or because of the suspension, expiration, or revocation of the provider's license.″

SECTION 4.

Said title is further amended by adding a new chapter to read as follows:

″CHAPTER 20E

33-20E-1.

As used in this chapter, the term:

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

(2) 'Emergency services' or 'emergency care' means those health care services that are provided for a condition of recent onset and 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:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

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

(4) 'Health care provider' or 'provider' means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced practice 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.

(5) '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.

(6) 'Health insurer' means an accident and sickness insurer, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity regulated by the Commissioner.

33-20E-2.

Each health insurer shall:

(1) Maintain a network that is sufficient in numbers and types of health care providers to ensure that all health care 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 an internet website, mobile application, 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.

33-20E-3.

(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-to-covered person ratios by specialty;

(2) Primary care provider-to-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 health care 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 health care services provided to disabled enrollees in accordance with the Americans with Disabilities Act of 1990, 42 U.S.C. Section 12101, et seq., as amended.

(c) No health insurer shall exclude from its provider network any duly 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 health care services covered under the policies or plans of such health insurer.

33-20E-4.

(a) Within 60 days after the submission of a proposed network plan 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 such notification.

(b) If the revised network plan is rejected, the health insurer shall have the right to request a hearing in accord with Code Section 33-2-17.

33-20E-5.

A health insurer examined under this chapter shall pay the cost of the examination in accord with Code Section 33-2-15.″

SECTION 5.

This Act shall become effective on July 1, 2021.

SECTION 6.

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