Senate Bill 20

By: Senators Kirkpatrick of the 32nd, Watson of the 1st, Hufstetler of the 52nd, Tillery of the 19th, Butler of the 55th and others

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 20E of Title 33 of the Official Code of Georgia Annotated, the "Surprise Billing Consumer Protection Act," so as to ensure consumer access to quality healthcare by setting adequacy standards for network plans offered by an insurer; to provide for a short title; to provide for definitions; to exempt ERISA plans and health maintenance organizations' health benefits plans; to establish standards for network plans; to provide that, under certain circumstances, an insurer shall cover healthcare services provided by a nonparticipating provider at an in-network level of benefits; to prohibit an insurer from denying preauthorization for healthcare services to be performed by a participating provider solely because the referral was made by a nonparticipating provider; to hold a covered person financially harmless when a network is inadequate for its contracted purposes; to hold a covered person financially responsible for healthcare services under certain circumstances; to establish an arbitration process between an insurer and a nonparticipating provider for payment of healthcare services; to require an insurer to make a minimum initial payment to a nonparticipating provider when a payment of healthcare services is disputed; to authorize the Commissioner to monitor and ensure compliance through multiple means; to provide for rules, regulations, and penalties; to amend Chapter 6 of Title 33 of the Official Code of Georgia Annotated, related to unfair trade practices, so as to make failure to comply with any insurer requirement in the Consumer Access to Contracted Healthcare (CATCH) Act an unfair claims settlement practice; to amend Chapter 20F of Title 33 of the Official Code of

Georgia Annotated, relating to self-funded healthcare plans, so as to permit a self-funded healthcare plan to elect to participate in and be bound by the CATCH Act; to provide for conforming changes; to provide for an effective date and applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

**SECTION 1.**

Chapter 20E of Title 33 of the Official Code of Georgia Annotated, the "Surprise Billing Consumer Protection Act," is amended by designating Code Sections 33-20E-1 through 33-20E-23 as Article 1.

**SECTION 2.**

Said chapter is further amended by replacing "chapter" with "article" wherever the former term appears in:

(1) Code Section 33-20E-1, relating to short title;

(2) Code Section 33-20E-2, relating to application to insurers and definitions;

(3) Code Section 33-20E-3, relating to exemption;

(4) Code Section 33-20E-4, relating to payment for emergency medical services;

(5) Code Section 33-20E-5, relating to payment for nonemergency medical services;

(6) Code Section 33-20E-7, relating to surprise bill exclusion and requirements;

(7) Code Section 33-20E-17, relating to referral of parties for violations;

(8) Code Section 33-20E-18, relating to limitation on litigation when arbitration sought;

(9) Code Section 33-20E-21, relating to exclusion from other statutory provisions; and

(10) Code Section 33-20E-23, relating to financial responsibilities for ground ambulance transportation.

**SECTION 3.**

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

″ARTICLE 2

33-20E-30.

This article shall be known and may be cited as the 'Consumer Access to Contracted Healthcare (CATCH) Act.'

33-20E-31.

As used in this article, the term:

(1) 'Accessible' means a participating provider in a healthcare plan's network is:

(A) Accepting new patients;

(B) Available within a reasonable travel distance and time or available within a reasonable time by means of medically appropriate telehealth, as determined by rules and regulations promulgated by the Commissioner; and

(C) Able to make appointments for urgent healthcare services within two business days; for behavioral health services within ten business days; for routine, preventive, or nonurgent healthcare services by primary care providers within 15 business days; or for acute care hospital or specialty care services by specialists or subspecialists within 30 business days; or

(D) For a clinical laboratory or pharmacy, able to provide urgent laboratory or pharmacy services within 24 hours and routine or nonurgent laboratory or pharmacy services within seven business days.

(2) 'Clinical laboratory' has the same meaning as provided in Code Section 31-22-1.

(3) 'Covered benefit' means nonemergency healthcare services to which a covered person is entitled under the terms of a healthcare plan.

(4) 'Covered person' has the same meaning as provided in Code Section 33-20E-2.

(5) 'Facility' has the same meaning as provided in Code Section 33-20E-2.

(6) 'Healthcare plan' has the same meaning as provided in Code Section 33-20E-2.

(7) 'Healthcare provider' or 'provider' has the same meaning as provided in Code Section 33-20E-2.

(8) 'Insurer' has the same meaning as provided in Code Section 33-20E-2.

(9) 'Network' means the group or groups of participating providers or facilities providing services under a healthcare plan offered by an insurer.

(10) 'Network plan' means a healthcare plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, providers managed, owned, under contract with, or employed by the insurer.

(11) 'Nonparticipating provider' has the same meaning as provided in Code Section 33-20E-2.

(12) 'Participating provider' has the same meaning as provided in Code Section 33-20E-2.

(13) 'Pharmacy' has the same meaning as provided in Code Section 26-4-5.

(14) 'Primary care' means healthcare services that address the patient as a whole; are provided by a physician or nonphysician professional where permitted; and are for a range of common physical, mental, or behavioral health conditions. Primary care providers include family practice and general practice physicians, internists, obstetricians or gynecologists, and pediatricians.

(15) 'Resolution organization' has the same meaning as provided in Code Section 33-20E-2.

(16) '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 or subspecialist physician or nonphysician professional where permitted.

(17) 'Telehealth' has the same meaning as provided in Code Section 33-24-56.4.

(18) 'Telemedicine' has the same meaning as provided in Code Section 33-24-56.4.

33-20E-32.

(a) Nothing in this article shall be applicable to a healthcare plan which is subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., unless such plan elects to participate in and agrees to comply with the CATCH Act, as provided in Code Section 33-20F-2.

(b) The requirements of this article shall not apply to a group model health maintenance organization that has an exclusive contract with a medical group practice to provide or arrange for the provision of substantially all healthcare services to enrollees in the healthcare plans of such organization.

33-20E-33.

(a)(1) An insurer providing a network plan shall contract with and maintain a network of providers in sufficient number and appropriate type, including primary care and specialty care, pharmacies, clinical laboratories, and facilities, throughout such plan's service area to ensure covered persons have access to the full scope of benefits and services covered under such plan.

(2) An insurer providing coverage for mental health or substance use disorders as part of a network plan shall contract with and maintain a network of providers that specialize in mental health and substance use disorder services in sufficient number and appropriate type throughout such plan's service area to ensure covered persons have access to the full scope of mental health and substance use disorder benefits and services covered under such plan.

(b) An insurer shall demonstrate that any network plan it provides offers:

(1) An adequate number of accessible acute care hospital services;

(2) An adequate number of accessible primary care providers;

(3) An adequate number of accessible specialty care providers, and, if the specialty care provider needed for a specific condition is not represented on the plan's list of participating specialty care providers, covered persons have access to nonparticipating healthcare providers;

(4) Accessible specialty care services; and

(5) Accessible clinical laboratories and pharmacies.

(c) The Commissioner shall determine network adequacy in accordance with the requirements of this Code section and may further assess network adequacy using appropriate criteria, including, but not limited to:

(1) Primary care provider to covered person ratios;

(2) Provider to covered person ratios by specialty;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons;

(8) Access to healthcare services through telehealth or telemedicine;

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

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

(d)(1) An insurer 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.

(2) An insurer shall notify the Commissioner and all affected covered persons of any material change to any existing network within 30 business days after the change occurs

and shall immediately update its provider directory in compliance with Chapter 20C of this title.

33-20E-34.

(a) An insurer shall not deny preauthorization for healthcare services to be performed by a participating provider solely because the covered person's referral to such provider was made by a nonparticipating provider.

(b) An insurer shall not:

(1) Require prior authorization, medical review, or administrative clearance for a telehealth service that would not be required if such service were provided in person;

(2) Require demonstration that it is necessary to provide a service to a covered person through telehealth;

(3) Require a provider to be employed by another provider or agency in order to provide a telehealth service that would not be required if such service were provided in person;

(4) Restrict or deny coverage of a telehealth service based solely on the communication technology or application used to deliver such service;

(5) Require a provider to be part of a telehealth network;

(6) Require a covered person to utilize telehealth or telemedicine in lieu of a nonparticipating provider accessible for in-person consultation or contact; or

(7) Be required to pay a facility fee to a hospital for telehealth services unless the hospital is the originating site as defined in subsection (b) of Code Section 33-24-56.4.

33-20E-35.

(a) An insurer shall provide a covered person in a network plan a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a nonparticipating provider when such plan does not have a type of participating provider

available to provide the covered benefit or when such plan does not have an accessible participating provider to provide the covered benefit to the covered person.

(b) Upon written notification from the covered person or his or her designee of the conditions described in subsection (a) of this Code section, the insurer shall have 72 hours to respond in writing designating an accessible participating provider. Otherwise, the insurer shall treat the healthcare services the covered person receives from a nonparticipating provider as if the services were provided by a participating provider, including counting the covered person's cost-sharing for such services toward the deductible and maximum out-of-pocket limit applicable to services obtained from participating providers under the plan.

(c)(1) The insurer shall document all covered benefits obtained from a nonparticipating provider under this Code section and shall provide this information to the Commissioner upon request.

(2) The insurer shall disclose to the Commissioner when more than 15 percent of claims for routine, preventive, and nonurgent covered benefits in a network plan for the preceding calendar year are provided by nonparticipating providers.

(d) The process established in this Code section is not intended to be used by insurers as a substitute for establishing and maintaining a sufficient network in accordance with the provisions of this article nor is it intended to be used by covered persons to circumvent the use of covered benefits available through the network delivery system options.

(e) Nothing in this Code section 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.

(f) Nothing in this Code section shall reduce a covered person's responsibilities if such person chose to receive nonemergency healthcare services from a nonparticipating provider when an accessible participating provider was designated by an insurer in writing and was, in fact, accessible.

33-20E-36.

(a) If a covered person receives healthcare services from a nonparticipating provider, such provider shall collect or bill no more than such person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such person's policy directly and such insurer shall directly pay such provider the greater of:

(1) The verifiable contracted amount paid by all eligible insurers subject to the provisions of this article for the provision of the same or similar services as determined by the department;

(2) The most recent verifiable amount agreed to by the insurer and the nonparticipating provider for the provision of the same services during such time as such provider was in-network with such insurer; or

(3) Such higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

Any amount that the insurer pays the nonparticipating provider under this subsection shall not be required to include any amount of coinsurance, copayment, or deductible owed by the covered person or already paid by such person.

(b) If a nonparticipating provider concludes that payment received from an insurer pursuant to this Code section is not sufficient given the complexity and circumstances of the services provided, such provider may initiate a request for arbitration with the Commissioner. Such arbitration shall proceed in accordance with the arbitration proceedings provided in Code Sections 33-20E-9 through 33-20E-21.

(c) No nonparticipating provider shall report to any credit reporting agency any covered person who receives a bill for healthcare services from such provider and does not pay such provider any copay, coinsurance, deductible, or other cost-sharing amount beyond what such covered person would pay if the nonparticipating provider had been a participating provider.

33-20E-37.

(a) The Commissioner may use information provided by a covered person, a provider, an insurer, a resolution organization, an arbitrator, or any other source to determine compliance with this article.

(b) The Commissioner is authorized to conduct a data call, market conduct examination, or compliance audit to determine compliance with this article, as authorized by Code Section 33-2-11, and the insurer subject to such data call, market conduct examination, or compliance audit shall pay all the actual expenses incurred, in accord with Code Section 33-2-15.

(c)(1) When the Commissioner determines noncompliance with this article, the Commissioner shall notify the insurer in writing of the determination and shall set forth the reasons for the determination.

(2) The Commissioner may set forth proposed revisions that will render compliance in the judgment of the Commissioner, may order that healthcare services provided by nonparticipating providers be covered at an in-network level of benefits, and may impose any administrative penalties authorized by this title.

(d) Within 30 days of notification from the Commissioner, the insurer shall submit a response to the Commissioner that addresses all of the Commissioner's concerns.

(e) Within 30 days of the submission of the response, the Commissioner shall determine whether such response is acceptable and shall notify the insurer in writing of the determination and shall set forth the reasons for the determination.

(f) If the response is deemed unacceptable to the Commissioner, the insurer shall have the right to request a hearing in accord with Code Section 33-2-17.

33-20E-38.

(a) The Commissioner may impose a monetary penalty of up to $2,000.00 for each and every act in violation of this article, unless the insurer knew or reasonably should have

known of the violation, in which case the monetary penalty imposed may be up to $5,000.00 for each and every act in violation.

(b) The Commissioner may take any action authorized, including, but not limited to, issuing an administrative order imposing monetary penalties, imposing a compliance plan, ordering the insurer to develop a compliance plan, or ordering the insurer to reprocess claims.

33-20E-39.

The Commissioner shall adopt rules and regulations to implement and administer this article.″

**SECTION 4.**

Chapter 6 of Title 33 of the Official Code of Georgia Annotated, relating to unfair trade practices, is amended in Code Section 33-6-34, relating to unfair claims settlement practices, by revising paragraph (15) as follows:

″(15) Failure to comply with any insurer requirement in Article 1 of Chapter 20E of Title 33, the 'Surprise Billing Consumer Protection Act,' or in Article 2 of said chapter, the 'Consumer Access to Contracted Healthcare (CATCH) Act' ~~including the failure to pay a resolution organization as required under Code Section 33-20E-16~~; and ″

**SECTION 5.**

Chapter 20F of Title 33 of the Official Code of Georgia Annotated, relating to self-funded healthcare plans, is amended in Code Section 33-20F-2, relating to election to participate in Surprise Billing Consumer Protection Act and notices, as follows:

″33-20F-2.

(a) ~~Notwithstanding any provision of law in Chapter 20E of this title, the 'Surprise Billing Consumer Protection Act,' a~~ A self-funded healthcare plan may elect on an annual basis to

participate in and be bound by ~~such Act~~ Article 1 of Chapter 20E of this title, the 'Surprise Billing Consumer Protection Act,' or by Article 2 of said chapter, the 'Consumer Access to Contracted Healthcare (CATCH) Act,' or both.

(b) A self-funded healthcare plan that elects to participate in either the Surprise Billing Consumer Protection Act or the Consumer Access to Contracted Healthcare (CATCH) Act, or both, shall provide notice to the Commissioner of its election decision on a form prescribed by the Commissioner. The completed form shall include an attestation that the self-funded healthcare plan has elected to participate in and be bound by the Surprise Billing Consumer Protection Act and by the Consumer Access to Contracted Healthcare (CATCH) Act to the extent that insurers are similarly bound. Such form shall be posted on the Commissioner's website for use by self-funded healthcare plans choosing to opt in.

(c) A self-funded healthcare plan may elect to initiate its participation on either January 1 of any year or on the first day of the self-funded healthcare plan's plan year of any year.

(d) On its election form, the plan must indicate whether it chooses to affirmatively renew its election on an annual basis or whether it should be presumed to have renewed on an annual basis until the Commissioner receives advance notice from the plan that it is terminating its election as of either December 31 of a calendar year or the last day of its plan year. Notices under this subsection shall be submitted to the Commissioner at least 30 days in advance of the effective date of the election to initiate participation and 30 days in advance of the effective date of the termination of participation.

(e) Self-funded healthcare plans opting in shall develop processes to address employee notifications or other responsibilities under ERISA that may arise from electing to participate in the Surprise Billing Consumer Protection Act and in the Consumer Access to Contracted Healthcare (CATCH) Act."

**SECTION 6.**

Said chapter is further amended by revising Code Section 33-20F-3, relating to website listing of participants, as follows:

"33-20F-3.

The department shall maintain on its website a list of all self-funded healthcare plans that have chosen to participate in and comply with the Surprise Billing Consumer Protection Act and with the Consumer Access to Contracted Healthcare (CATCH) Act."

**SECTION 7.**

Said chapter is further amended by revising Code Section 33-20F-4, relating to applicability, as follows:

"33-20F-4.

Nothing in this chapter shall be applicable to healthcare plans which are subject to the exclusive jurisdiction of ERISA, unless such plan elects to participate in and agrees to comply with the Surprise Billing Consumer Protection Act or with the Consumer Access to Contracted Healthcare (CATCH) Act."

**SECTION 8.**

Said chapter is further amended by revising Code Section 33-20F-5, relating to removal from participation by Commissioner and hearing, as follows:

"33-20F-5.

~~Notwithstanding any provision of law in the Surprise Billing Consumer Protection Act, in~~ In the event that a self-funded healthcare plan has chosen to participate in and comply with ~~such Act~~ the Surprise Billing Consumer Protection Act or with the Consumer Access to Contracted Healthcare (CATCH) Act, the Commissioner shall allow such participation. The Commissioner shall retain the authority, however, to remove or refuse to readmit such participant if the Commissioner determines that the self-funded healthcare plan is failing

or previously failed to comply with ~~the Surprise Billing Consumer Protection Act~~ such Acts. Any self-funded healthcare plan shall have the opportunity to request a hearing pursuant to Code Section 33-2-17 prior to the effective date of such removal or denial."

**SECTION 9.**

This Act shall become effective on January 1, 2024, and shall apply to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after such date.

**SECTION 10.**

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