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

AS PASSED

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 an exemption; to provide for standards for network plans; 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 provide for telehealth services; to provide for monitoring and reports; to authorize the Commissioner to ensure compliance through multiple means; to provide for rules, regulations, and penalties; to provide for a short title; to provide for related matters; 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.

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

SECTION 2.

Chapter 20E of Title 33 of the Official Code of Georgia Annotated, the "Surprise Billing Consumer Protection Act," is amended by adding new Code sections to read as follows:

"33-20E-24.

(a) The requirements of this Code section shall not apply to a health maintenance organization, as defined in Code Section 33-21-1, possessing a valid certificate of authority obtained in accordance with Code Section 33-21-2.

(b)(1) An insurer providing a network plan shall contract with and maintain a network of participating 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 participating 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.

(c) The Commissioner shall determine and may further assess the adequacy and breadth of a network plan using appropriate qualitative and quantitative criteria, which may include but are not limited to federal rules and regulations for network plans promulgated annually by the Center for Consumer Information and Insurance Oversight in the Notice of Benefit and Payment Parameters issued to qualified health plans, the ability of the network to meet the needs of all covered persons, the availability of participating providers that are within a reasonable time and distance to covered persons and accepting patients, appointment wait times, and the availability of other healthcare service delivery system options.

(d) 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.

(e) 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.

(f) The Commissioner shall adopt rules and regulations to implement and administer this Code section.

33-20E-25.

(a)(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 all covered persons under a network plan.

(2) Beginning January 1, 2025, and annually thereafter, in a manner and format as determined by the Commissioner, an insurer shall report to the Commissioner such quantitative data as necessary to demonstrate compliance with Code Section 33-20E-24.

(b) The Commissioner is authorized to conduct a data call, market conduct examination, or compliance audit to determine compliance with the provisions in Code Section 33-20E-24, 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 the provisions in Code Section 33-20E-24, the Commissioner shall notify the insurer of the determination and shall set forth the reasons for the determination. Prior to such determination, the Commissioner shall consider factors that might hinder an insurer's compliance, including, but not limited to, the availability of providers, the willingness of nonparticipating providers to enter into reasonable network contract agreements with an insurer, and good faith efforts by an insurer to enter into network contract agreements with such nonparticipating providers.

(2) The Commissioner may set forth proposed remedies 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 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-26.

(a) For each and every act in violation of Code Section 33-20E-24, the Commissioner may impose a monetary penalty of up to $2,000.00, 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.″

SECTION 3.

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 4.

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