The House Committee on Rules offers the following substitute to SB 307:

A BILL TO BE ENTITLED
AN ACT

To amend Chapter 46 of Title 33 of the Official Code of Georgia Annotated, relating to certification of private review agents, so as to provide for health insurers to implement and maintain a program that allows for the selective application of reductions in prior authorization requirements under certain circumstances; to provide for an annual filing; to provide for the promulgation of rules and regulations; to provide for related matters; to amend Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, so as to prohibit insurers from discriminating against certain healthcare facilities and providers in connection with the procurement, delivery, and administration of provider administered drugs; to provide for definitions; to provide for violation; to provide for construction; to provide for penalties; to amend Part 1 of Article 1 of Chapter 18 of Title 45 of the Official Code of Georgia Annotated, relating to the state employees' health insurance plan, so as to provide protection for covered persons under a state health plan when an in-network hospital becomes out-of-network prior to the end of the plan year; to provide for definitions; 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 46 of Title 33 of the Official Code of Georgia Annotated, relating to certification of private review agents, is amended by adding a new Code section to read as follows:

"33-46-20.1.

(a) Each insurer that utilizes prior authorization requirements shall implement and maintain a program that allows for the selective application of reductions in prior authorization requirements based on the stratification of healthcare providers' performance and adherence to evidence based medicine. Such program shall promote quality, affordable healthcare and reduce unnecessary administrative burdens for both the insurer and the healthcare provider.

(b) Criteria for participation by healthcare providers and the healthcare services included in the program shall be at the discretion of the insurer; provided, however, that such insurer shall submit to the department a filing concerning such program. Such filing shall include a full narrative description of the program, the criteria for participation in the program, a list of the procedures and services subject to the program, the number of healthcare providers participating in the program, and any other information deemed necessary by the department.

(c) No later than July 1, 2025, each insurer that utilizes prior authorization requirements shall make the filing provided for in subsection (b) of this Code section, and such filing shall be submitted annually in a form and manner provided for by rules and regulations promulgated by the Commissioner."

**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:

"33-24-59.34.

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

(1) 'Cost-sharing amount' means coinsurance, deductibles, and any other amounts imposed on an enrollee for a covered healthcare service under the covered person's health benefit plan.

(2) 'Covered person' means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan.

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

(4) 'Health benefit plan' means any hospital or medical insurance policy or certificate, healthcare plan contract or certificate, plan contract or certificate qualified higher deductible health plan, health maintenance organization or other managed care plan or subscriber contract, any health benefit plan established pursuant to Part 6 of Article 17 of Chapter 2 of Title 20 or Article 1 of Chapter 18 of Title 45, or a similar plan.

(5) 'Healthcare facility' means a hospital, ambulatory surgical center, birthing center, diagnostic and treatment center, hospice, outpatient clinic, healthcare provider's office, or similar institution.

(6) 'Healthcare provider' or 'provider' means any person, corporation, or healthcare facility licensed pursuant to Chapter 7 of Title 31 or Title 43 to provide healthcare services, including the administration of prescription medications, or otherwise lawfully administering prescription medications.

(7) 'Healthcare services' means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental, or behavioral health condition, illness, injury, or disease, including mental health and substance abuse disorder.

(8) 'Insurer' means an accident and sickness insurer, fraternal benefit society, healthcare corporation, health maintenance organization, managed care entity, provider sponsored healthcare corporation, or any similar entity regulated by the Commissioner or subject to the insurance laws and regulations of this state that provides, delivers, arranges for,

finances, pays for, or reimburses any healthcare services through a health benefit plan, a plan administrator of any health benefit plan, a pharmacy benefits manager of any health benefit plan, a plan administrator of a health benefit plan established pursuant to Part 6 of Article 17 of Chapter 2 of Title 20 or Article 1 of Chapter 18 of Title 45, or other administrator as defined in paragraph (1) of subsection (a) of Code Section 33-23-100.

(9) 'Network participation contract' means a contract between a healthcare provider and an insurer providing the terms and conditions under which the healthcare provider agrees to provide healthcare services to the insurer's covered persons.

(10) 'Participating healthcare provider' means a healthcare provider that has a network participation contract in effect with an insurer for any healthcare services.

(11) 'Provider administered drug' means a prescription medication that is typically administered and billed by a healthcare provider and that the treating healthcare provider determines cannot be reasonably or safely self-administered by the patient to whom the medication is prescribed or by any individual, other than a healthcare provider, assisting the patient with the self-administration.

(b) An insurer that refuses to authorize, approve, or appropriately pay a participating healthcare provider for provider administered drugs or the administration of provider administered drugs and related services shall be in violation of this Code section.

(c) No insurer shall deny, restrict, refuse to authorize or approve, fail to cover, or reduce payment to a participating healthcare provider for a provider administered drug or the administration of a provider administered drug because the provider administered drug is:

(1) Procured or administered by a participating healthcare provider that is not identified or selected by the insurer;

(2) Dispensed by or procured or obtained from a pharmacy, manufacturer, or supplier that is not identified or selected by the insurer; or

(3) Obtained by the participating healthcare provider from a pharmacy, manufacturer, or supplier that does not have a network participation contract with the insurer, provided the drug supplied by such pharmacy, manufacturer, or supplier meets the requirements set forth in the federal Drug Supply Chain Security Act, Pub. L.113-54, as amended.

(d) No insurer shall require a covered person to pay a higher cost-sharing amount or any other additional amounts for a provider administered drug because the provider administered drug is:

(1) Procured or administered by a participating healthcare provider that is not identified or selected by the insurer;

(2) Dispensed by or procured or obtained from a pharmacy, manufacturer, or supplier that is not identified or selected by the insurer; or

(3) Obtained from a pharmacy, manufacturer, or supplier that does not have a network participation contract with the insurer.

(e) No insurer shall require provider administered drugs to be dispensed by a pharmacy selected by the health benefit plan.

(f) No insurer shall limit or exclude coverage for a provider administered drug when not dispensed by a pharmacy selected by the health benefit plan if such provider administered drug would otherwise be covered under the health benefit plan.

(g) No insurer shall consider, as part of a health benefit plan's medical necessity criteria, the source from which a provider administered drug is procured or the site of delivery or administration of a provider administered drug.

(h) No insurer shall authorize or permit another person or entity acting on its behalf, including a pharmacy benefits manager, to administer claims or benefits under a network participation contract in violation of this Code section.

(i) No insurer shall interfere with the patient's right to choose to obtain a provider administered drug from his or her provider or pharmacy of choice, including interference through inducement, steering, or the offering of financial or other incentives.

(j) An insurer shall not require a specialty pharmacy to dispense a provider administered medication directly to a patient for the purpose of having the patient transport such medication to a healthcare provider for administration to the patient.

(k) An insurer may offer, but shall not require:

(1) The use of a home infusion pharmacy to dispense provider administered drugs to a patient for administration in his or her home; or

(2) The use of an infusion site external to a patient's healthcare provider office or clinic.

(l) Nothing in this Code section shall prohibit an insurer from establishing differing copayments or other cost-sharing amounts within the health benefit plan for provider administered drugs procured from or through, or for the administration of provider administered drugs by a healthcare provider that is not a participating healthcare provider.

(m) Except as provided in this Code section, nothing herein shall prohibit an insurer from refusing to authorize or approve, or from denying coverage for, a provider administered drug based upon failure to satisfy the required terms of coverage in the health benefit plan, including medical necessity criteria, provided that such criteria comply with subsection (g) of this Code section.

(n) Without limiting any other remedies or state laws that may apply, noncompliance with this Code section by an insurer may result in the imposition of penalties set forth in Code Section 33-2-24.

(o) The provisions of subsections (e), (f), and (i) of this Code section shall not apply to any licensed group model health maintenance organization with an exclusive medical group contract."

**SECTION 3.**

Part 1 of Article 1 of Chapter 18 of Title 45 of the Official Code of Georgia Annotated, relating to the state employees' health insurance plan, is amended by adding a new Code section to read as follows:

"45-18-6.2.

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

(1) 'Hospital' means a publicly or privately owned hospital licensed to operate as such by the Department of Community Health.

(2) 'Insurer' means a corporation licensed to transact accident and health insurance business in this state, healthcare corporation, health maintenance organization, or any other entity that enters into a contract with the board to provide healthcare coverage or services pursuant to a state health plan.

(3) 'State health plan' means:

(A) The state employees' health insurance plan established pursuant to this article;

(B) The health insurance plan for public school teachers and the health insurance plan for public school employees established pursuant to Subparts 2 and 3, respectively, of Part 6 of Article 17 of Chapter 2 of Title 20; and

(C) The health benefit plan established for members, employees, and retirees of the Board of Regents of the University System of Georgia pursuant to Code Section 31-2-4.

(b) On and after July 1, 2024, all contracts entered into or renewed by the board with an insurer shall ensure that, if a hospital that is in-network with an insurer for a state health plan during the designated open enrollment period becomes out-of-network with such insurer prior to the end of the plan year, the insurer shall continue to provide coverage to any covered person for such hospital at the same rate and in the same manner through the end of the plan year as if the hospital was in-network. Any such covered person shall be held harmless and shall not be subject to any change in co-payments, deductibles, or other cost-sharing requirements imposed by the insurer as a result of an in-network hospital becoming out-of-network."

**SECTION 4.**

This Act shall become effective on January 1, 2025, and shall apply to all health benefit plans issued, delivered, issued for delivery, or renewed in this state on or after such date and all provider administered drugs procured or administered on or after such date.

**SECTION 5.**

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