The Senate Insurance and Labor Committee offered the following substitute to HB 943:

A BILL TO BE ENTITLED
AN ACT

To amend Article 1 of Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to general provisions regarding insurance generally, so as to require that a health benefit policy that provides coverage for intravenously administered or injected chemotherapy for the treatment of cancer shall provide coverage no less favorable for orally administered chemotherapy; to provide a short title; to provide for definitions; to prohibit certain actions; to provide for certain insurance coverage of autism spectrum disorders; to provide for definitions; to provide for limitations; to provide for premium cap and other conditions; to provide for applicability; to provide for related matters; to provide for effective dates; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

PART I

SECTION 1-1.

This Act shall be known and may be cited as the "Cancer Treatment Fairness Act."

SECTION 1-2.

Article 1 of Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to general provisions regarding insurance generally, is amended by adding a new Code section to read as follows:

"33-24-56.5.

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

(1) 'Cost sharing requirements' includes co-payments, coinsurance, deductibles, and any other amounts paid by the covered person for a prescription dispensed by a licensed retail pharmacy.

(2) 'Health benefit policy' means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state on or after January 1, 2015. The term 'health benefit policy' does not

include the following limited benefit insurance policies: accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, Medicaid, medicare supplement, specified disease, vision, self-insured plans, and nonrenewable individual policies written for a period of less than six months.

(3) 'Insurer' means any person, corporation, or other entity authorized to provide health benefit policies under this title.

(b) A health benefit policy that provides coverage for intravenously administered or injected chemotherapy for the treatment of cancer shall provide coverage for orally administered chemotherapy for the treatment of cancer on a basis no less favorable than the intravenously administered or injected chemotherapy regardless of the formulation or benefit category determination by the insurer.

(c) An insurer providing a health benefit policy and any participating entity through which the insurer offers health services shall not:

(1) Vary the terms of any health benefit policy in effect on December 30, 2014, to avoid compliance with this Code section;

(2) Provide any incentive, including, but not limited to, a monetary incentive, or impose treatment limitations to encourage a covered person to accept less than the minimum protections available under this Code section;

(3) Penalize a health care practitioner or reduce or limit the compensation of a health care practitioner for recommending or providing services or care to a covered person as required under this Code section;

(4) Provide any incentive, including, but not limited to, a monetary incentive, to induce a health care practitioner to provide care or services that do not comply with this Code section; or

(5) Change the classification of any intravenously administered or injected chemotherapy treatment or increase the amount of cost sharing applicable to any intravenously administered or injected chemotherapy in effect on January 1, 2015, in order to achieve compliance with this Code section.

(d) An insurer that limits the total amount paid by a covered person through all cost sharing requirements to no more than $200.00 per filled prescription for any orally administered chemotherapy shall be deemed to be in compliance with this Code section."

PART II

SECTION 2-1.

Said article is further amended by revising Code Section 33-24-59.10, relating to insurance coverage for autism, as follows:

"33-24-59.10.

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

(1) 'Accident and sickness contract, policy, or benefit plan' shall have the same meaning as found in Code Section 33-24-59.1. Accident and sickness contract, policy, or benefit plan shall also include without limitation any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45. Accident and sickness contract, policy, or benefit plan' shall not include limited benefit insurance policies designed, advertised, and marketed to supplement major medical insurance such as accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and any other type of accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, or major medical insurance.

(2) ~~'Autism' means a developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills~~ 'Applied behavior analysis' means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(3) 'Autism spectrum disorder' means autism spectrum disorder as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(4) 'Treatment of autism spectrum disorder' includes the following types of care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder:

(A) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis shall be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts, except for those licensed psychologists specially trained and credentialed in applied behavioral analysis;

(B) Counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and

(C) Therapy services provided by a licensed or certified speech therapist, speech-language pathologist, occupational therapist, physical therapist, or marriage and family therapist.

~~(b) An insurer that provides benefits for neurological disorders, whether under a group or individual accident and sickness contract, policy, or benefit plan, shall not deny providing benefits in accordance with the conditions, schedule of benefits, limitations as to type and scope of treatment authorized for neurological disorders, exclusions, cost-sharing arrangements, or copayment requirements which exist in such contract, policy, or benefit plan for neurological disorders because of a diagnosis of autism. The provisions of this subsection shall not expand the type or scope of treatment beyond that authorized for any other diagnosed neurological disorder.~~ Accident and sickness contracts, policies, or benefit plans shall provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is six years of age or under in accordance with the following:

(1) The policy or contract shall provide coverage for any assessments, evaluations, or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder;

(2) The policy or contract shall provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this Code section at least annually;

(3) The policy or contract shall not include any limits on the number of visits;

(4) The policy or contract may limit coverage for applied behavior analysis to $35,000.00 per year. An insurer shall not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph; and

(5) This subsection shall not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy or contract. Coverage for prescription drugs for the treatment of autism spectrum disorders shall be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy or contract.

(c) Except as otherwise provided in this Code section, any policy or contract that provides coverage for services under this Code section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles, and exclusions to the extent that these provisions are not inconsistent with the requirements of this Code section.

(d) This Code section shall not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized family service plan, an individualized education plan as required by the federal Individuals with Disabilities Education Act, or an individualized service plan. This Code section also shall not be construed to limit benefits that are otherwise available to an individual under an accident and sickness contract, policy, or benefit plan.

(e)(1) An insurer, corporation, or health maintenance organization, or a governmental entity providing coverage for such treatment pursuant to this Code section, is exempt from providing coverage for behavioral health treatment required under this Code section and not covered by the insurer, corporation, health maintenance organization, or governmental entity providing coverage for such treatment pursuant to this Code section as of December 31, 2015, if:

(A) An actuary, affiliated with the insurer, corporation, or health maintenance organization, who is a member of the American Academy of Actuaries and meets the American Academy of Actuaries' professional qualification standards for rendering an actuarial opinion related to health insurance rate making, certifies in writing to the Commissioner that:

(i) Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, or health maintenance organization, or such governmental entity, for the most recent experience period of at least one year's duration, the costs associated with coverage of behavioral health treatment required under this Code section, and not covered as of December 31, 2015, exceeded 1 percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

(ii) Those costs solely would lead to an increase in average premiums charged of more than 1 percent for all insurance policies, subscription contracts, or health care plans commencing on inception or the next renewal date, based on the premium rating methodology and practices the insurer, corporation, or health maintenance organization, or such governmental entity, employs; and

(B) The Commissioner approves the certification of the actuary.

(2) An exemption allowed under paragraph (1) of this subsection shall apply for a one-year coverage period following inception or next renewal date of all insurance policies, subscription contracts, or health care plans issued or renewed during the one-year period following the date of the exemption, after which the insurer, corporation, or health maintenance organization, or such governmental entity, shall again provide coverage for behavioral health treatment required under this subsection.

(3) An insurer, corporation, or health maintenance organization, or such governmental entity, may claim an exemption for a subsequent year, but only if the conditions specified in this subsection again are met.

(4) Notwithstanding the exemption allowed under paragraph (1) of this subsection, an insurer, corporation, or health maintenance organization, or such governmental entity, may elect to continue to provide coverage for behavioral health treatment required under this subsection.

(f) Beginning January 1, 2015, to the extent that this Code section requires benefits that exceed the essential health benefits required under Section 1302(b) of the federal Patient Protection and Affordable Care Act, P. L. 111-148, the specific benefits that exceed the required essential health benefits shall not be required of a 'qualified health plan' as defined in such act when the qualified health plan is offered in this state through the exchange. Nothing in this subsection shall nullify the application of this Code section to plans offered outside the state's exchange.

(g) This Code section shall not apply to any accident and sickness contract, policy, or benefit plan offered by any employer with ten or fewer employees.

(h) Nothing in this Code section shall be construed to limit any coverage under any accident and sickness contract policy or benefit plan, including, but not limited to, speech therapy, occupational therapy, or physical therapy otherwise available under such plan.

(i) By January 15, 2016, and every January 15 thereafter, the department shall submit a report to the General Assembly regarding the implementation of the coverage required under this Code section. The report shall include, but shall not be limited to, the following:

(1) The total number of insureds diagnosed with autism spectrum disorder;

(2) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this Code section;

(3) The cost of such coverage per insured per month; and

(4) The average cost per insured for coverage of applied behavior analysis.

All health carriers and health benefit plans subject to the provisions of this Code section shall provide the department with all data requested by the department for inclusion in the annual report."

PART III

SECTION 3-1.

(a) Part I of this Act shall become effective on January 1, 2015.

(b) Part II and Part III of this Act shall become effective July 1, 2014.

SECTION 3-2.

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