House Bill 872

By: Representatives Knight of the 130th, Hatchett of the 150th, Cooper of the 43rd, Beskin of the 54th, Frye of the 118th, 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 require insurers to develop selection standards for provider participation; to provide for definitions; to provide for tiered network standards; to provide for certain insurer notifications prior to provider termination from a tiered network; to provide for appeal process and requirements; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

**SECTION 1.**

Title 33 of the Official Code of Georgia Annotated, relating to insurance is amended by adding a new chapter to read as follows:

"CHAPTER 20E

33-20E-1.

As used in this chapter, the term:

(1) 'Health care provider' or 'provider' means a health care professional, pharmacy, or facility.

(2) 'High-risk population' means a population presenting a risk of higher-than-average numbers of claims, losses, or health care utilization rates.

(3) 'Insurer' means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, and shall include an accident and sickness insurance company, a health maintenance organization, a health care plan, or any other entity providing a health insurance plan, a health benefit plan, or health care services.

(4) 'Network' means the group or groups of participating health care providers providing services under a network plan.

(5) 'Network plan' means a health benefit plan of an insurer that either requires a covered person to use health care providers managed by, owned by, under contract with, or employed by such insurer or a health benefit plan that creates incentives, including financial incentives, for a covered person to use such health care providers.

(6) 'Tiers' or 'tiered network' means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost sharing, or provider access requirements, or any combination thereof, apply for the same services.

33-20E-2.

(a) An insurer shall develop standards for the selection of providers in the insurer's network plan and the standards for the selection of providers in each health care specialty. If the insurer offers a tiered network, such insurer shall develop standards for providers' participation within each tier.

(b) Insurers shall use the standards developed pursuant to this Code section in selecting providers to participate with the respective tiers.

(c) Insurers shall not establish tier selection and criteria in a manner that would:

(1) Allow an insurer to discriminate against high-risk populations by excluding or placing providers in a tiered network based on their location in a geographic area that contains high-risk populations; or

(2) Exclude providers because they treat or specialize in treating high-risk populations.

(d) Nothing in this subsection prohibits an insurer from offering specific networks or products that are limited to designated service areas.

(e) An insurer shall make all applicable standards used for selecting and tier placement of providers available for review by the Commissioner and shall communicate such standards to providers that are participating in one or more of its networks. Additionally, an insurer shall make a description of its standards, in plain language, available to the public.

33-20E-3.

Upon request, and not more than quarterly, an insurer shall provide a provider that is participating in one or more of its tiered networks with a complete list of all network plans and products such insurer offers to consumers, with an indication of the provider's participation status within each network plan or product. The insurer shall respond to a provider's request within thirty days after receipt of such request.

33-20E-4.

(a) An insurer shall neither terminate a participating provider nor place a participating provider in a tiered network without at least 60 days' written notice informing such provider of the pending action. Such notice shall:

(1) Contain an explanation of the reasons for the proposed action in sufficient detail to enable the participating provider to challenge such proposed action, referencing the information on which the insurer is relying for the determination;

(2) Inform the participating provider of the opportunity to request the insurer to reconsider the pending action and the period for completing the reconsideration process; and

(3) Inform the participating provider of the insurer's ability to rescind the pending action.

(b) An insurer shall establish procedures for a participating provider to request an insurer to reconsider its decision to terminate such participating provider or place such participating provider within a tiered network. Such procedures shall include:

(1) A method by which the participating provider may submit a request for the insurer to reconsider a proposed pending action, including the name of the person or division to whom or to which the participating provider is to submit such request; and

(2) An opportunity to submit or have the insurer consider evidence that may correct information relevant to the pending action.

(c) The insurer shall complete the informal reconsideration process within 45 days after the date such insurer received the request for reconsideration from the participating provider unless the insurer and participating provider agree to an alternative deadline to complete the informal reconsideration process.

(d) An insurer shall not implement the pending action specific to the participating provider that is the subject of a request for reconsideration until such insurer issues a final decision to grant or deny the request to reconsider the pending action.

(e) When an insurer does not select a provider to participate in such insurer's provider network, such insurer shall provide a written notification to such provider. The insurer shall not be required to provide an opportunity for reconsideration to a provider who is not participating in any of such insurer's participating provider networks at the time of such notification.

(f) When an insurer advertises a physician as a participating provider to a patient when such patient is selecting his or her insurance plan, such insurer shall cover the provider charges at in-network rates during the contract year for such patient.

33-20E-5.

This chapter shall not:

(1) Prohibit an insurer from denying a provider that fails to meet selection criteria developed by the insurer in compliance with this chapter;

(2) Prohibit an insurer from creating an exclusive provider network; or

(3) Require an insurer to contract with any provider who is willing to abide by the terms and conditions for participation established by such insurer.

33-20E-6.

The Commissioner shall have the authority to enforce this chapter by requiring a corrective action plan that the insurer shall follow."

**SECTION 2.**

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