The House Committee on Rules offers the following substitute to SB 455:

A BILL TO BE ENTITLED
AN ACT

To amend Code Section 33-24-59.25 of the Official Code of Georgia Annotated, relating to establishment by health benefit plans of step therapy protocols, exception process, time requirements, appeals, construction, and application, so as to provide that step therapy protocols may not be required for medications prescribed for the treatment of serious mental illness under health benefit plans; to provide a definition; to amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, so as to provide that step therapy protocols may not be required for medications prescribed for the treatment of serious mental illness under Medicaid; to provide a definition; to amend Code Section 49-4-148 of the Official Code of Georgia Annotated, relating to recovery of medical assistance from third party liable for sickness, injury, disease, or disability, so as to revise certain provisions to comply with federal law; to bar liable third-party payers from refusing payment solely because a health care item or service did not receive prior authorization; to require a third-party payer to respond to a state inquiry regarding a health care claim within 60 days; to provide for an effective date; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Code Section 33-24-59.25 of the Official Code of Georgia Annotated, relating to establishment by health benefit plans of step therapy protocols, exception process, time requirements, appeals, construction, and application, is amended by adding a new subsection to read as follows:

"(e.1)(1) A health benefit plan shall not impose a step therapy protocol for a prescription drug prescribed for the treatment of serious mental illness.

(2) As used in this subsection, the term 'serious mental illness' means the following psychiatric illnesses as defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), in effect on July 1, 2024:

(A) Bipolar disorders, including hypomanic, manic, depressive, and mixed;

(B) Depression in childhood and adolescence;

(C) Major depressive disorders, single episode or recurrent;

(D) Obsessive-compulsive disorders;

(E) Paranoid and other psychotic disorders;

(F) Postpartum depression;

(G) Schizoaffective disorders, bipolar or depressive; and

(H) Schizophrenia."

SECTION 2.

Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, is amended by adding a new Code section to read as follows:

"49-4-159.4.

(a) As used in this Code section, the term 'serious mental illness' means the following psychiatric illnesses as defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), in effect on July 1, 2024:

(1) Bipolar disorders, including hypomanic, manic, depressive, and mixed;

(2) Depression in childhood and adolescence;

(3) Major depressive disorders, single episode or recurrent;

(4) Obsessive-compulsive disorders;

(5) Paranoid and other psychotic disorders;

(6) Postpartum depression;

(7) Schizoaffective disorders, bipolar or depressive; and

(8) Schizophrenia.

(b) On and after July 1, 2024, any contract entered into or renewed by the department with a provider of medical assistance shall prohibit the imposition of any step therapy protocol for a prescription drug prescribed for the treatment of serious mental illness.

(c) If necessary to implement the provisions of this Code section, the department shall submit a Medicaid state plan amendment or waiver request to the United States Department of Health and Human Services."

SECTION 3.

Code Section 49-4-148 of the Official Code of Georgia Annotated, relating to recovery of medical assistance from third party liable for sickness, injury, disease, or disability, is amended by revising subsection (b) as follows:

"(b) All insurers, as defined in Code Section 33-24-57.1, including but not limited to group health plans as defined in Section 607(1) of the federal Employee Retirement Security Act of 1974, managed care entities as defined in Code Section 33-20A-3, which offer health benefit plans, as defined in Code Section 33-24-59.5, pharmacy benefits managers, as defined in Code Section 33-64-1, and any other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall comply with this subsection. Such entities set forth in this subsection shall:

(1) Cooperate with the department in determining whether a person who is a recipient of medical assistance may be covered under that entity's health benefit plan and eligible to receive benefits thereunder for the medical services for which that medical assistance was provided and respond to any inquiry from the state regarding a claim for payment for

any health care item or service submitted not later than three years after such item or service was provided;

(2) Accept the department's ~~authorization for the provision of medical services~~ payment for a health care item or service on behalf of a recipient of medical assistance as the ~~entity's~~ third-party payer's authorization for the provision of those services and shall not refuse to pay for a health care item or service solely on the basis that the third-party payer did not previously authorize such item or service;

(3) Respond to a department inquiry regarding the status of a claim for payment for any health care item or service within 60 days of receiving the inquiry;

~~(3)~~(4) Comply with the requirements of Code Section 33-24-59.5, regarding the timely payment of claims submitted by the department for medical services provided to a recipient of medical assistance and covered by the health benefit plan, subject to the payment to the department of interest as provided in that Code section for failure to comply;

~~(4)~~(5) Provide the department, on a quarterly basis, eligibility and claims payment data regarding applicants for medical assistance or recipients for medical assistance;

~~(5)~~(6) Accept the assignment to the department or a recipient of medical assistance or any other entity of any rights to any payments for such medical care from a third party; and

~~(6)~~(7) Agree not to deny a claim submitted by the department solely on the basis of the date of submission of the claim, type or format of the claim, or a failure to present proper documentation at the point-of-sale which is the basis of the claim, if:

(A) The claim is submitted to the department within three years from when the item or service was furnished; and

(B) Any action by the department to enforce its rights with respect to such claim commenced within six years of the department's submission of the claim.

The requirements of paragraphs (2) and ~~(3)~~ (4) of this subsection shall only apply to a health benefit plan which is issued, issued for delivery, delivered, or renewed on or after April 28, 2001."

SECTION 4.

This Act shall become effective upon its approval by the Governor or upon its becoming law without such approval.

SECTION 5.

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