Senate Bill 342

By: Senators Kirkpatrick of the 32nd, Watson of the 1st, Hufstetler of the 52nd, Burke of the 11th, Jackson of the 41st and others

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, so as to provide for annual reporting regarding mental health parity in healthcare plans; to provide definitions; to establish penalties; to provide for rules and regulations; to provide for an effective date and applicability; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

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:

"33-24-59.31.

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

(1) 'Healthcare plan' means any hospital or medical insurance policy or certificate, healthcare plan contract or certificate, qualified higher deductible health plan, health maintenance organization or other managed care subscriber contract, or state healthcare plan. Such term shall not include limited benefit insurance policies or plans listed under paragraph (3) of Code Section 33-1-2, air ambulance insurance, Chapter 31 of this title, relating to credit insurance, Chapter 9 of Title 24, relating to workers' compensation, Part

A, B, C, or D of Title XVIII of the Social Security Act (Medicare), or any plan or program not described in this paragraph over which the Commissioner does not have regulatory authority.

(2) 'Individual market' means the market for healthcare plans where the healthcare plan is issued directly to a natural person and not through coverage under a group, blanket, or franchise healthcare plan. Such market includes healthcare plans acquired independently, through an agent or agency, or through a state, federal, or partnership exchange or marketplace operating in Georgia pursuant to Section 1311 of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(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 healthcare services, including those of an accident and sickness insurance company, a health maintenance organization, a healthcare plan, a managed care plan, or any other entity providing a health insurance plan, a health benefit plan, or a healthcare plan.

(4) 'Large group market' means the market within which coverage is sold to a group or subgroups for more than 50 employees, members, or enrollees.

(5) 'Medical/surgical benefits' has the same meaning stated in 45 C.F.R. Section 146.136(a) and 29 C.F.R. Section 2590.712(a) as of January 1, 2022.

(6) 'Mental health benefits' has the same meaning stated in 45 C.F.R. Section 146.136(a) and 29 C.F.R. Section 2590.712(a) as of January 1, 2022.

(7) 'Parity Act' means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26, and federal regulations implementing that act, as of January 1, 2022.

(8) 'Parity Act classifications' means the following classifications of benefits:

(A) Inpatient, in-network benefits;

(B) Inpatient, out-of-network benefits;

(C) Outpatient, in-network benefits;

(D) Outpatient, out-of-network benefits;

(E) Emergency care benefits; and

(F) Prescription drugs benefits.

(9) 'Small group market' means the market within which coverage is sold to a group or subgroup of at least two and no more than 50 employees, members, or enrollees.

(10) 'Substance use disorder benefits' has the same meaning stated in 45 C.F.R. Section 146.136(a) and 29 C.F.R. Section 2590.712(a) as of January 1, 2022.

(11) 'Treatment limitations' has the same meaning stated in 45 C.F.R. Section 146.136(a) and 29 C.F.R. Section 2590.712(a) as of January 1, 2022.

(b) An insurer subject to this Code section shall:

(1) Identify the five healthcare plans with the highest enrollment for each product offered by the insurer in the individual, small group, and large group markets; and

(2) Prepare a report for each identified healthcare plan that provides mental health benefits or substance use disorder benefits demonstrating whether or not the insurer provides actual parity in compliance with the requirements of the Parity Act and as further provided in subsection (c) of this Code section.

(c)(1) By January 1, 2023, and annually thereafter, each insurer subject to this Code section shall submit a report containing the following information to the Commissioner for each of the healthcare plans identified in paragraph (1) of subsection (b) of this Code section:

(A) A description of the process used to develop or select the medical necessity criteria for:

(i) Mental health benefits and substance use disorder benefits; and

(ii) Medical/surgical benefits;

(B) The criteria for a medical necessity determination for:

(i) Mental health benefits and substance use disorder benefits; and

(ii) Medical/surgical benefits;

(C) The reasons and frequency for a denial of benefits for:

(i) Mental health benefits and substance use disorder benefits; and

(ii) Medical/surgical benefits;

(D) The reasons and frequency for a denial of prior authorization requests for:

(i) Mental health benefits and substance use disorder benefits; and

(ii) Medical/surgical benefits;

(E) For each of the Parity Act classifications, a description of the treatment limitations that are applied to:

(i) Mental health benefits and substance use disorder benefits; and

(ii) Medical/surgical benefits;

(F) For each of the Parity Act classifications, actual claims paid and actual reimbursement rates for:

(i) Mental health benefits and substance use disorder benefits; and

(ii) Medical/surgical benefits;

(G) For healthcare plans subject to the Parity Act only, the results of the comparative analysis required by the Parity Act; and

(H) Such additional information as the Commissioner requires.

(2) The Commissioner shall establish a standard form for insurers to submit the report under paragraph (1) of this subsection.

(3) The report submitted under paragraph (1) of this subsection shall not be recognized as being proprietary, confidential, or to contain trade secrets; except such information provided in accordance with subparagraph (F) of paragraph (1) of this subsection shall be confidential by law and privileged and shall not be subject to Article 4 of Chapter 18 of Title 50, relating to open records.

(4) The Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties, including publishing aggregate reports of data to improve consumer awareness.

(d)(1) By July 1, 2023, an insurer subject to this Code section shall make current, accurate data available regarding the treatment limitations for medical conditions or surgical procedures compared to those for mental health or substance use disorders on the insurer's public-facing website in a summary form.

(2) The Commissioner shall develop a summary form for insurers to use when making current, accurate data available to the insured, prospective plan members, and the public as directed under paragraph (1) of this subsection.

(e) The Commissioner shall:

(1) Review each report submitted under paragraph (1) of subsection (c) of this Code section to assess the insurer's compliance with this title or with the Parity Act if applicable; and

(2) Notify an insurer in writing of any noncompliance with this title or with the Parity Act if applicable.

(f)(1) If the Commissioner determines that an insurer failed to submit a report or failed to submit a timely or sufficient report required under paragraph (1) of subsection (c) of this Code section, the Commissioner may impose a monetary penalty of up to $2,000.00 for each and every act in violation, unless the insurer knew or reasonably should have known that he or she was in violation, in which case the monetary penalty may be increased to an amount of up to $5,000.00 for each and every act in violation.

(2) If the Commissioner determines that an insurer failed to comply with this Code section or with the Parity Act if applicable, 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.

(g) The Commissioner shall adopt rules and regulations to implement and administer this Code section, to ensure uniform definitions and methodology for the reporting requirements established under this Code section."

SECTION 2.

This Act shall become effective January 1, 2023, and shall apply to all policies issued, delivered, issued for delivery, or renewed in this state on or after such date.

SECTION 3.

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