

The House Special Committee on Access to Quality Health Care offers the following substitute to SB 82:

A BILL TO BE ENTITLED  
AN ACT

1 To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to  
2 define a term relating to accurate provider directories; to prohibit insurers from unilaterally  
3 changing network participation contracts impacting coverage, access to, or costs of support  
4 services; to provide for penalties for noncompliance; to provide for definitions; to amend  
5 Chapter 18 of Title 45 of the Official Code of Georgia Annotated, relating to employees'  
6 insurance and benefits plans, so as to require that all contracts for healthcare coverage or  
7 services under the state health benefit plan contain a provision that ensures that every plan  
8 member has access to laboratory services at in-network rates within 50 miles or one hour of  
9 a plan member's place of business or residence; to provide for applicability; to provide for  
10 related matters; to provide for effective dates; to repeal conflicting laws; and for other  
11 purposes.

12 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

13 **SECTION 1.**

14 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
15 adding a new paragraph to Code Section 33-20C-1, relating to definitions relative to accurate  
16 provider directories, to read as follows:

S. B. 82 (SUB)

17 "(10.1) 'Public health emergency' includes, but is not limited to, a determination by the  
18 Secretary of Health and Human Services under Section 319 of the federal Public Health  
19 Service Act that a public health emergency exists when such determination includes the  
20 State of Georgia."

## 21 SECTION 2.

22 Said title is further amended by adding a new Code section to read as follows:

23 "33-24-59.31.

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

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

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

30 (3) 'Health benefit plan' means any hospital or medical insurance policy or certificate,  
31 healthcare plan contract or certificate, qualified higher deductible health plan, health  
32 maintenance organization or other managed care subscriber contract, the state health  
33 benefit plan, dental plan, or a similar plan.

34 (4) 'Healthcare facility' means hospital, ambulatory surgical center, birthing center,  
35 diagnostic and treatment center, hospice, or similar institution.

36 (5) 'Healthcare provider' means any person, corporation, facility, or institution licensed  
37 by this state or any other state to provide healthcare services or otherwise lawfully  
38 providing healthcare services, including, but not limited to, a doctor of medicine, doctor  
39 of osteopathy, hospital or other healthcare facility, dentist, nurse, optometrist, podiatrist,  
40 physical therapist, psychologist, occupational therapist, professional counselor,  
41 pharmacist, chiropractor, marriage and family therapist, or social worker.

42 (6) 'Insurer' means an accident and sickness insurer, fraternal benefit society, healthcare  
43 corporation, health maintenance organization, managed care entity, provider sponsored  
44 healthcare corporation, or any similar entity regulated by the Commissioner.

45 (7) 'Network participation contract' means a contract between a healthcare facility or  
46 healthcare provider and an insurer providing the terms and conditions under which the  
47 healthcare facility or healthcare provider agrees to provide healthcare services to a  
48 covered person pursuant to the health benefit plan.

49 (8) 'Policies' mean any guidelines, manuals, protocols, procedures, or other requirements  
50 established by an insurer with which healthcare facilities must comply in order to receive  
51 reimbursement for items or services provided to a covered person under a health benefit  
52 plan. Such policies include, but are not limited to, billing or reimbursement policies,  
53 provider manuals, and clinical guidelines.

54 (9) 'Support services' means clinically appropriate and medically necessary healthcare  
55 items or services provided as part or in support of an inpatient or outpatient healthcare  
56 service. Support services include, but are not limited to, laboratory services, pharmacy  
57 services, infusion services, radiology or other diagnostic testing services, and the  
58 provision of medical supplies or durable medical equipment.

59 (b) During the term of a network participation contract between an insurer and a healthcare  
60 facility or healthcare provider, the insurer shall not implement any unilateral change to its  
61 policies or health benefit plan or make any unilateral amendment to the network  
62 participation contract that would directly or indirectly:

63 (1) Substantially alter or limit coverage, authorization, or site of delivery of support  
64 services under the network participation contract;

65 (2) Preclude or limit access to support services from a healthcare facility or healthcare  
66 provider that was a participating facility or provider with respect to such services at the  
67 beginning of the term of the network participation contract;

68 (3) Result in a material adverse change in reimbursement or administrative costs of  
69 support services for the healthcare facility or healthcare provider; or

70 (4) Result in a higher cost-sharing requirement to the covered person if the support  
71 service is provided by the healthcare facility or healthcare provider that is providing the  
72 primary healthcare service of which the support service is part.

73 (c) This Code section shall not apply when the change to an insurer's policies or health  
74 benefit plan or to the network participation contract between an insurer and a healthcare  
75 facility or healthcare provider is:

76 (1) Required by law, regulation, or applicable regulatory authority or required as a result  
77 of changes in fee schedules, reimbursement methodology, or payment requirements  
78 established by a government agency or changes in current procedural terminology codes,  
79 reporting guidelines, and conventions by the American Medical Association or the  
80 American Dental Association;

81 (2) Expressly provided for under the terms of the network participation contract by the  
82 inclusion of or reference to a specific fee or fee schedule, reimbursement methodology,  
83 or payment policy indexing mechanism;

84 (3) Mutually agreed upon by the healthcare facility or healthcare provider and the insurer  
85 in writing; or

86 (4) Only related to items or services other than support services.

87 (d) Noncompliance with this Code section by an insurer may result in the imposition of  
88 penalties set forth in Code Section 33-2-24 or other state laws.

89 (e) This Code section shall not apply to any licensed group model health maintenance  
90 organization that has an exclusive contract with a medical group practice to provide or  
91 arrange for the provision of substantially all physician services to enrollees in health  
92 benefits plans of the health maintenance organization."

93 **SECTION 3.**

94 Chapter 18 of Title 45 of the Official Code of Georgia Annotated, relating to employees'  
95 insurance and benefits plans, is amended by adding a new Code section to read as follows:

96 "45-18-6.2.

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

98 (1) 'Qualified clinical laboratory' means a clinical laboratory located within this state and  
99 certified in accordance with Chapter 22 of Title 31, relating to clinical laboratories.

100 (2) 'State health benefit plan' means the health insurance plan or plans established  
101 pursuant to this part and Part 6 of Article 17 of Chapter 2 of Title 20 for state and public  
102 employees, dependents, and retirees.

103 (b) On and after July 1, 2022, all contracts entered into or renewed by the board with a  
104 contracted entity to provide healthcare coverage or services pursuant to the state health  
105 benefit plan shall include a provision requiring such contracted entity to:

106 (1) Ensure that every plan member shall have access to laboratory services at in-network  
107 rates at a qualified clinical laboratory within 50 miles or one hour of such plan member's  
108 place of business or residence; or

109 (2) Contract with a qualified clinical laboratory to provide laboratory services at  
110 in-network rates to a plan member at a location within 50 miles or one hour of such plan  
111 member's place of business or residence."

112 **SECTION 4.**

113 (a) Except as otherwise provided in this section, this Act shall become effective upon its  
114 approval by the Governor or upon its becoming law without such approval.

115 (b) Section 2 of this Act shall become effective on January 1, 2023, and shall apply to all  
116 health benefit plans issued, delivered, issued for delivery, or renewed in this state on or after  
117 such date.

118 (c) Section 3 of this Act shall become effective on July 1, 2022, and shall apply to all such  
119 contracts entered into or renewed on or after such date.

120

**SECTION 5.**

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