

The House Committee on Insurance offers the following substitute to SB 5:

A BILL TO BE ENTITLED

AN ACT

1 To amend Titles 33 and 45 of the Official Code of Georgia Annotated, relating to insurance
2 and public officers and employees, respectively, so as to provide for improved prior
3 authorization and to provide for the coverage of certain healthcare services; to provide for
4 health insurers to implement and maintain a program that allows for the selective application
5 of reductions in prior authorization requirements under certain circumstances; to provide for
6 an annual filing; to provide for the promulgation of rules and regulations; to require coverage
7 for healthcare services for pediatric autoimmune neuropsychiatric disorders associated with
8 streptococcal infection (PANDAS) and pediatric acute-onset neuropsychiatric syndrome
9 (PANS) in accordance with nationally recognized clinical practice guidelines; to provide for
10 definitions; to allow for deductibles; to prohibit special deductibles; to provide for rules and
11 regulations; to require major medical coverage for annual prostate cancer screenings for
12 certain men; to provide for definitions; to provide for Medicare supplement policies to be
13 issued and renewed for individuals under 65 years of age who are eligible by reason of
14 disability or end stage renal disease under federal law; to provide for open enrollment
15 periods; to prohibit an insurer from charging premium rates for such policies for such
16 individuals that exceed premium rates charged for individuals who are 65 years of age; to
17 provide for a short title; to provide for an effective date and applicability; to provide for
18 related matters; to repeal conflicting laws; and for other purposes.

S. B. 5 (SUB)

- 1 -

19 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

20 **PART I**
21 **SECTION 1-1.**

22 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended in
23 Chapter 46, relating to certification of private review agents, by adding a new Code section
24 to read as follows:

25 "33-46-20.1.

26 (a) Each insurer that utilizes prior authorization requirements shall implement and
27 maintain a program that allows for the selective application of reductions in prior
28 authorization requirements based on the stratification of healthcare providers' performance
29 and adherence to evidence based medicine. Such program shall promote quality,
30 affordable healthcare and reduce unnecessary administrative burdens for both the insurer
31 and the healthcare provider.

32 (b) Criteria for participation by healthcare providers and the healthcare services included
33 in the program shall be at the discretion of the insurer; provided, however, that such insurer
34 shall submit to the department a filing concerning such program. Such filing shall include
35 a full narrative description of the program, the criteria for participation in the program, a
36 list of the procedures and services subject to the program, the number of healthcare
37 providers participating in the program, and any other information deemed necessary by the
38 department.

39 (c) No later than July 1, 2026, each insurer that utilizes prior authorization requirements
40 shall make the filing provided for in subsection (b) of this Code section, and such filing
41 shall be submitted annually in a form and manner provided for by rules and regulations
42 promulgated by the Commissioner."

43 **PART II**
44 **SECTION 2-1.**

45 Said title is further amended in Chapter 24, relating to insurance generally, by adding a new
46 Code section to read as follows:

47 "33-24-59.34.

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

49 (1) 'Health benefit policy' means any individual or group plan, policy, or contract for
50 healthcare services issued, delivered, issued for delivery, or renewed in this state which
51 provides major medical benefits, including those contracts executed by the State of
52 Georgia on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a
53 healthcare corporation, health maintenance organization, preferred provider organization,
54 accident and sickness insurer, fraternal benefit society, hospital service corporation,
55 medical service corporation, or other insurer or similar entity. Such term shall not
56 include any self-insured health benefit plan subject to the exclusive jurisdiction of the
57 federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001,
58 et seq.

59 (2) 'Nationally recognized clinical practice guidelines' means evidence based clinical
60 practice guidelines developed by independent organizations or medical professional
61 societies utilizing a transparent methodology and reporting structure and with a conflict
62 of interest policy. Such guidelines establish standards of care informed by a systematic
63 review of evidence and an assessment of the benefits and risks of alternative care options
64 and include recommendations intended to optimize patient care.

65 (3) 'Pediatric acute-onset neuropsychiatric syndrome' or 'PANS' means a class of
66 acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting
67 in children and adolescents that are not otherwise explained by another known neurologic
68 or medical disorder.

69 (4) 'Pediatric autoimmune neuropsychiatric disorders associated with streptococcal
70 infections' or 'PANDAS' means a condition in which a streptococcal infection in a child
71 or adolescent causes the abrupt onset of clinically significant obsessions, compulsions,
72 tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and
73 remitting course of symptom severity.

74 (b) All health benefit policies issued or renewed on or after July 1, 2025, shall include
75 coverage for healthcare services for PANDAS or PANS for an individual covered under
76 such policy as provided in this Code section.

77 (c) Healthcare services for PANDAS or PANS for an individual covered under a health
78 benefit policy shall be covered for the purposes of diagnosis, treatment, appropriate
79 management, or ongoing monitoring of a covered person's disorder when such services are
80 supported by nationally recognized clinical practice guidelines.

81 (d) The benefits in a health benefit policy as provided for in this Code section shall be
82 subject to the same deductibles, coinsurance, copayment provisions, and other limitations
83 established for all covered benefits within such health benefit policy. Special deductibles,
84 coinsurance, copayment, and other limitations that are not generally applicable to other
85 healthcare services covered by a health benefit policy shall not be imposed on coverage for
86 healthcare services for PANDAS or PANS.

87 (e) The Commissioner shall promulgate rules and regulations necessary to implement the
88 provisions of this Code section."

89 **SECTION 2-2.**

90 Title 45 of the Official Code of Georgia Annotated, relating to public officers and employees,
91 is amended in Chapter 18, relating to employees' insurance and benefit plans, by adding a
92 new Code section to read as follows:

93 "45-18-4.2.

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

95 (1) 'Nationally recognized clinical practice guidelines' means evidence based clinical
96 practice guidelines developed by independent organizations or medical professional
97 societies utilizing a transparent methodology and reporting structure and with a conflict
98 of interest policy. Such guidelines establish standards of care informed by a systematic
99 review of evidence and an assessment of the benefits and risks of alternative care options
100 and include recommendations intended to optimize patient care.

101 (2) 'Pediatric acute-onset neuropsychiatric syndrome' or 'PANS' means a class of
102 acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting
103 in children and adolescents that are not otherwise explained by another known neurologic
104 or medical disorder.

105 (3) 'Pediatric autoimmune neuropsychiatric disorders associated with streptococcal
106 infections' or 'PANDAS' means a condition in which a streptococcal infection in a child
107 or adolescent causes the abrupt onset of clinically significant obsessions, compulsions,
108 tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and
109 remitting course of symptom severity.

110 (4) 'State health benefit plan' means the health insurance plan or plans established
111 pursuant to this article and Part 6 of Article 17 of Chapter 2 of Title 20 for state and
112 public employees, dependents, and retirees.

113 (b) Beginning January 1, 2026, the state health benefit plan shall include coverage for
114 healthcare services for PANDAS or PANS for an individual covered under such policy as
115 provided in this Code section.

116 (c) Healthcare services for PANDAS or PANS for an individual covered under the state
117 health benefit plan shall be covered for the purposes of diagnosis, treatment, appropriate
118 management, or ongoing monitoring of a covered person's disorder when such services are
119 supported by nationally recognized clinical practice guidelines.

120 (d) The benefits in the state health benefit plan as provided for in this Code section shall
121 be subject to the same deductibles, coinsurance, copayment provisions, and other

122 limitations established for all covered benefits within such plan. Special deductibles,
123 coinsurance, copayment, and other limitations that are not generally applicable to
124 healthcare services covered by such plan shall not be imposed on coverage for healthcare
125 services for PANDAS or PANS."

126 **PART III**
127 **SECTION 3-1.**

128 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended in
129 Chapter 24, relating to insurance generally, by adding a new Code section to read as follows:
130 "33-24-59.35.

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

132 (1) 'Health benefit policy' means any individual or group plan, policy, or contract for
133 healthcare services issued, delivered, issued for delivery, or renewed in this state which
134 provides major medical benefits by a healthcare corporation, health maintenance
135 organization, preferred provider organization, accident and sickness insurer, fraternal
136 benefit society, hospital service corporation, medical service corporation, or other insurer
137 or similar entity.

138 (2) 'Men with a family history of prostate cancer' means men who have a first-degree
139 relative:

140 (A) Who has been diagnosed with prostate cancer;

141 (B) Who developed prostate cancer;

142 (C) Whose death was a result of prostate cancer;

143 (D) Who has been diagnosed with a cancer known to be associated with an increased
144 risk of prostate cancer; or

145 (E) Who has a genetic alteration known to be associated with an increased risk of
146 prostate cancer.

- 147 (3) 'Men with a high risk for prostate cancer' means:
 148 (A) Men with a family history of prostate cancer who are 40 to 49 years of age;
 149 (B) Men who are 50 years of age and older; and
 150 (C) Other men, as may be determined by a physician.
 151 (b) A health benefit policy shall provide coverage for annual prostate cancer screenings
 152 for men with a high risk for prostate cancer. Such coverage shall include a digital rectal
 153 examination and a prostate-specific antigen test."

154 **PART IV**

155 **SECTION 4-1.**

156 This part shall be known and may be cited as the "Bridging the Gap for ALS and Chronic
 157 Kidney Disease Act of 2025."

158 **SECTION 4-2.**

159 Said title is further amended in Chapter 43, relating to Medicare supplement insurance, by
 160 revising Code Section 33-43-3, relating to duplicate benefits prohibited and establishment
 161 of standards, as follows:

162 "33-43-3.

163 (a) As used in this Code section, the term '42 U.S.C. Section 426(b) or 421-1' means such
 164 federal law as it existed on January 1, 2025.

165 ~~(a)(b)~~ No ~~medicare~~ Medicare supplement ~~insurance~~ policy or certificate in force in this
 166 state shall contain benefits which duplicate benefits provided by ~~medicare~~ Medicare.

167 ~~(b)(c)~~ Notwithstanding any other provision of Georgia law, a ~~medicare~~ Medicare
 168 supplement policy or certificate shall not exclude or limit benefits for losses incurred more
 169 than six months from the effective date of coverage because it involved a preexisting
 170 condition. The policy or certificate shall not define a preexisting condition more

171 restrictively than a condition for which medical advice was given or treatment was
172 recommended by or received from a physician within six months before the effective date
173 of coverage.

174 ~~(e)~~(d) The Commissioner shall adopt reasonable regulations to establish specific standards
175 for policy provisions of ~~medicare~~ Medicare supplement policies and certificates. Such
176 standards shall be in addition to and in accordance with applicable laws of this state. No
177 requirement of this title relating to minimum required policy benefits, other than the
178 minimum standards contained in this chapter, shall apply to ~~medicare~~ Medicare supplement
179 policies and certificates. The standards shall cover, but shall not be limited to:

- 180 (1) Terms of renewability;
- 181 (2) Initial and subsequent conditions of eligibility;
- 182 (3) Nonduplication of coverage;
- 183 (4) Probationary periods;
- 184 (5) Benefit limitations, exceptions, and reductions;
- 185 (6) Elimination periods;
- 186 (7) Requirements for replacement;
- 187 (8) Recurrent conditions; and
- 188 (9) Definitions of terms.

189 ~~(d)~~(e) The Commissioner shall adopt reasonable regulations to establish minimum
190 standards for benefits, claims payment, marketing practices, compensation arrangements,
191 and reporting practices for ~~medicare~~ Medicare supplement policies and certificates.

192 ~~(e)~~(f) The Commissioner may adopt from time to time such reasonable regulations as are
193 necessary to conform ~~medicare~~ Medicare supplement policies and certificates to the
194 requirements of federal law and regulations promulgated thereunder, including, but not
195 limited to:

- 196 (1) Requiring refunds or credits if the policies or certificates do not meet loss ratio
197 requirements;

- 198 (2) Establishing a uniform methodology for calculating and reporting loss ratios;
- 199 (3) Assuring public access to policies, premiums, and loss ratio information of issuers
200 of ~~medicare~~ Medicare supplement insurance;
- 201 (4) Establishing a process for approving or disapproving policy forms, certificate forms,
202 and proposed premium increases;
- 203 (5) Establishing a policy for holding public hearings prior to approval of premium
204 increases; and
- 205 (6) Establishing standards for ~~medicare~~ Medicare select policies and certificates.
- 206 ~~(f)~~(g) The Commissioner may adopt reasonable regulations that specify prohibited policy
207 provisions not otherwise specifically authorized by statute which, in the opinion of the
208 Commissioner, are unjust, unfair, or unfairly discriminatory to any ~~person~~ individual
209 insured or proposed to be insured under a ~~medicare~~ Medicare supplement policy or
210 certificate.
- 211 ~~(g)~~(h) Insurers offering ~~medicare~~ Medicare supplement policies in this state to ~~persons~~ for
212 individuals 65 years of age or older shall also offer ~~medicare~~ Medicare supplement policies
213 to ~~persons~~ for individuals in this state who are eligible for and enrolled in ~~medicare~~
214 Medicare by reason of disability or ~~end-stage~~ end stage renal disease, as specified under
215 42 U.S.C. Section 426(b) or 426-1. Such Medicare supplement policies shall be issued on
216 a guaranteed renewable basis under which the insurer shall be required to continue
217 coverage so long as premiums are paid on such policy. Except as otherwise provided in
218 this Code section, all benefits, protections, policies, and procedures that apply to ~~persons~~
219 individuals 65 years of age or older shall also apply to ~~persons~~ individuals who are eligible
220 for and enrolled in ~~medicare~~ Medicare by reason of disability or ~~end-stage~~ end stage renal
221 disease, as specified under 42 U.S.C. Section 426(b) or 426-1.
- 222 ~~(h)~~(i) Persons may enroll in a ~~medicare~~ Medicare supplement policy at any time authorized
223 or required by the federal government or within six months of:

224 (1) Enrolling in ~~medicare~~ Medicare Part B for an individual who is under 65 years of age
225 and is eligible for ~~medicare~~ Medicare ~~because by reason of~~ disability or ~~end-stage end~~
226 stage renal disease, as specified under 42 U.S.C. Section 426(b) or 426-1, whichever is
227 later;

228 (2) Receiving notice that such ~~person~~ individual has been retroactively enrolled in
229 ~~medicare~~ Medicare Part B due to a retroactive eligibility decision made by the Social
230 Security Administration; or

231 (3) Experiencing a qualifying event identified in regulations adopted pursuant to
232 subsection (c) of this Code section.

233 (j) Beginning January 1, 2026, in addition to the provisions in subsection (i) of this Code
234 section, an individual may enroll in a Medicare supplement policy when such individual
235 is currently enrolled in Medicare by reason of disability or end stage renal disease, as
236 specified under 42 U.S.C. Section 426(b) or 426-1, during a one-time open enrollment
237 period of six months beginning on January 1, 2026.

238 ~~(i)~~(k) No policy or certificate issued pursuant to this chapter shall prohibit payment made
239 by third parties on behalf of individual applicants or individuals within a group applicant
240 so long as:

241 (1) The third party is an immediate family member of a person lawfully exercising an
242 in-force power of attorney or legal guardianship; or

243 (2) The third party is a nonprofit, charitable organization that:

244 (A) Is the named requestor of an advisory opinion issued by the United States
245 Department of Health and Human Services (HHS) Office of Inspector General under
246 the requirements of 42 C.F.R. Part 1008; and

247 (B) Provides, upon request by the ~~medicare~~ Medicare supplement issuer, the specific
248 advisory opinion relied upon by the third party to make such payment and a written
249 certification that the advisory opinion is in full force and effect and has not been

250 rescinded, modified, or terminated by the United States Department of Health and
251 Human Services (HHS) Office of Inspector General.

252 ~~(j) Premiums for medicare supplemental insurance policies may differ between persons~~
253 ~~who qualify for medicare who are 65 years of age or older and those who qualify for~~
254 ~~medicare who are younger than 65 years of age; provided, however, that such differences~~
255 ~~in premiums shall not be excessive, inadequate, or unfairly discriminatory and shall be~~
256 ~~based on sound actuarial principles and reasonable in relation to the benefits provided.~~

257 (l) An insurer shall not charge premium rates for a standardized Plan A, Plan B, or Plan D
258 Medicare supplement policy or certificate for an individual under sixty-five years of age
259 who becomes eligible for Medicare by reason of disability or end stage renal disease, as
260 specified under 42 U.S.C. Section 426(b) or 426-1, that exceed premium rates charged for
261 such policies to an individual who is 65 years of age.

262 (m) An insurer shall not charge premium rates for any standardized lettered Medicare
263 supplement policy or certificate other than those specified in subsection (l) of this Code
264 section for an individual under 65 years of age who becomes eligible for Medicare by
265 reason of disability or end stage renal disease, as specified under 42 U.S.C. Section 426(b)
266 or 426-1, that exceed 200 percent of the premium rates charged for such policy or
267 certificate to an individual who is 65 years of age or issue to an individual under 65 years
268 of age who becomes eligible for Medicare by reason of disability or end stage renal
269 disease, as specified under 42 U.S.C. Section 426(b) or 426-1, a Medicare supplement
270 policy or certificate that contains a waiting period or a preexisting condition limitation or
271 exclusion."

272

PART V

273

SECTION 5-1.

274 This Act shall become effective on July 1, 2025, and shall apply to all policies or contracts
275 issued, delivered, issued for delivery, or renewed in this state on or after such date.

276

SECTION 5-2.

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