SENATE RESEARCH OFFICE
2015 Session **February 24, 2015**

Bill:	SB 158	**Sponsor:**	Senator Burke of the 11th
Version:	LC 33 5978ER	**Amends:**	Title 33
Status:	As Introduced	**Committee:**	Insurance and Labor

Consumer and Provider Protection Act

SUMMARY
Senate Bill 158 is a comprehensive effort to:
- Regulate “rental networks”;
- Require network contracts with healthcare providers to remain intact during a contract’s first year or on the anniversary of its renewal;
- Prohibits “All Products Clauses”; and
- Ensures network adequacy throughout Georgia.

To achieve these ends, the Act itself contains four Acts within itself:
- The Insurance Transparency Act;
- The Provider’s Right to Choose Act;
- The Provider Stability Act; and
- The Consumer Right to Access Act.

ANALYSIS

Insurer Transparency Act
This Act attempts to bring more clarity and transparency to rental networks by defining them and requiring them to register with the Insurance Commissioner within 30 days of commencing business in Georgia unless such entity is already licensed by the Commissioner as a health insurer. [1]

The Commissioner is authorized to revoke the registration of a rental network if it is discovered that the network provider has:
- Knowingly accessed or utilized a medical provider's contractual discount without a contractual relationship; or
- Leased, rented, or otherwise granted to a third party access to a provider network contract unless that third party accessing is:
    - A payor or third-party administrator;
    - A preferred provider organization or preferred provider network; or
    - An entity engaged in electronic claims.

Providers’ Right to Choose Act
This Act prohibits all-product clauses under the “Provider’s Right to Choose Act.” Specifically, it prohibits health insurers from requiring a provider to provide services under all health plans offered or sponsored by, or affiliated with, the insurer, or to participate in all of its provider network arrangements. In addition, a health insurer may not terminate any contractual relationship with a provider on the grounds that the provider did not agree to participate in a provider network arrangement.

[1] The legislation uses the term “Rental preferred provider network,” which means a preferred provider network that contracts with a health insurer or other payor or with another preferred provider network to grant access to the terms and conditions of its contract with medical physicians. Such contracts are often referred to as “renting” or “leasing” the network.

Provider Stability Act

Under current law, insurers in Georgia are permitted to modify the terms of their contracts with medical providers – including reimbursements – in the middle of multi-year contracts without the provider's consent. This Act requires health insurers to honor the terms of their contracts with physicians for the full duration of the agreement.

Specifically, this Act prohibits a health insurer from effecting a unilateral material change to a contract under which a provider is paid for providing items or services without the express agreement of the provider during either the first year of the contract or the initial term of the contract, whichever is longer. After that period, the health insurer may only execute a unilateral material change with the express agreement of the provider on the stipulated renewal date of the contract or the anniversary of the effective date of the contract, whichever is longer. However, the health insurer must provide a calculation that estimates any reduction in the provider's cumulative allowed amount based on 12 months, or an annualized shorter look back period, of actual data. A violation of this provision will result in a civil penalty from $500 to $2,000.

Consumer Right to Access Act

This Act requires each health insurer to:

- Maintain a network that is sufficient in numbers and types of providers to ensure that all services will be accessible without unreasonable delay. Emergency services must be available 24 hours per day;
- Report annually to the Commissioner the number of enrollees and the number of participating in-network health care providers; and
- Maintain a network directory on a website, mobile app, or other electronic means, through which a provider or enrollee may obtain a listing of all participating providers within each network.

The Commissioner is required to assess the provider network adequacy of each health insurer. The assessment is to be done annually at the time of license renewal or at the time of initial licensure. In assessing provider network adequacy, the Commissioner must consider, but is not limited to:

- Provider-covered person ratios by specialty;
- Primary care provider-covered person ratios;
- Geographic accessibility;
- Geographic population dispersion;
- Waiting times for visits with participating providers;
- Hours of operation;
- The volume of technological and specialty services available; and
- The availability and accessibility of appropriate and timely care provided to disabled enrollees in accordance with the Americans with Disabilities Act.

If the Commissioner determines that a plan is unsatisfactory, the Commissioner must set forth the reasons for the determination and may set forth proposed revisions which will render the plan satisfactory. The insurer must then prepare a revised plan within 45 days after the notification from the Commissioner. If the revised plan is rejected, the insurer will have the right to request a hearing within 45 days. Examined insurers will pay the cost of the examination in an amount determined by the Commissioner.

Health insurers are prohibited from excluding any appropriately licensed type of health care provider as a class from their provider networks. Each provider network must be adequate to meet the comprehensive needs of the enrollees.

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