



House Budget and Research Office

COVERDELL LEGISLATIVE OFFICE BUILDING, ROOM 412
ATLANTA, GEORGIA 30334
404-656-5050

MARTHA R. WIGTON
DIRECTOR

2020 SESSION: HEALTH AND HUMAN SERVICES BUDGET AND LEGISLATION HIGHLIGHTS

The FY 2021 budget funds a total of \$6 billion for Georgia's health care agencies, accounting for over 23% of the state's budget. The agencies within the health and human resources budget areas provide essential services for Georgia's most vulnerable individuals and families. Despite the reductions that had to be made to meet the revised revenue estimate, the General Assembly has continued to support and invest in these areas of the budget, resulting in continuous growth in the state's safety net; increasing access to benefits for Georgia's children, veterans, and low-income individuals; and extending the continuum of care for those with disabilities and mental health disorders. Below are highlights of the FY 2021 budget.

Health Budget

- HB 793 provides \$268.7 million for growth in the Medicaid programs to meet the projected need as well as recognizes \$165.4 million in savings due to a temporary 6.2% increase in the Federal Medical Assistance Percentage (FMAP) rate, as authorized by the 'Families First Coronavirus Response Act'.
- The FY 2021 budget supports HB 1114 (2020 Session) by adding \$19.7 million to provide six months of postpartum Medicaid coverage to mothers in order to address Georgia's high incidence of maternal mortality. Extending medical coverage for new mothers an additional four months beyond the current two-month limit after delivery will provide greater access to healthcare services and is expected to decrease and prevent maternal deaths in Georgia. The budget also includes \$125,000 to provide lactation care and services for new mothers and restores \$1.5 million in proposed cuts for maternal mortality prevention grants to hospitals.
- The General Assembly fully restores the \$13.9 million in cuts to the public health grants to counties as well as eliminates the 12 furlough days proposed for the Department of Public Health in order to minimize the impact on the county public health departments and agency staff that are on the front lines of the effort to reduce the COVID-19 pandemic.
- HB 793 adds \$12 million to the existing \$3 million for the Rural Hospital Stabilization program in order to support the success of this critical segment of Georgia's healthcare system that is focused on identifying solutions for the state's rural hospitals.
- The budget provides \$500,000 for two Federally Qualified Health Center start-up grants for a primary care center in Wayne County and a school-based primary care center in Irwin County, which is in addition to \$100,000 provided for charity clinics.
- Despite declining revenues, the budget does not include any Medicaid reimbursement rate cuts to health care providers. The General Assembly shows its support of providers by appropriating \$2.4 million for a 1% increase in the Medicaid reimbursement rate for 108 primary care codes; \$1.1 million for an increase in the reimbursement rate for silver diamine fluoride; and \$189,600 for a 3% increase in Medicaid ventilator reimbursement rates.

- In alignment with the Georgia General Assembly’s continuous efforts to support graduate medical education, the FY 2021 budget restores \$1.7 million to continue funding the Rural Surgery Initiative, child and adolescent psychiatry slots, a three-year primary care residency track, and fellowships at Augusta University; the Accelerated Track Program at Memorial Health; the start-up of a residency program at the South Georgia Medical Center; rural surgical fellowships at St. Joseph’s/Candler Hospital; and a psychiatry residency program at Gateway Behavioral Health. Additionally, the budget adds \$250,000 in new funding for the start-up of a rural psychiatry residency program at Colquitt Regional Medical Center.
- HB 793 fully restores the cuts to the Mercer School of Medicine and Morehouse School of Medicine operating grants, adding \$4.2 million combined back to the budget. Additionally, the budget includes \$841,192 to fund operations at Mercer University School of Medicine’s four-year medical school campus in Columbus as well as restores the \$463,000 cut to the Rural Health Systems Innovation Center at Mercer University School of Medicine.
- The FY 2021 budget provides \$1.2 million to support Grady Memorial Hospital’s efforts to continue the coordination of emergency room use in the 13-county metro Atlanta area.
- In support of public health programs, the General Assembly restores \$1 million for the Positive Alternatives for Pregnancy and Parenting Grant Program; \$443,750 for regional cancer coalitions; \$150,000 for the Sickle Cell Foundation of Georgia to continue funding the mobile testing unit; \$55,547 for Saint Joseph’s Mercy Care; \$49,000 to provide full funding for the Georgia Poison Center; and \$40,000 for Hepatitis-C testing.
- The budget reflects \$261.7 million dollars in federal funds authorized by the Paycheck Protection Program and Health Care Enhancement Act for COVID-19 testing as well as \$67.3 million in additional grant funding that was authorized by the ‘Coronavirus Aid, Relief, and Economic Security (CARES) Act’.

Human Resources Budget

- Compared to earlier versions of HB 793, \$99.1 million has been restored to the Department of Behavioral Health and Developmental Disabilities (DBHDD), the Department of Human Services (DHS), and the Department of Veterans Services (DVS). This funding restores over 200 positions and prevents the furlough of nearly 9,500 state employees. The positions restored are essential for areas like child and foster care support, federal eligibility case management, veterans’ services, and behavioral health.
- The General Assembly restores \$46 million in the Out of Home Care program as well as \$1.4 million to the Department of Human Services to prevent the closure of 54 Department of Families and Children Services (DFCS) offices statewide, or 33% of the division’s offices. Within the program area of Elder Community Living Services, \$3.4 million is provided to fully restore the original reductions to Meals on Wheels and non-Medicaid home and community-based services (HCBS). In 2019, these investments delivered over 4.2 million meals and served 35,947 clients.
- The General Assembly restores \$6 million for behavioral core services, increasing the safety net capacity of the state by serving an additional 6,446 individuals. Additionally, \$2.5 million in new funds are added for 95 crisis beds, allowing the state to serve nearly 5,000 people across 21 crisis units statewide. The conference committee restores \$1.5 million for housing vouchers in community settings and fully restores the initial \$1 million cut to the Georgia Mental Health Consumer Network, which allows the network to maintain their current training capacity for essential peer services. Funding is also

maintained for one crisis respite home previously identified in the FY 2020 budget, as well as \$530,000 to ensure statewide capacity for youth recovery clubhouses remains.

- \$3.6 million is restored for addiction and recovery services, allowing 17 recovery centers to remain open that employ 35 full-time recovery coaches and serve over 1,850 individuals statewide. These recovery centers provide hope and empowerment for those diagnosed with substance use disorder. Additionally, a full restoration of \$853,000 is provided for all eight treatment court providers that were originally slated for a reduction, granting some Georgians with the option of treatment instead of incarceration. Furthermore, funding for the nationally-recognized and vital Neonatal Intensive Care Unit (NICU) is restored. This NICU served 194 families in 2019 and saved an estimated \$9.1 million in health care costs for Georgians.
- In the area of developmental disabilities, \$8.3 million is provided for 100 new NOW/COMP waivers and to annualize 125 existing waivers for the intellectually and developmentally disabled. In 2019, over 13,000 clients were served and just under 6,000 are on the waitlist. These investments not only decrease the waitlist, but ensure that essential services are maintained even during economic uncertainty. Additionally, the General Assembly softened reductions for intensive family support services, the Marcus Autism Center, and the Matthew Reardon Center.
- The Department of Veterans Services receives \$1.2 million in one-time funds for renovations, technology improvements, and patient connectivity initiatives at the Georgia War Veterans Nursing Homes as well as \$450,000 in start-up funds for the sub-acute therapy unit at the Milledgeville nursing home.

Health and Human Services Legislation

HB 521 by Rep. Houston Gaines (117th) authorizes temporary licenses for dentists and dental hygienists who are licensed in other states to provide dental care to indigent populations in Georgia.

HB 578 by Rep. Katie Dempsey (13th) allows the Department of Human Services to review certain law enforcement conviction data for persons the department considers to hire as a volunteer, intern, or student.

HB 791 by Rep. Ron Stephens (164th) allows a pharmacist to exercise professional judgement in dispensing up to a 90-day supply of medication up to the total number of dosage units as authorized by the prescriber on the original prescription. Additionally, this bill requires health insurers to waive time restrictions for refills of a 30-day supply of certain prescription medications during emergencies.

HB 987 by Rep. Sharon Cooper (43rd) provides several new provisions for the protection of elderly persons in personal care homes with 25 beds or more and in assisted living facilities, to include: requiring an initial and annual training for direct care staff; maintaining a minimum on-site staffing ratio of one direct care staff person for every 15 residents during waking hours, and one for every 20 residents during non-waking hours; providing a 60-day notice to the Department of Community Health and residents of any bankruptcy or property eviction and a 14-day notice for any change of ownership that affects care; and providing a financial stability affidavit upon submission of application for licensure to affirm ability to operate for two years.

Additionally, assisted living facilities must maintain at least two direct care staff at all times and a registered nurse (RN) or licensed practical nurse (LPN) between eight and 40 hours per week depending on number of residents in facility.

House Bill 987 also provides a certification for memory care units that must provide the following staff: one dementia trained staff person for every 12 residents; one licensed social worker or professional counselor for eight hours per month; one RN, LPN, or certified medication aide at all times; at least two direct care staff at all times; at least one RN or LPN between eight and 40 hours on-site depending on number of residents; and initial and annual dementia specific training.

The bill adds a provision related to COVID-19. Each personal care home with 25 or more beds, each assisted living community, and each nursing home licensed in Georgia must: inform its residents and their representatives by 5:00 p.m. the next day following the occurrence of either a single confirmed infection of COVID-19 or another type of airborne infectious disease; maintain a minimum seven-day supply of protective masks, surgical gowns, eye protection, and gloves; maintain and publish policies and procedures pertaining to control and mitigation efforts; and include a pandemic plan for influenza and other infectious diseases. Unless previously tested, and no later than 90 days after its effective date, each resident and direct care staff person in a long-term facility in Georgia is required to receive an initial baseline molecular Severe Acute Respiratory Syndrome (SARS) CoV-2 test.

Additionally, this bill creates the State Board of Long-Term Care Facility Administrators consisting of nine members: three members who are nursing home administrators in Georgia; three members who are either a personal care home or assisted living community administrator; two members of the public who are not administrators; and one member who is a health care professional.

Furthermore, House Bill 987 imposes a mandatory fine of at least \$5,000, and increases the maximum daily fine for long-term care facilities from \$1,000 to \$2,000 up to a total of \$40,000 for any violation that causes the death or serious physical injury of a resident.

HB 1090 by Rep. Deborah Silcox (52nd) requires employers to provide break time to employees who need to express breast milk. Additionally, this bill allows the labor commissioner to set the amount of deductible earnings related to a person's unemployment up to \$300 and grants the commissioner of insurance the authority to adopt emergency rules during a declared statewide emergency and authorize a work-sharing program.

HB 1114 by Rep. Sharon Cooper (43rd) requires the Department of Community Health to provide Medicaid coverage, and pursue a waiver if needed, to provide coverage for lactation care and services to pregnant and lactating women, children who are breastfeeding or receiving their mother's milk, and postpartum care for mothers for a period of up to six months following birth. This bill will become effective only upon the effective date of a specific appropriation of funds by the General Assembly.

HB 1125 by Rep. Trey Kelley (16th) requires the Department of Community Health and the Georgia Composite Medical Board to identify and compile information on an annual basis that identifies individuals at high risk for

breast cancer. Additionally, the bill requires the State Health Benefit Plan to include coverage for breast cancer screening for women ages 30 or older who are at high risk of breast cancer.

SB 372 by Sen. Blake Tillery (19th) modernizes various provisions relating to public health. The bill allows first responders to purchase Naloxone, adds the duty of raising awareness of women's reproductive health issues for the Office of Women's Health, and increases the number of years before the records of a deceased citizen are transferred to state archives from 100 to 125 years from the time of birth.

SB 482 by Sen. Dean Burke (11th) establishes the Georgia All-Payer Claims Database (GAPCD). Claims data is the information included in an institutional, professional, or pharmacy claim for a covered individual, including the amount paid to a provider of health care services, plus any amount owed by the covered individual.

Additionally, the bill creates an advisory committee to make recommendations regarding the creation of the framework and implementation plan for the GAPCD to facilitate the reporting of health care data. The committee will make initial recommendations to the director of the Office of Health Strategy and Coordination no later than March 1, 2021. The objective of the GAPCD is to facilitate data-driven and evidence-based improvements in access, quality, and cost of health care in order to understand health care expenditure patterns. The committee will conduct an evaluation of the GAPCD at least every five years to ensure these purposes are met.

The director will seek funding for the creation of the all-payer health claims database and report to the governor and General Assembly on the status of the funding effort and final data elements recommended by the advisory committee no later than March 15, 2021. The GAPCD will be created if sufficient funding is received through gifts, grants, donations, or appropriations on or before January 1, 2022.

Special Committee on Access to Quality Healthcare Legislation

HB 789 by Rep. Mark Newton (123rd), also known as the 'Surprise Bill Transparency Act', creates a health benefit plan surprise bill rating system that is defined by the number of green check marks and red X marks between zero and four. The number of check marks and X marks is determined by the number of qualified hospital-based specialty group types, or lack thereof, with which the health benefit plan is contracted for the provision of health care services. The bill defines "hospital-based specialty groups" as anesthesiologists, pathologists, radiologists, and emergency medicine physicians.

The insurer must make this rating system available for patients to view online for each network plan. If a rating is less than four check marks, the insurer advertising a hospital as in-network must describe which specialty group type is not contracted with the health benefit plan. If an insurer processes a claim on a covered person from an out-of-network specialty group provider at an out-of-network rate, the insurer must update the relevant rating within 30 days to reflect any necessary reduction in the rating.

HB 888 by Rep. Lee Hawkins (27th), also known as the 'Surprise Billing Consumer Protection Act', provides definitions and provisions that only apply to health care plans that are subject to the regulatory authority of the

Department of Insurance (DOI). "Surprise bill" means a bill resulting from an occurrence in which charges arise from a covered person receiving health care services from an out-of-network provider at an in-network facility.

Section 4 requires that regardless of whether a health care provider furnishing emergency medical services is a participating provider or not, an insurer providing benefits to covered persons with respect to emergency medical services must pay for the emergency medical services without need for any prior authorization determination or any retrospective payment denial for these services. In the event a covered person receives emergency medical services from a non-participating emergency medical provider, the provider notifies the person that no monies are owed for the provision of the services except the person's deductible, co-insurance, co-payment, or other cost-sharing amount. The provider collects or bills the person's cost-sharing amount, and the insurers directly pay the provider: the greater of the verifiable contracted amount paid by all eligible insurers for the same or similar service; the most recent verifiable amount agreed to by the insurer and non-participating provider; or a higher amount the insurer deems appropriate given the complexity and circumstances of the services provided. Any amount the insurer pays the non-participating provider is not required to include any amount of cost-sharing payments owed or paid by the person. A health care plan does not deny benefits for emergency medical services previously rendered based upon a covered person's failure to provide subsequent notification in accordance with plan provisions where the covered person's medical condition prevented timely notification. In the event a covered person receives emergency services from a non-participating facility, the facility bills the covered person no more than the person's cost-sharing amount. This part of the legislation adds out-of-network hospitals to the arbitration process for emergency services only.

Section 5 requires an insurer that provides benefits with non-emergency medical services to pay for these services in the event that the services result in a surprise bill regardless of whether the provider furnishing the services is a participating provider or not. In the event a covered person receives non-emergency medical services by a non-participating provider, the non-participating provider must notify the person that no monies are owed for the provision of services except the person's cost-sharing amount and collects or bills for that amount. Any amount that the insurer pays the non-participating provider is not required to include any of the cost-sharing portion owed by the covered person. For purposes of the covered person's financial responsibilities, the health care plan treats the non-emergency medical services received from a non-participating provider as if a participating provider rendered the services.

Section 6 states that no health care plan may deny or restrict the provision of covered benefits from a participating provider to a covered person solely because the covered person obtains treatment from a non-participating provider leading to a balance bill. The insurer provides notice of this protection in writing to the covered person.

Section 7 states nothing in this act reduces a covered person's financial responsibilities in the event that the covered person chooses to receive non-emergency medical services from an out-of-network provider. These services are not considered a surprise bill. The covered person's choice must be documented via written and oral consent in advance of the provision of services. Additionally, the covered person's choice may only occur after the person has been provided with an estimate of the potential charges. If during the provision of non-emergency medical services a covered person requests that the attending provider refer the person to another provider for the immediate provision of additional non-emergency medical services, the referring provider is

exempt from the requirements of this act if the following are is satisfied: the referring provider advises the covered person that the referred provider may be a non-participating provider and may charge higher fees than a participating provider; the covered person orally and in writing acknowledges that the referred provider may be a non-participating provider and may charge higher fees than a participating provider; the written acknowledgment is on a document provided by the referring provider and includes language to be determined by the commissioner through rule and regulation; and the referring provider records the satisfaction of these requirements in the person's medical file.

Section 8 requires the DOI to maintain an all-payer health claims database and a record of insurer payments, which tracks the payments by a wide variety of health care services and by geographical areas of Georgia. DOI updates information in this database at least annually and maintains the information on its website. If an appropriation is not provided for this database, DOI will update information from other verifiable data as deemed appropriate on at least an annual basis.

Section 9 provides that if an out-of-network provider or facility concludes that payment received from an insurer is not sufficient given the complexity and circumstances of the services provided, the provider may initiate a request for arbitration with DOI. The provider submits this request within 30 days of receipt of payment for the claim and concurrently provides the insurer with a copy of the request. A request for arbitration may involve a single patient and a single type of health care service, a single patient and multiple types of health care services, multiple patients and a single type of health care service, or multiple substantially similar health care services in the same specialty on multiple patients.

Section 10 allows the DOI to dismiss certain requests for arbitration, if the disputed claim is: related to a health care plan that is not regulated by Georgia; pending action in state or federal court at the time of the request for arbitration; subject to a binding claims resolution process entered into prior to July 1, 2021; made against a health care plan subject to the exclusive jurisdiction of the 'Employee Retirement Income Security Act of 1974'; or in accord with other circumstances as may be determined by DOI rule.

Section 11 requires that within 30 days of the insurer's receipt of the provider's or facility's request for arbitration, the insurer submit to the commissioner all data necessary to determine whether the insurer's payment to the provider was in compliance. The commissioner is not required to make a determination prior to referring the dispute to a resolution organization for arbitration.

Section 12 authorizes the commissioner to promulgate rules implementing an arbitration process and to select one or more resolution organizations to arbitrate certain claim disputes between insurers and out-of-network providers or facilities. Prior to proceeding with arbitration, the commissioner will allow the parties 30 days from receipt of the request for arbitration to negotiate a settlement. The parties must notify the commissioner in a timely manner the result of the negotiation. If the parties have not notified the commissioner of the result within those 30 days, the commissioner has five days to refer the dispute to a resolution organization. DOI will contract with one or more resolution organizations by July 1, 2021 to review and consider claim disputes between insurers and out-of-network providers.

Section 13 states that upon the commissioner's referral of a dispute to a resolution organization, the parties have five days to select an arbitrator by mutual agreement. If the parties have not notified the resolution organization of their mutual selection before the fifth day, the resolution organization will select an arbitrator from among its members. Any selected arbitrator will be independent of the parties and will not have a personal, professional, or financial conflict with any party to the arbitration. The arbitrator will have experience or knowledge in health care billing and reimbursement rates and will not communicate ex parte with either party.

Section 14 requires that the parties have 10 days after the selection of the arbitrator to submit in writing to the resolution organization each party's final offer and each party's argument in support of their offer. The parties' initial arguments are limited to 20 written pages per party. The parties may submit documents in support of their arguments, and the arbitrator may require additional written arguments and documentation as necessary, but the arbitrator may require the additional filing no more than once. Additional written arguments are limited to no more than 10 pages per party. The arbitrator may set filing times and extend filing times as appropriate. Failure of either party to submit the supportive documentation may result in a default against the party for failing to make the timely submission.

Section 15 requires that each party submit one proposed payment amount to the arbitrator. The arbitrator picks one of the two amounts and reveals that amount in the arbitrator's final decision. The arbitrator does not modify the selected amount. In making a decision, the arbitrator considers the complexity and circumstances of each case, including, but not limited to, the level of training, education, and experience of the provider and other factors. The arbitrator's final decision is in writing and describes the basis for a decision. Notwithstanding Code Section 33-20E-14, a decision will be made within 30 days of the commissioner's referral. Any default or final decision issued by the arbitrator is binding upon the parties and not appealable through the court system.

Section 16 requires the party whose final offer amount is not selected by the arbitrator to pay the arbitrator's expenses and fees, and any other fees assessed by the resolution organization directly to the resolution organization. In the event of default, the defaulting party is also responsible for the resolution organization's assessed fees. In the event that both parties default, both parties are responsible for paying the organization one-half of all monies due. Monies due will be paid in full to the resolution organization within 15 days of the losing party's receipt of the arbitrator's final decision. Within three days of the organization's receipt of monies due to the party whose final offer was selected, the monies will be distributed to that party.

Following the resolution of arbitration, the commissioner refers any case that a provider has acted in violation of this chapter to the appropriate state agency or governing entity with governing authority over the provider. The referral includes a description of violations and the commissioner's recommendation for enforcement action. That agency or governing entity may initiate an investigation regarding the referral within 30 days of receiving the referral and conclude it within 90 days of receiving the referral.

Sections 18 thru 23 provide that once a request for arbitration has been filed with the commissioner by a provider, neither the provider nor the insurer in a dispute will file a lawsuit in court regarding the same out-of-network claim. Each resolution organization contracted with the DOI reports to DOI on a quarterly basis the results of all disputes referred to an organization as follows: the number of arbitrations filed, settled, arbitrated,

defaulted, or dismissed during the previous calendar year, and whether the arbitrators' decisions were in favor of the insurer or the provider. On or before July 1, 2022 and each July 1 thereafter, the commissioner will provide a written report to the House Committee on Insurance and the Senate Insurance and Labor Committee. This report, also posted on the DOI's website, summarizes the arbitrations. Non-participating providers do not report to any credit-reporting agency any covered person who receives a surprise bill for the receipt of health care services from a provider and does not pay the provider any co-pay, coinsurance, deductible, or other cost-sharing amount beyond what the covered person would pay the non-participating provider had the non-participating provider been a participating provider. Nothing in this chapter reduces a covered person's financial responsibilities with regard to ground ambulance transportation. This act is effective on January 1, 2021.

HB 918 by Rep. Sharon Cooper (43rd) amends 'The Pharmacy Audit Bill of Rights' to exclude the cost of claims by prescription number as a criterion in determining which claims to audit. Audits will not include more than 100 prescriptions per audit and an entity will not audit more than 200 prescriptions in any 12-month period.

A pharmacy is not responsible for any penalty or fee in connection with an audit. There is no recoupment of funds from a pharmacy in connection with claims for which the pharmacy has already been paid without first complying with these requirements. There is no recoupment from a pharmacy except in cases of fraud, a miss-filled prescription, or an error that resulted in an over-payment, in which case the recoupment is limited to the amount over-paid. Additionally, this bill limits the auditing of a pharmacy to no more than once every six months.

HB 946 by Rep. David Knight (130th) and **SB 313** by Sen. Dean Burke (11th) requires any physician employed or contracted with a pharmacy benefits manager (PBM) that is advising or making determinations specific to an insured individual to: have actively seen patients within the past five years; and has practiced in the same specialty area for which the physician is providing advisement within the past five years. The Department of Community Health (DCH) is encouraged to require the use of a licensed Georgia physician for prior authorization, step therapy appeals, or determination reviews for contracts and amendments entered into with a PBM.

This bill grants the Department of Insurance regulatory authority of PBMs in Georgia. Any methodologies utilized by a PBM in connection with reimbursement must be filed with the department. A PBM must utilize the national average drug acquisition cost as a point of reference for the ingredient drug product component of a pharmacy's reimbursement for drugs appearing on the national average drug acquisition cost list. A report must be filed with the department every four months detailing all drugs appearing on the national average drug acquisition cost list reimbursed at 10 percent and below the national average drug acquisition cost, as well as all drugs reimbursed at 10 percent and above this national average. For each drug in the report, a PBM must include: the month the drug was dispensed; the quantity of the drug dispensed; the amount the pharmacy was reimbursed per unit or dosage; whether the dispensing pharmacy was an affiliate; whether the drug was dispensed pursuant to a state or local government health plan; and the national average drug acquisition cost on the day the drug was dispensed.

This bill requires that PBMs will not engage in any practice that: discriminates in reimbursement, assesses any fees or adjustments, or excludes a pharmacy from the PBM's network; in any way bases pharmacy

reimbursement for a drug on the patient outcomes, scores, or metrics; includes imposing a point-of-sale fee or retroactive fee; or derives any revenue from a pharmacy or insured in connection with performing PBM services.

PBMs are required to pass on to the health plan 100 percent of all rebates it receives from pharmaceutical manufacturers and report annually to each health plan the aggregate amount of all rebates and other payments that the PBM received from manufactures in connection with claims if administered on behalf of the health plan. PBMs must offer the option of charging a health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug. A PBM must report in the aggregate to a health plan the difference between the amount the PBM reimburses a pharmacy and the amount the PBM charges a health plan. This information will be confidential and not subject to open records unless the health plan is administered by the DCH.

HB 991 by Rep. Matt Hatchett (150th) creates the Health Care Transparency and Accountability Oversight Committee. The committee has authority to review the performance and conduct of all state health care plan contractors and their subcontractors. The oversight committee is composed of nine members: a physician, a pharmacist, and a consumer member who receives benefits from a state health care plan, each appointed by the governor; and six members of the General Assembly, including two members appointed by the governor, two members appointed by the lieutenant governor, and two members appointed by the speaker of the House.

SB 303 by Sen. Ben Watson (1st) requires each insurer, except health maintenance organizations, to make available on its website an interactive mechanism for members of the public to: compare the payment amounts accepted by in-network providers for health care services; obtain an estimate of the average amount accepted by in-network providers for the health care services; obtain an estimate of the out-of-pocket costs that a person will owe his or her provider for a health care service; and compare quality metrics applicable to in-network providers for major diagnostic categories.

SB 391 by Sen. Kay Kirkpatrick (32nd) requires health insurers to waive time restrictions for refills of a 30-day supply of certain prescription medications during emergencies.

Insurance Committee Legislation

HB 716 by Rep. Shaw Blackmon (146th) requires any carrier that issues a health benefit plan through an agent to pay a commission to that agent and file with the Department of Insurance the proposed commission rates relevant to all such agents. The commission paid to the agents must be consistent with the amount proposed in the rates filed and required by the Department of Insurance.

HB 1050 by Rep. Eddie Lumsden (12th) adds "health care management organizations" to the life and health association guarantee fund and equally splits future assessments for long-term care insurer insolvencies between the association's member insurers.

SB 28 by Sen. Lester Jackson (2nd) establishes additional criteria for co-payments in certain health benefit plans. The bill adds a provision regarding insurance requiring co-payments to: be reasonable in relation to the covered benefits to which they apply; must serve as an incentive rather than a barrier to access appropriate care; and must not unfairly deny necessary health care services.