The Senate Committee on Insurance and Labor offered the following substitute to HB 63:

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 require health benefit plans to establish step therapy protocols; to provide for a step therapy exception process; to provide for definitions; to provide for statutory construction; to provide for 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:

"33-24-59.25.

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

(1) 'Health benefit plan' means any hospital, health, or medical expense insurance policy; hospital or medical service contract; employee welfare benefit plan; contract or agreement with a health maintenance organization; subscriber contract or agreement; contract or agreement with a preferred provider organization; accident and sickness insurance benefit plan; or other insurance contract under any other name. The term shall include any health insurance plan established under Article 1 of Chapter 18 of Title 45, the 'State Employees' Health Insurance Plan and Post-employment Health Benefit Fund.'

(2) 'Practitioner' means a physician, dentist, podiatrist, or optometrist and shall include any other person licensed under the laws of this state to use, mix, prepare, dispense, prescribe, and administer drugs in connection with medical treatment for individuals to the extent provided by the laws of this state.

(3) 'Step therapy exception' means that a step therapy protocol should be overridden in favor of immediate coverage of the practitioner's selected prescription drug, provided that the drug is covered under the health benefit plan.

(4) 'Step therapy protocol' means an evidence based and updated protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are deemed medically appropriate for a particular patient, including self-administered and physician-administered drugs, and are covered by an insurer or health benefit plan.

(b) A step therapy exception shall be granted by a health benefit plan if the prescribing provider's submitted justification and supporting clinical documentation, if needed, is completed and determined to support such provider's statement that:

(1) The required prescription drug is contraindicated or will cause an adverse reaction or physical or mental harm to the patient;

(2) The required prescription drug is expected to be ineffective based on the known clinical condition of the patient and the known characteristics of the prescription drug regimen;

(3) The patient has tried the required prescription drug or another prescription drug in the same pharmacological class or with the same mechanism of action as the required drug while on their current or immediately preceding health plan and such drug was discontinued due to lack of efficacy, diminished effect, or an adverse event; or

(4) The patient is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on their current or immediately preceding health plan, the patient received coverage for the prescription drug and the practitioner gives documentation in accordance with this subsection that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the patient based on the known characteristics of the patient and the known characteristics of the required prescription drug.

(c) Drug samples shall not be considered trial and failure of a preferred prescription drug in lieu of trying the step therapy required prescription drug.

(d) A health benefit plan shall grant or deny a step therapy exception or appeal of a step therapy exception within:

(1) Twenty-four hours in an urgent health care situation; and

(2) Two business days from the date such request or appeal is submitted in a nonurgent health care situation.

If the health benefit plan fails to respond in accordance with the established time frame, such step therapy exception or an appeal shall be deemed approved.

(e) Upon the granting of a step therapy exception, the health benefit plan shall immediately authorize coverage for the prescription drug prescribed by the patient's practitioner, provided that the drug is covered under the health benefit plan. Any step therapy exception

denial shall be eligible for a physician's or a patient's appeal in accordance with the health benefit plan's existing appeal procedures.

(f) This Code section shall not be construed to prevent:

(1) A health benefit plan from requiring a patient to try an AB-rated generic equivalent prior to providing coverage for the equivalent-branded prescription drug;

(2) A health benefit plan from requiring a patient to try an interchangeable biological product prior to providing coverage for the biological product; or

(3) A practitioner from prescribing a prescription drug that is determined by such practitioner to be medically necessary.

(g) This Code section shall not be construed to impact a health benefit plan's ability to substitute a generic drug for a brand name drug.

(h) This Code section shall not apply to the provision of health care services pursuant to a contract entered into by an insurer and the Department of Community Health for recipients of Medicaid or PeachCare for Kids.

(i) This Code section shall apply only to health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2020.″

SECTION 2.

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