

House Bill 291

By: Representatives Rogers of the 26<sup>th</sup>, Knox of the 24<sup>th</sup>, Meadows of the 5<sup>th</sup>, and Dodson of the 75<sup>th</sup>

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 remove the requirement that managed care plans obtain certain acknowledgments; to provide  
3 for the maximum duration of certain credit life policies; to provide for a mortgagee group  
4 policy; to increase the maximum amount of coverage on an agricultural loan group policy;  
5 to provide that certain required provisions in group life insurance policies shall not apply to  
6 policies issued to a creditor to insure mortgagors; to require that certain individual and  
7 blanket accident and sickness policies insure certain dependent children of the insured up to  
8 and including age 25; to provide an exception for certain matters concerning renewability of  
9 policies; to clarify certain definitions; to clarify the applicable groups for blanket accident  
10 and sickness insurance; to provide an exception for intentional misrepresentation of material  
11 fact in applying for or procuring insurance as to treatment of certain statements made by a  
12 policyholder or insured person; to clarify the application of certain provisions to group and  
13 blanket accident and sickness insurance; to clarify certain provisions regarding insurance  
14 portability and renewability; to provide for related matters; to repeal conflicting laws; and  
15 for other purposes.

16 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

17 style="text-align:center">**SECTION 1.**

18 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
19 striking paragraph (1) of Code Section 33-20A-5, relating to standards for certification, and  
20 inserting in lieu thereof a new paragraph (1) to read as follows:

21 "(1) DISCLOSURE TO ENROLLEES AND PROSPECTIVE ENROLLEES.

22 (A) A managed care entity shall disclose to enrollees and prospective enrollees who  
23 inquire as individuals into a plan or plans offered by the managed care entity the  
24 information required by this paragraph. In the case of an employer negotiating for a  
25 health care plan or plans on behalf of his or her employees, sufficient copies of

1 disclosure information shall be made available to employees upon request. Disclosure  
2 of information under this paragraph shall be readable, understandable, and on a  
3 standardized form containing information regarding all of the following for each plan  
4 it offers:

5 (i) The health care services or other benefits under the plan offered as well as  
6 limitations on services, kinds of services, benefits, or kinds of benefits to be provided,  
7 which disclosure may also be published on an Internet service site made available by  
8 the managed care entity at no cost to such enrollees;

9 (ii) Rules regarding copayments, prior authorization, or review requirements  
10 including, but not limited to, preauthorization review, concurrent review, postservice  
11 review, or postpayment review that could result in the patient's being denied coverage  
12 or provision of a particular service;

13 (iii) Potential liability for cost sharing for ~~out-of-network~~ out-of-network services,  
14 including, but not limited to, providers, drugs, and devices or surgical procedures that  
15 are not on a list or a formulary;

16 (iv) The financial obligations of the enrollee, including premiums, deductibles,  
17 copayments, and maximum limits on out-of-pocket expenses for items and services  
18 (both in and out of network);

19 (v) The number, mix, and distribution of participating providers. An enrollee or a  
20 prospective enrollee shall be entitled to a list of individual participating providers  
21 upon request, and the list of individual participating providers shall also be updated  
22 at least every 30 days and may be published on an Internet service site made available  
23 by the managed care entity at no cost to such enrollees;

24 (vi) Enrollee rights and responsibilities, including an explanation of the grievance  
25 process provided under this article;

26 (vii) An explanation of what constitutes an emergency situation and what constitutes  
27 emergency services;

28 (viii) The existence of any limited utilization incentive plans;

29 (ix) The existence of restrictive formularies or prior approval requirements for  
30 prescription drugs. An enrollee or a prospective enrollee shall be entitled, upon  
31 request, to a description of specific drug and therapeutic class restrictions;

32 (x) The existence of limitations on choices of health care providers;

33 (xi) A statement as to where and in what manner additional information is available;

34 (xii) A statement that a summary of the number, nature, and outcome results of  
35 grievances filed in the previous three years shall be available for inspection. Copies  
36 of such summary shall be made available at reasonable costs; and

1 (xiii) A summary of any agreements or contracts between the managed care plan and  
2 any health care provider or hospital as they pertain to the provisions of Code Sections  
3 33-20A-6 and 33-20A-7. Such summary shall not be required to include financial  
4 agreements as to actual rates, reimbursements, charges, or fees negotiated by the  
5 managed care plan and any health care provider or hospital; provided, however, that  
6 such summary may include a disclosure of the category or type of compensation,  
7 whether capitation, fee for service, per diem, discounted charge, global  
8 reimbursement payment, or otherwise, paid by the managed care plan to each class  
9 of health care provider or hospital under contract with the managed care plan.

10 (B) Such information shall be disclosed to each enrollee under this article at the time  
11 of enrollment and at least annually thereafter.

12 (C) Any managed care plan licensed under Chapter 21 of this title is deemed to have  
13 met the certification requirements of this paragraph.

14 ~~(C.1) Any managed care plan licensed in this state shall obtain a signed~~  
15 ~~acknowledgment from each enrollee at the time of enrollment and upon any subsequent~~  
16 ~~product change elected by an enrollee acknowledging that the enrollee has been~~  
17 ~~informed of the following:~~

18 ~~(i) The number, mix, and distribution of participating providers. An enrollee shall~~  
19 ~~be entitled to a list of individual participating providers and the list shall be updated~~  
20 ~~at least every 30 days and may be published on an Internet service site made available~~  
21 ~~by the managed care entity at no cost to such enrollee;~~

22 ~~(ii) The existence of limitations and disclosure of such limitations on choices of~~  
23 ~~health care providers; and~~

24 ~~(iii) A summary of any agreements or contracts between the managed care plan and~~  
25 ~~any health care provider or hospital as they pertain to the provisions of Code Sections~~  
26 ~~33-20A-6 and 33-20A-7. Such summary shall not be required to include financial~~  
27 ~~agreements as to actual rates, reimbursements, charges, or fees negotiated by the~~  
28 ~~managed care plan and any health care provider or hospital; provided, however, such~~  
29 ~~summary may include a disclosure of the category or type of compensation, whether~~  
30 ~~capitation, fee for service, per diem, discounted charge, global reimbursement~~  
31 ~~payment, or otherwise, paid by the managed care plan to each class of health care~~  
32 ~~provider or hospital under contract with the managed care plan.~~

33 (D) A managed care entity which negotiates with a primary care physician to become  
34 a health care provider under a managed care plan shall furnish that physician, beginning  
35 on and after January 1, 2001, with a schedule showing fees payable for common office  
36 based services provided by such physicians under the plan;".

**SECTION 2.**

Said title is further amended by striking Code Section 33-27-1, relating to group requirements generally, and inserting in lieu thereof a new Code Section 33-27-1 to read as follows:

"33-27-1.

No policy of group life insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) **EMPLOYEE GROUPS.** A policy issued to an employer or to the trustees of a fund established by an employer, which employer or trustee shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy shall be all of the employees of the employer or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term 'employees' shall include the employees of one or more subsidiary corporations and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietors, or partnerships, if the business of the employer and of such affiliated corporations, proprietors, or partnerships is under common control through stock ownership or contract or otherwise. The policy may provide that the term 'employees' shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term 'employees' shall include retired employees. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. A policy issued to insure the employees of a public body may provide that the term 'employees' shall include elected or appointed officials;

(B) The premium for the policy shall be paid by the policyholder either from the employer's own funds or from charges collected from the insured employee specifically for such insurance or from funds contributed by both the employer and the employee. A policy in which no part of the premium is to be derived from funds contributed by the insured employee must insure each eligible employee, except for any employee as to whom evidence of individual insurability is not satisfactory to the insurer;

(C) The policy must cover at least two employees at date of issue; and

(D) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or by the employer or trustee.

1 (2) DEBTOR GROUPS. A policy issued to a creditor or to a trustee or agent appointed by  
2 two or more creditors, which creditor, trustee, or agent shall be deemed the policyholder,  
3 to insure debtors of the creditor, subject to the following requirements:

4 (A) The debtors eligible for insurance under the policy shall be all of the debtors of the  
5 creditor whose indebtedness is repayable either in installments, including any  
6 extraordinary payment of an installment or lease-purchase obligation, or in one sum at  
7 the end of a period not in excess of 24 months from the initial date of debt or all of any  
8 class or classes thereof determined by conditions pertaining to the indebtedness or to  
9 the purchase giving rise to the indebtedness. The policy may provide that the term  
10 'debtors' shall include the debtors of one or more subsidiary corporations and the  
11 debtors of one or more affiliated corporations, proprietors, or partnerships, if the  
12 business of the policyholder and of such affiliated corporations, proprietors, or  
13 partnerships is under common control through stock ownership, contract, or otherwise.  
14 No debtor shall be eligible unless the indebtedness constitutes an irrevocable obligation  
15 to repay which is binding upon him during his lifetime at the time the insurance  
16 becomes effective upon his life;

17 (B) The premium for the policy shall be paid by the policyholder either from the  
18 creditor's funds, from charges collected from the insured debtors, or from both. A  
19 policy on which part or all of the premium is to be derived from the collection from the  
20 insured debtors of identifiable charges not required of uninsured debtors shall not  
21 include, in the class or classes of debtors eligible for insurance, debtors under  
22 obligations outstanding at its date of issue without evidence of individual insurability  
23 unless at least 75 percent of the then eligible debtors elect to pay the required charges.  
24 A policy on which no part of the premium is to be derived from the collection of such  
25 identifiable charges must insure all eligible debtors or all except any as to whom  
26 evidence of individual insurability is not satisfactory to the insurer;

27 (C) The policy may be issued only if the policy reserves to the insurer the right to  
28 require evidence of individual insurability if less than 75 percent of the new entrants  
29 become insured. The policy may exclude from the classes eligible for insurance classes  
30 of debtors determined by age;

31 (D) The amount of insurance on the life of any debtor shall at no time exceed the  
32 amount owed by him which is repayable in installments, the amount of the unpaid  
33 indebtedness, or \$75,000.00, whichever is less. Where the indebtedness is repayable  
34 in one sum to the creditor, the insurance on the life of any debtor shall in no instance  
35 be in effect for a period in excess of ~~18~~ 24 months, except that such insurance may be  
36 continued for an additional period not exceeding six months in the case of default,  
37 extension, or recasting of the loan; and

1 (E) The insurance shall be payable to the policyholder. Such payment shall reduce or  
2 extinguish the unpaid indebtedness of the debtor to the extent of such payment.

3 (3) MORTGAGEE GROUP. A policy issued to a creditor, or to a trustee or agent appointed  
4 by two or more creditors, which creditor, trustee, or agent shall be deemed the  
5 policyholder, to insure mortgagors of the creditor. The insurance must be written in  
6 connection with a credit transaction that is secured by a first mortgage or deed of trust;  
7 made to finance the purchase of real property or the construction of a dwelling thereon,  
8 or to refinance a prior credit transaction made for the purpose; and shall be payable to the  
9 policyholder. Such payment shall reduce or extinguish the unpaid mortgage of the  
10 mortgagor to the extent of such payment.

11 (4) AGRICULTURAL LOANS. Notwithstanding the provisions of this Code section, group  
12 life insurance in connection with agricultural loans may be written up to the amount of  
13 the loan or loan commitment on the nondecreasing or level term plan; however, the  
14 amount of insurance on the life of any such debtor shall not on any anniversary date of  
15 the insurance exceed the amount then owed by him which is repayable in installments,  
16 the amount of the then unpaid indebtedness, or ~~\$40,000.00~~ \$75,000.00, whichever is less.

17 ~~(4)~~(5) LABOR UNION GROUPS. A policy issued to a labor union, which shall be deemed  
18 the policyholder, to insure members of such union for the benefit of persons other than  
19 the union or any of its officials, representatives, or agents, subject to the following  
20 requirements:

21 (A) The members eligible for insurance under the policy shall be all of the members  
22 of the union or all of any class or classes thereof determined by conditions pertaining  
23 to their employment or to membership in the union, or both;

24 (B) The premium for the policy shall be paid by the policyholder either wholly from  
25 the union's funds or partly from such funds and partly from funds contributed by the  
26 insured members specifically for their insurance. No policy may be issued on which  
27 the entire premium is to be derived from funds contributed by the insured members  
28 specifically for their insurance. A policy on which no part of the premium is to be  
29 derived from funds contributed by the insured members specifically for their insurance  
30 must insure all eligible members or all except any as to whom evidence of individual  
31 insurability is not satisfactory to the insurer;

32 (C) The policy must cover at least 25 members at date of issue; and

33 (D) The amounts of insurance under the policy must be based upon some plan  
34 precluding individual selection either by the members or by the union.

35 ~~(5)~~(6) TRUSTEE GROUPS. A policy issued to the trustees of a fund established by two or  
36 more employers or by one or more labor unions or by one or more employers and one or  
37 more labor unions, which trustees shall be deemed the policyholder, to insure employees

1 of the employers or members of the unions for the benefit of persons other than the  
2 employers or the unions, subject to the following requirements:

3 (A) The persons eligible for insurance shall be all of the employees of the employers,  
4 all of the members of the unions, or all of any class or classes of employees or union  
5 members determined by conditions pertaining to their employment, to membership in  
6 the unions, or to both. The policy may provide that the term 'employees' shall include  
7 retired employees and the individual proprietor or partners if an employer is an  
8 individual proprietor or a partnership. No director of a corporate employer shall be  
9 eligible for insurance under the policy unless such person is otherwise eligible as a bona  
10 fide employee of the corporation by performing services other than the usual duties of  
11 a director. No individual proprietor or partner shall be eligible for insurance under the  
12 policy unless he is actively engaged in and devotes a substantial part of his time to the  
13 conduct of the business of the proprietor or partnership. The policy may provide that  
14 the term 'employees' shall include the trustees or their employees, or both, if their duties  
15 are principally connected with such trusteeship;

16 (B) The premium for the policy shall be paid by the trustees wholly from funds  
17 contributed by the employer or employers of the insured persons, by the union or  
18 unions, or by both or partly from such funds and partly from funds contributed by the  
19 insured persons. No policy may be issued on which the entire premium is to be derived  
20 from funds contributed by the insured persons specifically for their insurance. A policy  
21 on which no part of the premium is to be derived from funds contributed by the insured  
22 persons specifically for their insurance must insure all eligible persons or all except any  
23 as to whom evidence of individual insurability is not satisfactory to the insurer;

24 (C) The policy must cover at date of issue at least 100 persons; and, if the fund is  
25 established by the members of an association of employers, the policy may be issued  
26 only if either the participating employers constitute at date of issue at least 60 percent  
27 of those employer members whose employees are not already covered for group life  
28 insurance or the total number of persons covered at date of issue exceeds 600; and the  
29 policy shall not require that, if a participating employer discontinues membership in the  
30 association, the insurance of his employees shall cease solely by reason of the  
31 discontinuance; and

32 (D) The amounts of insurance under the policy must be based upon some plan  
33 precluding individual selection either by the insured persons or by the policyholder,  
34 employers, or unions.

35 ~~(6)~~(7) ASSOCIATION GROUPS. The lives of a group of individuals may be insured under  
36 a policy issued to an association, which shall be deemed the policyholder, to insure  
37 members of such association for the benefit of persons other than the association. As

1 used in this paragraph, the term 'association' means an association of governmental or  
 2 public employees, an association of employees of a common employer, or an  
 3 organization formed and operated in good faith for purposes other than that of procuring  
 4 insurance and composed of members engaged in a common trade, business, or profession.

5 The policy shall be subject to the following requirements:

6 (A) The members eligible for insurance under the policy shall be all of the members  
 7 of the association or all of any class or classes of the association determined by  
 8 conditions pertaining to their employment, to their trade, business, or profession, to  
 9 their membership in the association, or to any two or more of such conditions. The  
 10 policy may provide that officers and employees of the association who are bona fide  
 11 members may be insured under the policy;

12 (B) The policy must cover at least 25 members at date of issue;

13 (C) The amounts of insurance under the policy must be based upon some plan  
 14 precluding individual selection either by the association or by the members; and

15 (D) The premium for the policy shall be paid by the policyholder either from the  
 16 association's own funds, or from charges collected from the insured members  
 17 specifically for the insurance, or from both.

18 ~~(7)~~(8) BANK AND CREDIT UNION GROUPS. A bank authorized to do business in this state  
 19 may carry insurance upon its depositors for amounts not to exceed the savings deposit  
 20 balances of each depositor or \$5,000.00, whichever is less, and a credit union organized  
 21 pursuant to the laws of this state or the Federal Credit Union Act may carry insurance  
 22 upon its members for amounts not to exceed the share and deposit balances of each  
 23 member or \$5,000.00, whichever is less. Such insurance shall be subject to the  
 24 requirements of subparagraphs (A) through (D) of paragraph ~~(6)~~ (7) of this Code section.

25 ~~(8)~~(9) MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

26 (A) The lives of a group of individuals may be insured under a policy issued to a legal  
 27 entity providing a multiple employer welfare arrangement. As used in this paragraph,  
 28 the term 'multiple employer welfare arrangement' means any employee benefit plan  
 29 which is established or maintained for the purpose of offering or providing life  
 30 insurance benefits to the employees of two or more employers, including self-employed  
 31 individuals and their dependents. The term does not apply to any plan or arrangement  
 32 which is established or maintained by a tax-exempt rural electric cooperative or a  
 33 collective bargaining agreement.

34 (B) The amounts of insurance under the policy must be based upon some plan  
 35 precluding individual selection either by the employees, employers, or trustee.

36 ~~(9)~~(10) SPECIAL EMPLOYEE GROUPS. A corporation or a trustee of a trust established by  
 37 a corporation which has an insurable interest in employees pursuant to subsection (c) of

1 Code Section 33-24-3 and authority to effectuate insurance on employees pursuant to  
 2 paragraph (4) or (5) of subsection (a) of Code Section 33-24-6 may establish an employee  
 3 group to effectuate group life insurance policies on employees when such corporation or  
 4 trustee of a trust is providing life, health, disability, retirement, or similar benefits to  
 5 employees, provided that the premium for such group policies is wholly paid by the  
 6 corporation or trustee of the trust and the proceeds of such policies are used to provide  
 7 supplemental funding for such employee benefit plans."

### 8 SECTION 3.

9 Said title is further amended by striking paragraph (1) of subsection (b) of Code Section  
 10 33-27-3, relating to required policy provisions, and inserting in lieu thereof a new paragraph  
 11 (1) to read as follows:

12 "(1) The provisions of paragraphs (6), (8), (9), and (10) of subsection (a) of this Code  
 13 section shall not apply to policies issued to a creditor to insure debtors or mortgagors of  
 14 such creditor."

### 15 SECTION 4.

16 Said title is further amended by striking paragraph (3) of subsection (a) of Code Section  
 17 33-29-2, relating to requirements as to policies generally, and inserting in lieu thereof a new  
 18 paragraph (3) to read as follows:

19 "(3) It purports to insure only one person, provided that a policy may insure, originally  
 20 or by subsequent amendment upon the application of an adult member of a family who  
 21 shall be deemed the policyholder, any two or more eligible members of that family,  
 22 including husband, wife, dependent children, or any children, under a specified age which  
 23 shall not exceed 19 years, and any other person dependent upon the policyholder;  
 24 provided, further, that, if a policy purports to insure a dependent child of the policyholder,  
 25 the child shall continue to be insured up to and including age 25 so long as the policy  
 26 continues in effect, the child remains a dependent of the policyholder, and the child, in  
 27 each calendar year since reaching the age specified in the policy for termination of  
 28 benefits as a dependent of the policyholder, has been enrolled for five calendar months  
 29 or more as a full-time student in a postsecondary institution of higher learning or, if not  
 30 so enrolled, would have been eligible to be so enrolled and was prevented from being so  
 31 enrolled due to illness or injury;".



1 (6) Under a policy issued to cover any other substantially similar group which in the  
 2 discretion of the Commissioner may be subject to the issuance of a group accident and  
 3 sickness policy or contract; or

4 ~~(6)~~(7)(A) Under a policy issued to a legal entity providing a multiple employer welfare  
 5 arrangement, which means any employee benefit plan which is established or  
 6 maintained for the purpose of offering or providing accident and sickness benefits to  
 7 the employees of two or more employers, including self-employed individuals, and  
 8 their dependents.

9 (B) The amounts of insurance under the policy must be based upon some plan  
 10 precluding individual selection either by the employees, employers, or trustee."

### 11 SECTION 8.

12 Said title is further amended by striking Code Section 33-30-3, relating to "blanket accident  
 13 and sickness insurance" defined, and inserting in lieu thereof a new Code Section 33-30-3 to  
 14 read as follows:

15 "33-30-3.

16 'Blanket accident and sickness insurance' is that form of group accident and sickness  
 17 insurance covering the groups of persons listed in paragraphs (1) through (6) and issued  
 18 upon the following basis:

19 (1) Under a group policy or contract issued to any common carrier or to any operator,  
 20 owner, or lessee of a means of transportation, who or which shall be deemed the  
 21 policyholder, covering a group defined as all persons or all persons of a class who may  
 22 become passengers on such common carrier or such means of transportation;

23 (2) Under a group policy or contract issued to an employer, who shall be deemed the  
 24 policyholder, covering all employees, dependents, or guests defined by reference to  
 25 specified hazards incident to the activities or operations of the employer or any class of  
 26 employees, dependents, or guests similarly defined;

27 (3) Under a group policy or contract issued to a school or other institution of learning,  
 28 a camp, the sponsor of the institution of learning or camp, or to the head or principal  
 29 thereof, who or which shall be deemed the policyholder, covering students or campers;  
 30 and supervisors and employees may be included;

31 (4) Under a group policy or contract issued in the name of any religious, charitable,  
 32 recreational, educational, or civic organization, which shall be deemed the policyholder,  
 33 covering participants in activities sponsored by the organization;

34 (5) Under a group policy or contract issued to a sports team or sponsors thereof, which  
 35 shall be deemed the policyholder, covering members, officials, and supervisors; or

1 (6) Under a group policy or contract issued to cover any other risk or class of risks which  
 2 in the discretion of the Commissioner may be properly eligible for blanket accident and  
 3 sickness insurance. The discretion of the Commissioner may be exercised on an  
 4 individual risk basis or class of risks, or both."

#### 5 SECTION 9.

6 Said title is further amended by striking paragraphs (1) and (4) of Code Section 33-30-4,  
 7 relating to required provisions generally, and inserting in lieu thereof new paragraphs (1) and  
 8 (4) to read as follows:

9 "(1) A provision that, in the absence of fraud or intentional misrepresentation of material  
 10 fact in applying for or procuring coverage under the terms of the group policy or contract,  
 11 all statements made by the policyholder or by any insured person shall be deemed  
 12 representations and not warranties, and that no statement made for the purpose of  
 13 effecting insurance shall avoid the insurance or reduce benefits unless contained in a  
 14 written instrument signed by the policyholder or the insured person, a copy of which has  
 15 been furnished to the policyholder or to the person or his beneficiary;"

16 "(4) A provision that, with respect to termination of benefits for, or coverage of, any  
 17 person who is a dependent child of an insured, the child shall continue to be insured up  
 18 to and including age 25 so long as the coverage of the member continues in effect, the  
 19 child remains a dependent of the insured parent or guardian, and the child, in each  
 20 calendar year since reaching any age specified for termination of benefits as a dependent,  
 21 has been enrolled for five calendar months or more as a full-time student at a  
 22 postsecondary institution of higher learning or, if not so enrolled, would have been  
 23 eligible to be so enrolled and was prevented from being so enrolled due to illness or  
 24 injury. This paragraph shall not apply to group policies under which an employer  
 25 provides coverage for dependents of its employees and pays the entire cost of the  
 26 coverage without any charge to the employee or dependents; and".

#### 27 SECTION 10.

28 Said title is further amended by striking subsection (b) of Code Section 33-30-6, relating to  
 29 authority to issue blanket accident and sickness policies, and inserting in lieu thereof a new  
 30 subsection (b) to read as follows:

31 "(b) Every blanket and group policy, certificate of insurance, or by whatever name called  
 32 shall contain provisions which in the opinion of the Commissioner are at least as favorable  
 33 to the policyholder and the individual insured as the following:

34 (1) A provision that the policy and the application shall constitute the entire contract  
 35 between the parties, and that all statements made by the policyholder shall, in absence of

1 fraud or intentional misrepresentation of material fact in applying for or procuring  
2 coverage under the terms of the group policy or contract, be deemed representations and  
3 not warranties, and that no such statements shall be used in defense to a claim under the  
4 policy, unless contained in a written application;

5 (2) A provision that written notice of sickness or of injury must be given to the insurer  
6 within 20 days after the date when such sickness or injury occurred. Failure to give  
7 notice within that time shall neither invalidate nor reduce any claim if it shall be shown  
8 not to have been reasonably possible to give the notice and that notice was given as soon  
9 as was reasonably possible;

10 (3) A provision that the insurer will furnish to the policyholder such forms as are usually  
11 furnished by it for filing proof of loss. If the forms are not furnished before the expiration  
12 of ten working days after the giving of notice, the claimant shall be deemed to have  
13 complied with the requirements of the policy as to proof of loss upon submitting, within  
14 the time fixed in the policy for filing proof of loss, written proof covering the occurrence,  
15 character, and extent of the loss for which claim is made;

16 (4) A provision that in the case of claim for loss of time for disability, written proof of  
17 the loss must be furnished to the insurer within 30 days after the commencement of the  
18 period for which the insurer is liable, and that subsequent written proofs of the  
19 continuance of the disability must be furnished to the insurer at such intervals as the  
20 insurer may reasonably require, and that in the case of claim for any other loss, written  
21 proof of the loss must be furnished to the insurer within 90 days after the date of the loss.  
22 Failure to furnish the proof within such time shall neither invalidate nor reduce any claim  
23 if it shall be shown not to have been reasonably possible to furnish the proof and that the  
24 proof was furnished as soon as was reasonably possible;

25 (5) A provision incorporating and restating the substance of the provisions of  
26 subsections (b) and (c) of Code Section 33-24-59.5, relating to time limits for payment  
27 of claims for benefits under health benefit policies and sanctions for failure to pay timely.  
28 If a policy provides benefits for loss of time, such policy shall also provide that, subject  
29 to proof of such loss, all accrued benefits payable under the policy for loss of time will  
30 be paid not later than at the expiration of each period of 30 days during the continuance  
31 of the period for which the insurer is liable and any balance remaining unpaid at the  
32 termination of such period will be paid immediately upon receipt of such proof;

33 (6) A provision that the insurer, at its own expense, shall have the right and opportunity  
34 to examine the person of the insured when and so often as it may reasonably require  
35 during the pendency of a claim under the policy and shall also have the right and  
36 opportunity to make an autopsy in case of death, if an autopsy is not prohibited by law;

1 (7) A provision that no action at law or in equity shall be brought to recover under the  
 2 policy prior to the expiration of 60 days after written proof of loss has been furnished in  
 3 accordance with the requirements of the policy, and that no action shall be brought after  
 4 the expiration of three years after the time written proof of loss is required to be  
 5 furnished; and

6 (8) A provision that, with respect to termination of benefits for, or coverage of, any  
 7 person who is a dependent child of an insured, the child shall continue to be insured up  
 8 to and including age 25 so long as the coverage of the insured parent or guardian  
 9 continues in effect, the child remains a dependent of the parent or guardian, and the child,  
 10 in each calendar year since reaching any age specified for termination of benefits as a  
 11 dependent, has been enrolled for five months or more as a full-time student at a  
 12 postsecondary institution of higher learning or, if not so enrolled, would have been  
 13 eligible to be so enrolled and was prevented from being so enrolled due to illness or  
 14 injury."

#### 15 **SECTION 11.**

16 Said title is further amended by striking subsection (a) of Code Section 33-30-9, relating to  
 17 payment of benefits under blanket accident and sickness policies, and inserting in lieu thereof  
 18 a new subsection (a) to read as follows:

19 "(a) All benefits under any group blanket accident and sickness policy shall be payable to  
 20 the person insured, to his designated beneficiary or beneficiaries, or to his estate, provided  
 21 that if the person insured is a minor or mental incompetent, the benefits may be made  
 22 payable to his parent, guardian, or other person actually supporting him or, if the entire cost  
 23 of the insurance has been borne by the employer, the benefits may be made payable to the  
 24 employer."

#### 25 **SECTION 12.**

26 Said title is further amended by striking Code Section 33-30-15, relating to continuation of  
 27 similar coverage, and inserting in lieu thereof a new Code Section 33-30-15 to read as  
 28 follows:

29 "33-30-15.

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

31 (1) 'Affiliation period' means a period, used by health maintenance organizations in lieu  
 32 of a preexisting condition exclusion clause, beginning on the enrollment date, which must  
 33 expire before health insurance coverage provided by a health maintenance organization  
 34 becomes effective. The health maintenance organization is not required to provide health

1 care benefits during such period, nor is it authorized to charge premiums over such a  
2 period.

3 (2) 'Creditable coverage' under another health benefit plan means medical expense  
4 coverage with no greater than a 90 day gap in coverage under any of the following:

5 (A) Medicare or Medicaid;

6 (B) An employer based accident and sickness insurance or health benefit arrangement;

7 (C) An individual accident and sickness insurance policy, including coverage issued  
8 by a health maintenance organization, nonprofit hospital or nonprofit medical service  
9 corporation, health care corporation, or fraternal benefit society;

10 (D) A spouse's benefits or coverage under medicare or Medicaid or an employer based  
11 health insurance or health benefit arrangement;

12 (E) A conversion policy;

13 (F) A franchise policy issued on an individual basis to a member of a true association  
14 as defined in subsection (b) of Code Section 33-30-1;

15 (G) A health plan formed pursuant to 10 U.S.C. Chapter 55;

16 (H) A health plan provided through the Indian Health Service or a tribal organization  
17 program or both;

18 (I) A state health benefits risk pool;

19 (J) A health plan formed pursuant to 5 U.S.C. Chapter 89;

20 (K) A public health plan; or

21 (L) A Peace Corps Act health benefit plan.

22 (3) 'Insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit  
23 hospital service corporation, nonprofit medical service corporation, health care  
24 corporation, health maintenance organization, or any similar entity and any self-insured  
25 health care plan not subject to the exclusive jurisdiction of the federal Employee  
26 Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.

27 (4) 'Newly eligible employee group member' means a Georgia domiciled employee  
28 group member or the dependent of a currently enrolled Georgia domiciled employee  
29 group member who has creditable coverage and who first becomes eligible to elect  
30 coverage under an employer sponsored group comprehensive major medical or  
31 hospitalization plan. A newly eligible employee group member also includes:

32 (A) During a special enrollment period, existing ~~employees~~ employee group members  
33 and existing dependents of existing ~~employees~~ employee group members who declined  
34 coverage when first offered because of the existence of other creditable coverage, if all  
35 the following conditions are met:

36 (i) The employee group member or ~~employee's~~ employee group member's dependent  
37 had creditable coverage at such time when the group coverage was first offered;

1 (ii) The employee group member stated in writing that such creditable coverage was  
2 the reason for declining enrollment in group coverage, if such statement is required  
3 by the employer policyholder;

4 (iii) The coverage of the employee group member or ~~employee's~~ employee group  
5 member's dependent was under COBRA and has been exhausted or the creditable  
6 coverage was terminated as a result of loss of eligibility for the creditable coverage  
7 or employer policyholder contributions toward such creditable coverage were  
8 terminated; and

9 (iv) The employee group member requests such enrollment not later than 31 days  
10 after the date of exhaustion or termination of the creditable coverage; or

11 (B) In the case of marriage, if the employee group member requests such enrollment  
12 not later than 31 days following the date of marriage or the date dependent coverage is  
13 first made available, whichever is later, coverage of the spouse shall commence not  
14 later than the first day of the first month beginning after the date the completed request  
15 for enrollment is received.

16 (b) Notwithstanding any other provision of this title which might be construed to the  
17 contrary, on and after July 1, 1998, all group basic hospital or medical expense, major  
18 medical, or comprehensive medical expense coverages which are issued, delivered, issued  
19 for delivery, or renewed in this state shall provide the following:

20 (1) Subject to compliance with the provisions of subsections (c) and (d) of this Code  
21 section, any newly eligible employee, group member, subscriber, enrollee, or dependent  
22 who has had creditable coverage under another health benefit plan within the previous  
23 90 days shall be eligible for coverage immediately upon completion of any employer  
24 policyholder imposed waiting period; and

25 (2) Once such creditable coverage terminates, including termination of such creditable  
26 coverage after any period of continuation of coverage required under Code Section  
27 33-24-21.1 or the provisions of Title X of the Omnibus Budget Reconciliation Act of  
28 1986, the insurer must offer a conversion policy to the eligible employee, group member,  
29 subscriber, enrollee, or dependent.

30 (c) Notwithstanding any provisions of this Code section which might be construed to the  
31 contrary, such coverages may include a limitation for preexisting conditions not to exceed  
32 12 months for ~~enrollees~~ enrollee group members who enroll when newly eligible and 18  
33 months for group members who enroll late ~~enrollees~~ following the effective date of  
34 coverage; provided, however, that:

35 (1) Such coverages shall waive any time period applicable to the preexisting condition  
36 exclusion or limitation for the period of time an individual was previously covered by  
37 creditable coverage; or

1 (2) Such coverages shall waive any time period applicable to the preexisting condition  
 2 exclusion or limitation in accordance with an insurer's election of an alternative method  
 3 pursuant to Section 701(c)(3)(B) of the Employee Retirement Income Security Act of  
 4 1974.

5 (d) The preexisting condition limitation described in subsection (c) of this Code section  
 6 shall not apply to pregnancies.

7 (e) The preexisting condition limitation described in subsection (c) of this Code section  
 8 shall not apply to newborn children or newly adopted children where such children are  
 9 added to the plan by the insured no later than 31 days following the date of birth or the date  
 10 placed for adoption under order of the court of jurisdiction.

11 (f) In case of a group health plan offered by a health maintenance organization, an  
 12 affiliation period may be offered in place of the preexisting condition limitation described  
 13 in subsection (c) of this Code section, provided that the affiliation period:

14 (1) Is applied uniformly without regard to any health status related factors;

15 (2) Does not exceed:

16 (A) Two months for newly eligible ~~employees~~ employee group members and  
 17 dependents; or

18 (B) Three months for group members who enroll late ~~enrollees~~; and

19 (3) Runs concurrently with any employer policyholder imposed waiting period under the  
 20 plan.

21 (g) The Commissioner shall promulgate appropriate procedures and guidelines by rules  
 22 and regulations to implement the provisions of this Code section after notification and  
 23 review of such regulations by the appropriate standing committees of the House of  
 24 Representatives and Senate in accordance with the requirements of applicable law. The  
 25 Commissioner may allow in such regulations methods other than that described in  
 26 subsection (f) of this Code section for health maintenance organizations to address adverse  
 27 selection, as authorized by the Employee Retirement Income Security Act of 1974, Section  
 28 701(g)(3)."

### 29 SECTION 13.

30 Said title is further amended by striking paragraph (1) of Code Section 33-30-22, relating to  
 31 definitions regarding preferred provider arrangements, and inserting in lieu thereof a new  
 32 paragraph (1) to read as follows:

33 "(1) 'Emergency services' or 'emergency care' means ~~covered services included in a~~  
 34 ~~preferred provider arrangement provided to a person after the sudden onset of a medical~~  
 35 ~~condition manifested by symptoms of such severity~~ those health care services that are  
 36 provided for a condition of recent onset and sufficient severity, including, but not limited

1 to, severe pain, that would lead a prudent layperson, possessing an average knowledge  
2 of medicine and health, to believe that his or her condition, sickness, or injury is of such  
3 a nature that the failure to provide immediately such services ~~obtain immediate medical~~  
4 care could reasonably be expected to result in:

- 5 (A) Placing the patient's health in serious jeopardy;  
6 (B) ~~Impairment~~ Serious impairment to bodily functions; or  
7 (C) ~~Dysfunction~~ Serious dysfunction of any bodily organ or part."

8 **SECTION 14.**

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