Senate Bill 218

By: Senators Rogers of the 21st and Hudgens of the 47th

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to create the Georgia Health Insurance Risk Pool; to provide alternative mechanism coverage for the availability of individual health insurance; to provide definitions; to provide for a risk pool board; to provide for powers, duties, and authority of the board; to provide for the selection of an administrator; to provide for the duties of the Commissioner of Insurance with respect to the board and pool; to provide for the establishment of rates; to provide for eligibility for and termination of coverage; to provide for minimum pool benefits; to provide for certain exclusions for preexisting conditions; to provide for funding and assessments; to provide for complaint procedures; to provide for audits; to provide for certain reports; to provide for applicability; to provide for related matters; to repeal the Georgia High Risk Health Insurance Plan; to provide effective dates; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by striking subparagraph (b)(15)(D) of Code Section 33-6-4, relating to the enumeration of unfair methods of competition and unfair or deceptive acts or practices, and inserting in lieu thereof a new subparagraph (b)(15)(D) to read as follows:

"(D) It is unfairly discriminatory to terminate group coverage for a subject of family violence because coverage was originally issued in the name of the perpetrator of the family violence and the perpetrator has divorced, separated from, or lost custody of the subject of family violence, or the perpetrator´s coverage has terminated voluntarily or involuntarily. If termination results from an act or omission of the perpetrator, the subject of family violence shall be deemed ~~a qualifying~~ an eligible individual under Code Section 33-24-21.1 or 33-29A-2 and may obtain continuation and ~~conversion of such coverages~~ alternative mechanism coverage for the availability of individual health

insurance coverage, as contemplated by Section 2741 of the federal Public Health Service Act, 42 U.S.C. Section 300gg-41, notwithstanding the act or omission of the perpetrator. A person may request and receive family violence information to implement the continuation and conversion of coverages under this subparagraph."

SECTION 2.

Said title is further amended by striking Code Section 33-24-21.1, relating to group accident and sickness contracts, and inserting in lieu thereof a new Code Section 33-24-21.1 to read as follows:

"33-24-21.1.

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

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

(A) Medicare or Medicaid;

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

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

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

(E) A conversion policy;

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

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

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

(I) A state health benefits risk pool;

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

(K) A public health plan; or

(L) A Peace Corps Act health benefit plan.

(2) 'Eligible dependent' means a person who is entitled to medical benefits coverage under a group contract or group plan by reason of such person´s dependency on or relationship to a group member.

(3) 'Group contract or group plan' is synonymous with the term 'contract or plan' and means:

(A) A group contract of the type issued by a nonprofit medical service corporation established under Chapter 18 of this title;

(B) A group contract of the type issued by a nonprofit hospital service corporation established under Chapter 19 of this title;

(C) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(D) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(E) A group accident and sickness insurance policy or contract, as defined in Chapter 30 of this title.

(4) 'Group member' means a person who has been a member of the group for at least six months and who is entitled to medical benefits coverage under a group contract or group plan and who is an insured, certificate holder, or subscriber under the contract or plan.

(5) 'Insurer' means an insurance company, health care corporation, nonprofit hospital service corporation, medical service nonprofit corporation, health care plan, or health maintenance organization.

~~(6) 'Qualifying eligible individual' means:~~

~~(A) A Georgia domiciliary, for whom, as of the date on which the individual seeks coverage under this Code section, the aggregate of the periods of creditable coverage is 18 months or more; and~~

~~(B) Who is not eligible for coverage under any of the following:~~

~~(i) A group health plan, including continuation rights under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA);~~

~~(ii) Part A or Part B of Title XVIII of the federal Social Security Act; or~~

~~(iii) The state plan under Title XIX of the federal Social Security Act or any successor program.~~

(b) Each group contract or group plan delivered or issued for delivery in this state, other than a group accident and sickness insurance policy, contract, or plan issued in connection with an extension of credit, which provides hospital, surgical, or major medical coverage, or any combination of these coverages, on an expense incurred or service basis, excluding contracts and plans which provide benefits for specific diseases or accidental injuries only, shall provide that members ~~and qualifying eligible individuals~~ whose insurance under the group contract or plan would otherwise terminate shall be entitled to continue their hospital, surgical, and major medical insurance coverage under that group contract or plan for themselves and their eligible dependents.

(c) Any group member ~~or qualifying eligible individual~~ whose coverage has been terminated and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage

and the coverage of his or her eligible dependents continued under the contract or plan. Such coverage must continue for the fractional policy month remaining, if any, at termination plus three additional policy months upon payment of the premium by cash, certified check, or money order, at the option of the employer, to the policyholder or employer, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. Such premium payment must include any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage. At the end of such period, the group member shall have the same conversion rights that were available on the date of termination of coverage in accordance with the conversion privileges contained in the group contract or group plan.

(d)~~(1)~~ A group member shall not be entitled to have coverage continued if: (A) termination of coverage occurred because the employment of the group member was terminated for cause; (B) termination of coverage occurred because the group member failed to pay any required contribution; or (C) any discontinued group coverage is immediately replaced by similar group coverage including coverage under a health benefits plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. Further, a group member shall not be entitled to have coverage continued if the group contract or group plan was terminated in its entirety or was terminated with respect to a class to which the group member belonged. ~~This subsection shall not affect conversion rights available to a qualifying eligible individual under any contract or plan.~~

~~(2) A qualifying eligible individual shall not be entitled to have coverage continued if the most recent creditable coverage within the coverage period was terminated based on one of the following factors: (A) failure of the qualifying eligible individual to pay premiums or contributions in accordance with the terms of the health insurance coverage or failure of the issuer to receive timely premium payments; (B) the qualifying eligible individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage; or (C) any discontinued group coverage is immediately replaced by similar group coverage including coverage under a health benefits plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. This subsection shall not affect conversion rights available to a group member under any contract or plan.~~

(e) If the group contract or group plan terminates while any group member ~~or qualifying eligible individual~~ is covered or whose coverage is being continued, the group administrator, as prescribed by the insurer, must notify each such group member ~~or~~

~~qualifying eligible individual~~ that he or she must exercise his or her conversion rights within~~:~~

~~(1) Thirty~~ 30 days of such notice ~~for group members who are not qualifying eligible individuals; or~~

~~(2) Sixty-three days of such notice for qualifying eligible individuals~~.

(f) Every group contract or group plan, other than a group accident and sickness insurance policy, contract, or plan issued in connection with an extension of credit, which provides hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred or service basis, excluding policies which provide benefits for specific diseases or for accidental injuries only, shall contain a conversion privilege provision.

(g) Eligibility for the converted policies or contracts shall be as follows:

(1) ~~Any qualifying eligible individual whose insurance and its corresponding eligibility under the group policy, including any continuation available, elected, and exhausted under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than fraud or failure of the qualifying eligible individual to pay a required premium contribution to the employer or, if so required, to the insurer directly and who has at least 18 months of creditable coverage immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group based coverage covering such qualifying eligible individual and any eligible dependents who were covered under the qualifying eligible individual´s coverage under the group contract or group plan. Such conversion coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The insurer must offer qualifying eligible individuals at least two distinct conversion options from which to choose. One such choice of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in this state or comparable to a standard option of coverage available under the group or individual health insurance laws of this state. The other choice may be more limited in nature but must also qualify as creditable coverage. Each coverage shall be filed, together with applicable rates, for approval by the Commissioner. Such choices shall be known as the 'Enhanced Conversion Options';~~

~~(2) Premiums for the enhanced conversion options for all qualifying eligible individuals shall be determined in accordance with the following provisions:~~

~~(A) Solely for purposes of this subsection, the claims experience produced by all groups covered under comprehensive major medical or hospitalization accident and~~

~~sickness insurance for each insurer shall be fully pooled to determine the group pool rate. Except to the extent that the claims experience of an individual group affects the overall experience of the group pool, the claims experience produced by any individual group of each insurer shall not be used in any manner for enhanced conversion policy rating purposes;~~

~~(B) Each insurer´s group pool shall consist of each insurer´s total claims experience produced by all groups in this state, regardless of the marketing mechanism or distribution system utilized in the sale of the group insurance from which the qualifying eligible individual is converting. The pool shall include the experience generated under any medical expense insurance coverage offered under separate group contracts and contracts issued to trusts, multiple employer trusts, or association groups or trusts, including trusts or arrangements providing group or group-type coverage issued to a trust or association or to any other group policyholder where such group or group-type contract provides coverage, primarily or incidentally, through contracts issued or issued for delivery in this state or provided by solicitation and sale to Georgia residents through an out-of-state multiple employer trust or arrangement; and any other group-type coverage which is determined to be a group shall also be included in the pool for enhanced conversion policy rating purposes; and~~

~~(C) Any other factors deemed relevant by the Commissioner may be considered in determination of each enhanced conversion policy pool rate so long as it does not have the effect of lessening the risk-spreading characteristic of the pooling requirement. Duration since issue and tier factors may not be considered in conversion policy rating. Notwithstanding subparagraph (A) of this paragraph, the total premium calculated for all enhanced conversion policies may deviate from the group pool rate by not more than plus or minus 50 percent based upon the experience generated under the pool of enhanced conversion policies so long as rates do not deviate for similarly situated individuals covered through the pool of enhanced conversion policies;~~

~~(3)~~ Any group member ~~who is not a qualifying eligible individual and~~ whose insurance under the group policy has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than eligibility for medicare (reaching a limiting age for coverage under the group policy) or failure of the group member to pay a required premium contribution, and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group coverage covering such group member and any eligible dependents who were covered under the group member´s coverage under the group contract or group plan. Such conversion

coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The premium of the basic converted policy shall be determined in accordance with the insurer´s table of premium rates applicable to the age and classification of risks of each person to be covered under that policy and to the type and amount of coverage provided. This form of conversion coverage shall be known as the 'Basic Conversion Option'; and

~~(4)~~(2) Nothing in this Code section shall be construed to prevent an insurer from offering additional options to ~~qualifying eligible individuals or~~ group members.

(h) Each group certificate issued to each group member ~~or qualifying eligible individual~~, in addition to setting forth any conversion rights, shall set forth the continuation right in a separate provision bearing its own caption. The provisions shall clearly set forth a full description of the continuation and conversion rights available, including all requirements, limitations, and exceptions, the premium required, and the time of payment of all premiums due during the period of continuation or conversion.

(i) This Code section shall not apply to limited benefit insurance policies. For the purposes of this Code section, the term 'limited benefit insurance' means accident and sickness insurance designed, advertised, and marketed to supplement major medical insurance. The term limited benefit insurance includes accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and any other accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, and comprehensive major medical insurance coverage.

(j) The Commissioner shall adopt such rules and regulations as he or she deems necessary for the administration of this Code section. Such rules and regulations may prescribe various conversion plans, including minimum conversion standards and minimum benefits, but not requiring benefits in excess of those provided under the group contract or group plan from which conversion is made, scope of coverage, preexisting limitations, optional coverages, reductions, notices to covered persons, and such other requirements as the Commissioner deems necessary for the protection of the citizens of this state.

(k) This Code section shall apply to all group plans and group contracts delivered or issued for delivery in this state on or after July 1, 1998, and to group plans and group contracts then in effect on the first anniversary date occurring on or after July 1, 1998.″

SECTION 3.

Said title is further amended by striking Chapter 29A, relating to individual health insurance coverage availability and assignment systems, and inserting a new Chapter 29A to read as follows:

"CHAPTER 29A

33-29A-1.

(a) It is the intention of this chapter to provide an acceptable alternative mechanism for the availability of individual health insurance coverage, as contemplated by Section 2741 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-41. This chapter shall be construed and administered so as accomplish such intention.

(b) Any reference in this chapter to any federal statute shall refer to that federal statute as it existed on January 1, 1997, including its amendment by the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.

33-29A-2.

(a) As used in this chapter, the term:

(1) 'Benefit Plan' means coverage offered by the pool to eligible persons.

(2) 'Board' means the board of directors of the Georgia Health Insurance Risk Pool created under this chapter.

(3) 'Commissioner' means the Commissioner of Insurance.

(4) 'Covered Person' means any individual resident of this state, excluding dependents, who is eligible to receive benefits from any insurer.

(5) 'Creditable coverage' and 'eligible individual' have the same meaning as specified in Sections 270l and 2741 of the federal Public Health Service Act, 42 U.S.C.A. Sections 300gg and 300gg-41, except that a person shall not be an eligible individual under this chapter if such person is eligible for or has declined any continuation or conversion coverage or has terminated any such coverage prior to its exhaustion.

(6) 'Department' means the Georgia Department of Insurance.

(7) 'Dependent' means a spouse or unmarried child under the age of 18 years residing with the individual and a child who is a full-time student according to the provisions of subparagraph (3) of subsection (a) of Code Section 33-29-2 or paragraph (4) of Code Section 33-30-4.

(8) 'Family member' means a parent, grandparent, brother, or sister.

(9) 'Health insurance' means any hospital or medical expense incurred policy, nonprofit health care services plan contract, health maintenance organization, subscriber contract,

or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise, when sold to an individual or as a group policy. This term does not include limited benefit insurance policies. For the purposes of this Code section, the term 'limited benefit insurance' means accident and sickness insurance designed, advertised, and marketed to supplement major medical insurance. The term 'limited benefit insurance' includes accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, limited benefit, or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers´ compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, and includes any other accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, and comprehensive major medical insurance coverage.

(10) 'Health insurance issuer' and 'health maintenance organization' have the same meaning as specified in Section 2791 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-92.

(11) 'Health insurer' means any health insurance issuer which is not a managed care organization.

(12) 'Insurance arrangement' means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers, employees, or other personnel, but does not include health care services covered through an insurer.

(13) 'Insured' means a person who is a resident of this state and a citizen of the United States and who is eligible to receive benefits from the pool. The term 'insured' may include dependents and family members.

(14) 'Insurer' means any entity that is authorized in this state to write health insurance or that provides health insurance or pays medical claims in this state. For the purposes of this chapter, the term 'insurer' includes an insurance company; nonprofit health care services plan; health care corporation or surviving health care corporation as defined in Code Section 33-20-3; fraternal benefits society; health maintenance organization; third-party administrator; to the extent permitted by federal law, any self-insured arrangement covered by Section 3 of the federal Employment Retirement Income Security Act of 1974, 29 U.S.C. Section 1002, as amended, that provides health care benefits in this state; any other entity providing a plan of health insurance or health benefits subject to state insurance regulation; association plans; and any stop-loss plan providing stop-loss coverage to a health insurer or health plan in Georgia.

(15) 'Managed care organization' means a health maintenance organization or a nonprofit health care corporation.

(16) 'Medicare' means coverage provided by Part A and Part B of Title XVIII of the federal Social Security Act, 42 U.S.C. Section 1395c, et seq.

(17) 'Payer' means any person or entity that contributes financially toward the operation of the pool.

(18) 'Physician' means a person licensed to practice medicine in Georgia.

(19) 'Plan of operation' means the plan of operation of the pool and includes the articles, bylaws, and operating rules of the pool that are adopted by the board.

(20) 'Pool' means the Georgia Health Insurance Risk Pool.

(21) 'Resident' means:

(A) An individual who has been legally domiciled in Georgia for a minimum of 90 days;

(B) An individual who is legally domiciled in Georgia on the date of application to the pool and who is eligible for enrollment in the pool as a result of the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191; or

(C) An individual who is legally domiciled in Georgia on the date of application to the pool and is eligible for the credit for health insurance costs under Section 35 of the federal Internal Revenue Code of 1986.

(22) 'Third-party administrator' means any entity that is paying or processing health insurance claims for any Georgia resident.

(b) Any other term which is used in this chapter and which is also defined in Section 2791 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-92, and not otherwise defined in this chapter shall have the same meaning specified in said Section 2791.

33-29A-3.

(a) There is created a body corporate and politic to be known as the 'Georgia Health Insurance Risk Pool' which shall be deemed to be an instrumentality of the state and a public corporation. The Georgia Health Insurance Risk Pool shall have perpetual existence and any change in the name or composition of the plan shall in no way impair the obligations of any contracts existing under this chapter.

(b) The Commissioner, Governor, Speaker of the House of Representatives, and President of the Senate shall appoint members of the board for staggered six-year terms as provided by this Code section.

(c) The Commissioner shall appoint:

(1) Two persons affiliated with different insurers admitted and authorized to write health insurance in this state, one of whom must represent a domestic insurer;

(2) One person affiliated with a third-party administrator or other case management organization having, as a line of business or specialty, disease state management, case management, patient safety management, or other risk reduction methodologies; and

(3) One person licensed to sell health insurance in the state.

(d) The Speaker of the House of Representatives shall appoint one person representing the medical provider community, such as a physician licensed to practice medicine in this state, a hospital administrator, or an advanced nurse practitioner.

(e) The Governor shall appoint one employer whose principal business location is in the State of Georgia and who can reasonably be expected to offer health insurance coverage to his or her employees.

(f) The President of the Senate shall appoint one representative of the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the pool. Representatives of the general public include persons whose only affiliation with an insurance company or plan, group hospital service corporation, or health maintenance organization is as an insured or person who has coverage through a plan provided by the corporation or organization.

(g) If a vacancy occurs on the board, the person or officer who made the original appointment to the board shall fill the vacancy for the unexpired term with a person who has the appropriate qualifications to fill that position on the board.

(h) The Commissioner shall designate one of the appointees to the board to serve as chairperson. The chairperson shall serve at the pleasure of the Commissioner.

(i) A member of the board shall not be liable for an action or omission performed in good faith in the performance of the powers and duties under this chapter and a cause of action shall not arise against a member for such action or omission.

(j) Initial terms for board members shall be staggered as follows:

(1) One of the persons affiliated with insurers shall have a two-year initial term and one shall have a six-year initial term, as designated by the Commissioner at the time of such appointment;

(2) The person licensed to sell insurance in the state shall have a four-year initial term;

(3) The employer representative shall have a six-year initial term;

(4) The provider representative shall have a four-year initial term;

(5) The board member affiliated with a third-party administrator or other case management organization shall have a four-year initial term; and

(6) The general public representative shall have a two-year initial term.

Thereafter, members shall be appointed and serve six-year terms.

33-29A-4.

(a) The initial board of the pool shall submit to the Commissioner a plan of operation for the pool that will assure the fair, reasonable, and equitable administration of the pool.

(b) In addition to the other requirements of this chapter, the plan of operation must include procedures for:

(1) Operation of the pool;

(2) Selecting an administrator;

(3) Creating a fund, under management of the board, for administrative expenses;

(4) Handling, accounting, and auditing of money and other assets of the pool;

(5) Developing and implementing a program to publicize the existence of the pool, the eligibility requirements for coverage under the pool, enrollment procedures, and to foster public awareness of the plan;

(6) Creation of a grievance committee to review complaints presented by applicants for coverage from the pool and insureds who receive coverage from the pool; and

(7) Other matters as may be necessary and proper for the execution of the board´s powers, duties, and obligations under this chapter.

(c) After notice and hearing, the Commissioner shall approve the plan of operation if it is determined that the plan is suitable to assure the fair, reasonable, and equitable administration of the pool.

(d) The plan of operation shall become effective on the date it is approved by the Commissioner.

(e) If the initial board fails to submit a suitable plan of operation within 180 days following the appointment of the initial board, the Commissioner, after notice and hearing, may adopt all necessary and reasonable rules to provide a plan for the pool. The rules adopted under this subsection shall continue in effect until the initial board submits, and the Commissioner approves, a plan of operation as provided under this Code section.

(f) The board shall amend the plan of operation as necessary to carry out this chapter. All amendments to the plan of operation shall be submitted to the Commissioner for approval before becoming part of the plan.

(g) By not later than December 1, 2005, the board shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives the results of an actuarial study conducted by the board to determine, including, but not limited to:

(1) The impact that the creation of the plan will have on the small group insurance market and the individual market on premiums paid by insureds. This shall include an estimate of the total anticipated aggregate savings for all small employers in the state;

(2) The number of individuals the pool could reasonably cover at various premium levels; and

(3) An analysis of various sources of funding and a recommendation as to the best source of funding for the future anticipated deficits of the pool.

33-29A-5.

(a) The pool is authorized to exercise any of the authority that an insurance company authorized to write health insurance in this state may exercise under the laws of this state.

(b) As part of its authority, the pool shall have the authority to:

(1) Provide health benefits coverage to persons who are eligible for that coverage under this chapter;

(2) Enter into contracts that are necessary to carry out its powers and duties under this chapter including, with the approval of the Commissioner, entering into contracts with similar pools in other states for the joint performance of common administrative functions or with other organizations for the performance of administrative functions;

(3) Sue and be sued, including taking any legal actions necessary or proper to recover or collect assessments due the pool;

(4) Institute any legal action necessary to avoid payment of improper claims against the pool or the coverage provided by or through the pool, to recover any amounts erroneously or improperly paid by the pool, to recover any amount paid by the pool as a mistake of fact or law, and to recover other amounts due the pool;

(5) Establish appropriate rates, rate schedules, rate adjustments, expense allowance, agents´ referral fees, and claim reserve formulas and perform any actuarial function appropriate to the operation of the pool;

(6) Adopt policy forms, endorsements, and riders and applications for coverage;

(7) Issue insurance policies subject to this chapter and the plan of operation;

(8) Appoint appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in operating the pool and performing any of the functions of the pool;

(9) Employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions;

(10) Contract for stop-loss insurance for risks incurred by the pool;

(11) Borrow money as necessary to implement the purposes of the pool;

(12) Issue additional types of health insurance policies to provide optional coverages which comply with applicable provisions of state and federal law;

(13) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization case management, disease-state management, and other risk reduction practices for the

purpose of maximizing effectiveness and cost savings to the pool, its insureds, and payers;

(14) Design, utilize, contract, or otherwise arrange for delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations;

(15) Provide for reinsurance on either a facultative or treaty basis, or both; and

(16) Develop through research and surveys of insurers offering individual health insurance coverage in this state reasonable guidelines for acceptance of risk in the individual health insurance market.

(c) The board shall promulgate a list of medical or health conditions for which a person shall be eligible for pool coverage without applying for health insurance. The list shall be effective on the first day of the operation of the pool and may be amended from time to time as may be appropriate and as treatment outcomes and disease state management practices change due to advances in medicine.

(d) Not later than June 1 of each year, the board shall make an annual report to the Governor, the General Assembly, and the Commissioner. The report shall summarize the activities of the pool in the preceding calendar year, including information regarding net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses.

33-29A-6.

(a) After completing a competitive bidding process as provided by the plan of operation, the board may select one or more insurers or a third-party administrator certified by the department to administer the pool.

(b) The board shall establish criteria for evaluating the bids submitted. The criteria shall include:

(1) An insurer´s or third-party administrator´s proven ability to handle individual accident and sickness insurance;

(2) The efficiency of an insurer´s or third-party administrator´s claims paying procedures;

(3) An estimate of total charges for administering the pool;

(4) An insurer´s or third-party administrator´s ability to administer the pool in a cost-efficient manner; and

(5) The financial condition and stability of the insurer or third-party administrator.

(c) The administering insurer or third-party administrator shall perform such functions relating to the pool as may be assigned to it, including:

(1) Perform eligibility and administrative claims payment functions for the pool;

(2) Establish a billing procedure for collection of premiums from persons insured by the pool;

(3) Perform functions necessary to assure timely payment of benefits to persons covered under the pool, including:

(A) Providing information relating to the proper manner of submitting a claim for benefits to the pool and distributing claim forms; and

(B) Evaluating the eligibility of each claim for payment by the pool;

(4) Submit regular reports to the board relating to the operation of the pool; and

(5) Determine after the close of each calendar year the net written and earned premiums, expense of administration, and paid and incurred losses of the pool for that calendar year and report this information to the board and the Commissioner on forms prescribed by the Commissioner.

33-29A-7.

The Commissioner may by rule and regulation establish additional powers and duties of the board and may adopt other rules and regulations as are necessary and proper to implement this chapter. The Commissioner by rule and regulation shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments made and collected under Code Section 33-29A-12.

33-29A-8.

(a) Rates and rate schedules may be adjusted for appropriate risk factors, including age and variation in claim costs, and the board may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(b) The pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. The initial pool rate may not be less than 125 percent and may not exceed 150 percent of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection; however, in no event shall pool rates exceed 150 percent of rates applicable to individual standard risks.

(c) All rates and rate schedules shall be submitted to the Commissioner for approval, and the Commissioner must approve the rates and rate schedules of the pool before use by the

pool. The Commissioner in evaluating the rates and rate schedule of the pool shall consider the factors provided for in this Code section.

33-29A-9.

(a) Any individual person who is and continues to be a resident of Georgia and a citizen of the United States shall be eligible for coverage from the pool if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by two insurers. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection;

(2) A refusal by an insurer to issue insurance except at a rate exceeding the pool rate;

(3) Diagnosis of the individual with one of the medical or health conditions listed by the board in accordance with subsection (c) of Code Section 33-29A-5. A person diagnosed with one or more of these conditions shall be eligible for a pool coverage without applying for other health insurance coverage;

(4) In the case of an individual who is eligible for coverage under the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191, the individual´s maintenance of health insurance coverage for the previous 18 months with no gap in coverage greater than 63 days of which the most recent coverage was through an employer sponsored plan;

(5) In the case of an individual who is eligible for coverage under the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191, the individual´s maintenance of health insurance coverage through this state´s 'Enhanced Conversion Option,' 'Georgia Health Insurance Assignment System' or 'Georgia Health Benefits Assignment System' at a rate exceeding the pool rate; or

(6) Legal domicile in Georgia and eligibility for the credit for health insurance costs under Section 35 of the federal Internal Revenue Code of 1986.

(b) Each dependant of a person who is eligible for coverage from the pool shall also be eligible for coverage from the pool unless that person is enrolled in or is eligible to enroll in any form of health insurance or insurance arrangement, whether public or private. In the case of a child who is the primary insured, resident family members shall also be eligible for coverage.

(c) A person may maintain pool coverage for the period of time the person is satisfying a preexisting waiting period under another health insurance policy or insurance arrangement intended to replace the pool policy.

(d) A person is not eligible for coverage from the pool if the person;

(1) Has in effect on the date pool coverage takes effect, or is eligible to enroll in, health insurance coverage from an insurer or insurance arrangement;

(2) Is eligible for other health care benefits at the time application is made to the pool, including COBRA continuation, except;

(A) Coverage, including COBRA continuation, other continuation, or conversion coverage, maintained for the period of time the person is satisfying any preexisting condition waiting period under a pool policy; or

(B) Individual coverage conditioned by the limitation described by paragraphs (1) through (3) of subsection (a) of this Code section.

(3) Has terminated coverage in the pool within 12 months of the date that application is made to the pool, unless the person demonstrates a good faith reason for the termination;

(4) Is confined in a county jail or imprisoned in a state prison;

(5) Has premiums that are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider, except as provided in paragraph (6) of subsection (a) of Code Section 33-29A-9;

(6) Has had prior coverage with the pool terminated for nonpayment of premiums or fraud; or

(7) Has voluntarily terminated coverage outside the pool within six months of the date that application is made to the pool unless the person demonstrates a good faith reason for the termination.

(e) Pool coverage shall cease:

(1) On the date a person is no longer a resident of this state, except for a child who is a full-time student according to provisions of subparagraph (3) of subsection (a) of Code Section 33-29-2 or paragraph (4) of Code Section 33-30-4 and who is financially dependent upon the parent, a child for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent;

(2) On the date a person requests coverage to end;

(3) Upon the death of the covered person;

(4) On the date state law requires cancellation of the policy;

(5) At the option of the pool, 30 days after the pool sends to the person any inquiry concerning the person´s eligibility, including an inquiry concerning the person´s residence, to which the person does not reply;

(6) On the thirty-first day after the day on which a premium payment for pool coverage becomes due if the payment is not made before that date; or

(7) At such time as the person ceases to meet the eligibility requirements of this Code section.

(f) A person who ceases to meet the eligibility requirements of this Code section may have his or her coverage terminated at the end of the policy period.

33-29A-10.

(a) The pool shall offer pool coverage consistent with major medical expense coverage to each eligible person who is not eligible for medicare. The board, with the approval of the Commissioner, shall establish:

(1) The coverages to be provided by the pool;

(2) At least two health benefit products to be offered by the pool;

(3) The applicable schedules of benefits; and

(4) Any exclusions to coverage and other limitations.

(b) The benefits provisions of the pool´s health benefits coverages shall include the following:

(1) All required or applicable definitions;

(2) A list of any exclusions or limitations to coverage;

(3) A description of covered services required under the pool; and

(4) The deductibles, coinsurance options, and copayment options that are required or permitted under the pool.

(c) The board may adjust deductibles, the amounts of stop-loss coverage, and the time periods governing preexisting conditions to preserve the financial integrity of the pool. If the board makes such an adjustment, it shall report in writing that adjustment together with its reasons for the adjustment to the Commissioner. The report shall be submitted not later than the thirtieth day after the date the adjustment is made.

(d) Benefits otherwise payable under pool coverage shall be reduced by amounts paid or payable through any other health insurance or insurance arrangement and by all hospital and medical expense benefits paid or payable under any workers´ compensation coverage, automobile insurance whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(e) The pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the pool may be reduced or refused as an offset against any amount recoverable under this subsection.

33-29A-11.

(a) Except as otherwise provided by this Code section, pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

(b) The preexisting conditions limitation provided in this Code section shall be reduced by aggregated creditable coverage that was in effect up to a date not more than 63 days before application for coverage in the pool.

(c) An eligible individual who is eligible for enrollment in the pool as a result of the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191, and has 18 months of prior creditable coverage, the most recent of which is employer sponsored coverage, shall be eligible for coverage without regard to the 12 month preexisting conditions limitation.

(d) An eligible individual who is eligible for the credit for health insurance under Section 35 of the federal Internal Revenue Code of 1986 shall be eligible for coverage without regard to the 12 month preexisting conditions limitation only if he or she had three months of prior creditable coverage as of the date on which the individual seeks to enroll in pool coverage, not counting any period prior to a 63 day break in coverage.

33-29A-12.

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the pool, the board shall assess insurers at such time and for such amounts as the board finds necessary for continued operation of the pool. Assessments shall be due not less than 30 days after prior written notice to the insurers and shall accrue interest at a rate not to exceed 12 percent per annum on and after the due date.

(b) Each insurer shall be assessed in an amount established by the risk pool board amount not to exceed $2.00 per covered person insured or reinsured by each insurer per month.

(c) The board shall make reasonable efforts designed to ensure that each covered person is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered persons all individuals whose coverage is insured, including by way of excess or stop-loss coverage, in whole or in part. The board shall allow an insurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary excess or stop-loss insurer for the purposes of determining its assessment under this Code section.

(d) Each insurer´s assessment may be verified by the board based on annual statements and other reports deemed to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the pool, board, or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums. Future losses shall include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any insurer that fails to pay an assessment when due. Such forfeiture may not exceed 5 percent of the unpaid assessment per month, but no forfeiture shall be less than $100.00 per month.

33-29A-13.

An applicant or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board. The grievance committee shall report to the board after completion of the review of each complaint. The board shall retain all written complaints regarding the pool at least until the third anniversary of the date the pool received the complaint.

33-29A-14.

(a) The state auditor shall conduct annually a special audit of the pool. The state auditor´s report shall include a financial audit and an economy and efficiency audit.

(b) The state auditor shall report the cost of each audit conducted under this chapter to the board. The board shall then promptly remit that amount to the state auditor for deposit to the general fund.

33-29A-15.

For purpose of assessments, this chapter shall apply only to an insurance policy or evidence of coverage that is delivered, issued for delivery, or renewed on or after July 1, 2005. Notwithstanding other changes in law contained in this chapter, coverage for persons eligible as a result of the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191, shall continue to be issued health insurance coverage through this state´s 'Georgia Health Insurance Assignment System,' or 'Georgia Health Benefits Assignment System' under rules and procedures established under this chapter prior to July 1, 2005, until December 31, 2005.

33-29A-16.

Coverages available under the Georgia Health Insurance Risk Pool must be made available not later than January 1, 2006."

SECTION 4.

Said title is further amended by striking paragraph (2) of subsection (b) of Code Section 33-30-15, relating to continuation of similar coverage, and inserting in lieu thereof a new paragraph (2) to read as follows:

"(2) Once such creditable coverage terminates, including termination of such creditable coverage after any period of continuation of coverage required under Code Section 33-24-21.1 or the provisions of Title X of the Omnibus Budget Reconciliation Act of 1986, the insurer must ~~offer a conversion policy~~ provide notice of eligibility for coverage under the state´s alternative mechanism of the availability of individual health insurance coverage as provided under Chapter 29A of this title, as contemplated by Section 2741 of the federal Public Health Service Act, 42 U.S.C. Section 300gg-41, to the eligible employee, member, subscriber, enrollee, or dependent."

SECTION 5.

Said title is further amended by repealing and reserving Chapter 44, relating to high risk health insurance plans.

SECTION 6.

Sections 1, 2, and 4 of this Act shall become effective on January 1, 2006. The remainder of this Act shall become effective on July 1, 2005.

SECTION 7.

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