

The House Committee on Insurance offers the following substitute to HB 291:

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 provide an exception to the requirement that major medical insurance policies or plans
3 provide for carry-over deductibles; to remove the requirement that managed care plans obtain
4 certain acknowledgments; to enact the "Georgia Telemedicine Act"; to provide for a short
5 title; to provide for definitions; to provide for legislative intent; to provide that health
6 insurance policies shall include payment for certain telemedicine services; to provide for
7 conditions, exceptions, and limitations; to provide for the maximum duration of certain credit
8 life policies; to provide for a mortgagee group policy; to increase the maximum amount of
9 coverage on an agricultural loan group policy; to provide that certain required provisions in
10 group life insurance policies shall not apply to policies issued to a creditor to insure
11 mortgagors; to require that certain individual and blanket accident and sickness policies
12 insure certain dependent children of the insured up to and including age 25; to provide an
13 exception for certain matters concerning renewability of policies; to clarify certain
14 definitions; to clarify the applicable groups for blanket accident and sickness insurance; to
15 provide an exception for intentional misrepresentation of material fact in applying for or
16 procuring insurance as to treatment of certain statements made by a policyholder or insured
17 person; to clarify the application of certain provisions to group and blanket accident and
18 sickness insurance; to clarify certain provisions regarding insurance portability and
19 renewability; to provide for related matters; to repeal conflicting laws; and for other
20 purposes.

21 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

22 **SECTION 1.**

23 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
24 striking paragraph (14) of Code Section 33-6-5, relating to other unfair methods of
25 competition and unfair and deceptive acts or practices, and inserting in lieu thereof a new
26 paragraph (14) to read as follows:

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

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

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

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

14 (vii) An explanation of what constitutes an emergency situation and what constitutes
15 emergency services;

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

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

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

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

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

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

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

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

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

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

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

11 ~~(iii) A summary of any agreements or contracts between the managed care plan and~~
 12 ~~any health care provider or hospital as they pertain to the provisions of Code Sections~~
 13 ~~33-20A-6 and 33-20A-7. Such summary shall not be required to include financial~~
 14 ~~agreements as to actual rates, reimbursements, charges, or fees negotiated by the~~
 15 ~~managed care plan and any health care provider or hospital, provided, however, such~~
 16 ~~summary may include a disclosure of the category or type of compensation, whether~~
 17 ~~capitation, fee for service, per diem, discounted charge, global reimbursement~~
 18 ~~payment, or otherwise, paid by the managed care plan to each class of health care~~
 19 ~~provider or hospital under contract with the managed care plan.~~

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

24 SECTION 3.

25 Said title is further amended by adding a new Code Section 33-24-56.4 to read as follows:

26 "33-24-56.4.

27 (a) This Code section shall be known and may be cited as the 'Georgia Telemedicine Act.'

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

29 (1) 'Health benefit policy' means any individual or group plan, policy, or contract for
 30 health care services issued, delivered, issued for delivery, executed, or renewed in this
 31 state, including, but not limited to, those contracts executed by the State of Georgia on
 32 behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer.

33 (2) 'Insurer' means an accident and sickness insurer, fraternal benefit society, hospital
 34 service corporation, medical service corporation, health care corporation, health
 35 maintenance organization, preferred provider organization, provider sponsored health

1 care corporation, managed care entity, or any similar entity authorized to issue contracts
2 under this title or to provide health benefit policies.

3 (3) 'Telemedicine' means the practice, by a duly licensed physician or other health care
4 provider acting within the scope of such provider's practice, of health care delivery,
5 diagnosis, consultation, treatment, or transfer of medical data by means of audio, video,
6 or data communications which are used during a medical visit with a patient or which are
7 used to transfer medical data obtained during a medical visit with a patient. Standard
8 telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof
9 do not constitute telemedicine services.

10 (c) It is the intent of the General Assembly to mitigate geographic discrimination in health
11 care delivery by recognizing the application of telemedicine for covered services provided
12 within the scope of practice of a physician or other health care provider as a method of
13 delivery of medical care by which an individual shall receive medical services from a
14 health care provider without face-to-face contact with the provider.

15 (d) On and after July 1, 2005, every health benefit policy that is issued, amended, or
16 renewed shall include payment for services that are covered under such health benefit
17 policy and are appropriately provided through telemedicine in accordance with generally
18 accepted health care practices and standards prevailing in the applicable professional
19 community at the time the services were provided. The coverage required in this Code
20 section may be subject to all terms and conditions of the applicable health benefit plan.

21 (e) Nothing in this Code section shall preclude any health professional, within the scope
22 of the health professional's practice, from employing the technology of telemedicine or
23 participating in the application of telemedicine within the health professional's practice or
24 under the direction of another health professional with such scope of practice. Such action
25 shall not be interpreted as practicing medicine without a license."

26 SECTION 4.

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

30 "33-27-1.

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

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

1 (A) The employees eligible for insurance under the policy shall be all of the employees
 2 of the employer or all of any class or classes thereof determined by conditions
 3 pertaining to their employment. The policy may provide that the term 'employees' shall
 4 include the employees of one or more subsidiary corporations and the employees,
 5 individual proprietors, and partners of one or more affiliated corporations, proprietors,
 6 or partnerships, if the business of the employer and of such affiliated corporations,
 7 proprietors, or partnerships is under common control through stock ownership or
 8 contract or otherwise. The policy may provide that the term 'employees' shall include
 9 the individual proprietor or partners if the employer is an individual proprietor or a
 10 partnership. The policy may provide that the term 'employees' shall include retired
 11 employees. 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. A policy issued to insure the
 14 employees of a public body may provide that the term 'employees' shall include elected
 15 or appointed officials;

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

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

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

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

28 (A) The debtors eligible for insurance under the policy shall be all of the debtors of the
 29 creditor whose indebtedness is repayable either in installments, including any
 30 extraordinary payment of an installment or lease-purchase obligation, or in one sum at
 31 the end of a period not in excess of 24 months from the initial date of debt or all of any
 32 class or classes thereof determined by conditions pertaining to the indebtedness or to
 33 the purchase giving rise to the indebtedness. The policy may provide that the term
 34 'debtors' shall include the debtors of one or more subsidiary corporations and the
 35 debtors of one or more affiliated corporations, proprietors, or partnerships, if the
 36 business of the policyholder and of such affiliated corporations, proprietors, or
 37 partnerships is under common control through stock ownership, contract, or otherwise.

1 No debtor shall be eligible unless the indebtedness constitutes an irrevocable obligation
 2 to repay which is binding upon him during his lifetime at the time the insurance
 3 becomes effective upon his life;

4 (B) The premium for the policy shall be paid by the policyholder either from the
 5 creditor's funds, from charges collected from the insured debtors, or from both. A
 6 policy on which part or all of the premium is to be derived from the collection from the
 7 insured debtors of identifiable charges not required of uninsured debtors shall not
 8 include, in the class or classes of debtors eligible for insurance, debtors under
 9 obligations outstanding at its date of issue without evidence of individual insurability
 10 unless at least 75 percent of the then eligible debtors elect to pay the required charges.
 11 A policy on which no part of the premium is to be derived from the collection of such
 12 identifiable charges must insure all eligible debtors or all except any as to whom
 13 evidence of individual insurability is not satisfactory to the insurer;

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

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

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

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

35 (4) AGRICULTURAL LOANS. Notwithstanding the provisions of this Code section, group
 36 life insurance in connection with agricultural loans may be written up to the amount of
 37 the loan or loan commitment on the nondecreasing or level term plan; however, the

1 amount of insurance on the life of any such debtor shall not on any anniversary date of
 2 the insurance exceed the amount then owed by him which is repayable in installments,
 3 the amount of the then unpaid indebtedness, or ~~\$40,000.00~~ \$75,000.00, whichever is less.

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

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

11 (B) The premium for the policy shall be paid by the policyholder either wholly from
 12 the union's funds or partly from such funds and partly from funds contributed by the
 13 insured members specifically for their insurance. No policy may be issued on which
 14 the entire premium is to be derived from funds contributed by the insured members
 15 specifically for their insurance. A policy on which no part of the premium is to be
 16 derived from funds contributed by the insured members specifically for their insurance
 17 must insure all eligible members or all except any as to whom evidence of individual
 18 insurability is not satisfactory to the insurer;

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

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

22 ~~(5)~~(6) TRUSTEE GROUPS. A policy issued to the trustees of a fund established by two or
 23 more employers or by one or more labor unions or by one or more employers and one or
 24 more labor unions, which trustees shall be deemed the policyholder, to insure employees
 25 of the employers or members of the unions for the benefit of persons other than the
 26 employers or the unions, subject to the following requirements:

27 (A) The persons eligible for insurance shall be all of the employees of the employers,
 28 all of the members of the unions, or all of any class or classes of employees or union
 29 members determined by conditions pertaining to their employment, to membership in
 30 the unions, or to both. The policy may provide that the term 'employees' shall include
 31 retired employees and the individual proprietor or partners if an employer is an
 32 individual proprietor or a partnership. No director of a corporate employer shall be
 33 eligible for insurance under the policy unless such person is otherwise eligible as a bona
 34 fide employee of the corporation by performing services other than the usual duties of
 35 a director. No individual proprietor or partner shall be eligible for insurance under the
 36 policy unless he is actively engaged in and devotes a substantial part of his time to the
 37 conduct of the business of the proprietor or partnership. The policy may provide that

1 the term 'employees' shall include the trustees or their employees, or both, if their duties
2 are principally connected with such trusteeship;

3 (B) The premium for the policy shall be paid by the trustees wholly from funds
4 contributed by the employer or employers of the insured persons, by the union or
5 unions, or by both or partly from such funds and partly from funds contributed by the
6 insured persons. No policy may be issued on which the entire premium is to be derived
7 from funds contributed by the insured persons specifically for their insurance. A policy
8 on which no part of the premium is to be derived from funds contributed by the insured
9 persons specifically for their insurance must insure all eligible persons or all except any
10 as to whom evidence of individual insurability is not satisfactory to the insurer;

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

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

22 ~~(6)~~(7) ASSOCIATION GROUPS. The lives of a group of individuals may be insured under
23 a policy issued to an association, which shall be deemed the policyholder, to insure
24 members of such association for the benefit of persons other than the association. As
25 used in this paragraph, the term 'association' means an association of governmental or
26 public employees, an association of employees of a common employer, or an
27 organization formed and operated in good faith for purposes other than that of procuring
28 insurance and composed of members engaged in a common trade, business, or profession.

29 The policy shall be subject to the following requirements:

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

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

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

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

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

13 ~~(8)~~(9) MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

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

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

24 ~~(9)~~(10) SPECIAL EMPLOYEE GROUPS. A corporation or a trustee of a trust established by
25 a corporation which has an insurable interest in employees pursuant to subsection (c) of
26 Code Section 33-24-3 and authority to effectuate insurance on employees pursuant to
27 paragraph (4) or (5) of subsection (a) of Code Section 33-24-6 may establish an employee
28 group to effectuate group life insurance policies on employees when such corporation or
29 trustee of a trust is providing life, health, disability, retirement, or similar benefits to
30 employees, provided that the premium for such group policies is wholly paid by the
31 corporation or trustee of the trust and the proceeds of such policies are used to provide
32 supplemental funding for such employee benefit plans."

33 SECTION 5.

34 Said title is further amended by striking paragraph (1) of subsection (b) of Code Section
35 33-27-3, relating to required policy provisions, and inserting in lieu thereof a new paragraph
36 (1) to read as follows:

SECTION 8.

Said title is further amended by striking subsection (c) of Code Section 33-29-8, relating to provision in policies renewable or cancelable at option of insurer for refund of premiums, and inserting in lieu thereof a new subsection (c) to read as follows:

"(c) For the purpose of this ~~Code section~~ chapter, a major medical policy is any policy which provides benefits of at least 75 percent of necessary, reasonable, and customary charges for medical care, including hospitalization in semiprivate accommodations, with maximum lifetime benefit of at least \$100,000.00, subject only to such exceptions, restrictions, limitations, and deductible as the Commissioner may deem reasonable."

SECTION 9.

Said title is further amended by striking paragraphs (5) and (6) of subsection (a) of Code Section 33-30-1, relating to "group accident and sickness insurance" defined, and inserting in lieu thereof new paragraphs (5), (6), and (7) to read as follows:

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

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

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

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

SECTION 10.

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

1 "33-30-3.

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

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

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

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

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

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

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

26 **SECTION 11.**

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

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

1 (4) A provision that in the case of claim for loss of time for disability, written proof of
2 the loss must be furnished to the insurer within 30 days after the commencement of the
3 period for which the insurer is liable, and that subsequent written proofs of the
4 continuance of the disability must be furnished to the insurer at such intervals as the
5 insurer may reasonably require, and that in the case of claim for any other loss, written
6 proof of the loss must be furnished to the insurer within 90 days after the date of the loss.
7 Failure to furnish the proof within such time shall neither invalidate nor reduce any claim
8 if it shall be shown not to have been reasonably possible to furnish the proof and that the
9 proof was furnished as soon as was reasonably possible;

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

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

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

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

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

3 (I) A state health benefits risk pool;

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

5 (K) A public health plan; or

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

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

12 (4) 'Newly eligible employee group member' means a Georgia domiciled employee
13 group member or the dependent of a currently enrolled Georgia domiciled employee
14 group member who has creditable coverage and who first becomes eligible to elect
15 coverage under ~~an employer~~ a group sponsored comprehensive major medical or
16 hospitalization plan. A newly eligible employee group member also includes:

17 (A) During a special enrollment period, existing employees group members and
18 existing dependents of existing employees group members who declined coverage
19 when first offered because of the existence of other creditable coverage, if all the
20 following conditions are met:

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

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

26 (iii) The coverage of the employee group member or employee's group member's
27 dependent was under COBRA and has been exhausted or the creditable coverage was
28 terminated as a result of loss of eligibility for the creditable coverage or employer
29 policyholder contributions toward such creditable coverage were terminated; and

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

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

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

5 (1) Subject to compliance with the provisions of subsections (c) and (d) of this Code
6 section, any newly eligible ~~employee~~, group member, subscriber, enrollee, or dependent
7 who has had creditable coverage under another health benefit plan within the previous
8 90 days shall be eligible for coverage immediately upon completion of any ~~employer~~
9 policyholder imposed waiting period; and

10 (2) Once such creditable coverage terminates, including termination of such creditable
11 coverage after any period of continuation of coverage required under Code Section
12 33-24-21.1 or the provisions of Title X of the Omnibus Budget Reconciliation Act of
13 1986, the insurer must offer a conversion policy to the eligible ~~employee~~, group member,
14 subscriber, enrollee, or dependent.

15 (c) Notwithstanding any provisions of this Code section which might be construed to the
16 contrary, such coverages may include a limitation for preexisting conditions not to exceed
17 12 months for ~~enrollees~~ group members who enroll when newly eligible and 18 months for
18 group members who enroll late ~~enrollees~~ following the effective date of coverage;
19 provided, however, that:

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

23 (2) Such coverages shall waive any time period applicable to the preexisting condition
24 exclusion or limitation in accordance with an insurer's election of an alternative method
25 pursuant to Section 701(c)(3)(B) of the Employee Retirement Income Security Act of
26 1974.

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

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

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

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

37 (2) Does not exceed:

- 1 (A) Two months for newly eligible ~~employees~~ group members and dependents; or
- 2 (B) Three months for group members who enroll late ~~enrollees~~; and
- 3 (3) Runs concurrently with any ~~employer~~ policyholder imposed waiting period under the
- 4 plan.
- 5 (g) The Commissioner shall promulgate appropriate procedures and guidelines by rules
- 6 and regulations to implement the provisions of this Code section after notification and
- 7 review of such regulations by the appropriate standing committees of the House of
- 8 Representatives and Senate in accordance with the requirements of applicable law. The
- 9 Commissioner may allow in such regulations methods other than that described in
- 10 subsection (f) of this Code section for health maintenance organizations to address adverse
- 11 selection, as authorized by the Employee Retirement Income Security Act of 1974, Section
- 12 701(g)(3)."

13 SECTION 15.

14 Said title is further amended by striking paragraph (1) of Code Section 33-30-22, relating to

15 definitions regarding preferred provider arrangements, and inserting in lieu thereof a new

16 paragraph (1) to read as follows:

- 17 "(1) 'Emergency services' or 'emergency care' means ~~covered services included in a~~
- 18 ~~preferred provider arrangement provided to a person after the sudden onset of a medical~~
- 19 ~~condition manifested by symptoms of such severity~~ those health care services that are
- 20 provided for a condition of recent onset and sufficient severity, including, but not limited
- 21 to, severe pain, that would lead a prudent layperson, possessing an average knowledge
- 22 of medicine and health, to believe that his or her condition, sickness, or injury is of such
- 23 a nature that the failure to provide immediately such services obtain immediate medical
- 24 care could ~~reasonably be expected to~~ result in:
- 25 (A) Placing the patient's health in serious jeopardy;
- 26 (B) ~~Impairment~~ Serious impairment to bodily functions; or
- 27 (C) ~~Dysfunction~~ Serious dysfunction of any bodily organ or part."

28 SECTION 16.

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