

The Senate Insurance and Labor Committee offered the following substitute to HB 320:

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 create the Georgia Health Insurance Risk Pool; to provide alternative mechanism coverage  
3 for the availability of individual health insurance; to change the rate of the insurance  
4 premium tax; to provide for the use of such tax; to provide definitions; to provide for a risk  
5 pool board; to provide for powers, duties, and authority of the board; to provide for the  
6 selection of an administrator; to provide for the duties of the Commissioner of Insurance with  
7 respect to the board and pool; to provide for the establishment of rates; to provide for  
8 eligibility for and termination of coverage; to provide for minimum pool benefits; to provide  
9 for certain exclusions for preexisting conditions; to provide for funding; to provide for  
10 assessments under certain circumstances; to provide for certain tax credits; to provide for  
11 complaint procedures; to provide for audits; to provide for certain reports; to provide for  
12 applicability; to provide for related matters; to repeal the Georgia High Risk Health  
13 Insurance Plan; to provide effective dates; to repeal conflicting laws; and for other purposes.

14 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

**SECTION 1.**

15 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
16 striking subparagraph (b)(15)(D) of Code Section 33-6-4, relating to the enumeration of  
17 unfair methods of competition and unfair or deceptive acts or practices, and inserting in lieu  
18 thereof a new subparagraph (b)(15)(D) to read as follows:  
19

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

1 ~~such coverages~~ alternative mechanism coverage for the availability of individual health  
 2 insurance coverage, as contemplated by Section 2741 of the federal Public Health  
 3 Service Act, 42 U.S.C. Section 300gg-41, notwithstanding the act or omission of the  
 4 perpetrator. A person may request and receive family violence information to  
 5 implement the continuation and conversion of coverages under this subparagraph."

## 6 SECTION 2.

7 Said title is further amended by striking Code Section 33-8-4, relating to amount and method  
 8 of computing tax on insurance premiums generally, and inserting in lieu thereof a new Code  
 9 Section 33-8-4 to read as follows:

10 "33-8-4.

11 (a) All foreign, alien, and domestic insurance companies doing business in this state shall  
 12 pay a tax of 2 1/4 percent upon the gross direct premiums received by them on and after  
 13 July 1, 1955. The tax shall be levied upon persons, property, or risks in Georgia, from  
 14 January 1 to December 31, both inclusive, of each year without regard to business ceded  
 15 to or assumed from other companies. The tax shall be imposed upon gross premiums  
 16 received from direct writings without any deductions allowed for premium abatements of  
 17 any kind or character or for reinsurance or for cash surrender values paid, or for losses or  
 18 expenses of any kind; provided, however, deductions shall be allowed for premiums  
 19 returned on change of rate or canceled policies; provided, further, that deductions may be  
 20 permitted for return premiums or assessments, including all policy dividends, refunds, or  
 21 other similar returns paid or credited to policyholders and not reapplied as premium for  
 22 additional or extended life insurance. The term 'gross direct premiums' shall not include  
 23 annuity considerations.

24 (b) For purposes of this chapter, annuity considerations received by nonprofit corporations  
 25 licensed to do business in this state issuing annuities to fund retirement benefits for  
 26 teachers and staff personnel of private secondary schools and colleges and universities shall  
 27 not be considered gross direct premium."

## 28 SECTION 3.

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

32 "33-24-21.1.

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

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

- 1 (A) Medicare or Medicaid;
- 2 (B) An employer based accident and sickness insurance or health benefit arrangement;
- 3 (C) An individual accident and sickness insurance policy, including coverage issued
- 4 by a health maintenance organization, nonprofit hospital or nonprofit medical service
- 5 corporation, health care corporation, or fraternal benefit society;
- 6 (D) A spouse's benefits or coverage under Medicare or Medicaid or an employer based
- 7 health insurance or health benefit arrangement;
- 8 (E) A conversion policy;
- 9 (F) A franchise policy issued on an individual basis to a member of a true association
- 10 as defined in subsection (b) of Code Section 33-30-1;
- 11 (G) A health plan formed pursuant to 10 U.S.C. Chapter 55;
- 12 (H) A health plan provided through the Indian Health Service or a tribal organization
- 13 program or both;
- 14 (I) A state health benefits risk pool;
- 15 (J) A health plan formed pursuant to 5 U.S.C. Chapter 89;
- 16 (K) A public health plan; or
- 17 (L) A Peace Corps Act health benefit plan.
- 18 (2) 'Eligible dependent' means a person who is entitled to medical benefits coverage
- 19 under a group contract or group plan by reason of such person's dependency on or
- 20 relationship to a group member.
- 21 (3) 'Group contract or group plan' is synonymous with the term 'contract or plan' and
- 22 means:
- 23 (A) A group contract of the type issued by a nonprofit medical service corporation
- 24 established under Chapter 18 of this title;
- 25 (B) A group contract of the type issued by a nonprofit hospital service corporation
- 26 established under Chapter 19 of this title;
- 27 (C) A group contract of the type issued by a health care plan established under Chapter
- 28 20 of this title;
- 29 (D) A group contract of the type issued by a health maintenance organization
- 30 established under Chapter 21 of this title; or
- 31 (E) A group accident and sickness insurance policy or contract, as defined in Chapter
- 32 30 of this title.
- 33 (4) 'Group member' means a person who has been a member of the group for at least six
- 34 months and who is entitled to medical benefits coverage under a group contract or group
- 35 plan and who is an insured, certificate holder, or subscriber under the contract or plan.

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

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

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

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

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

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

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

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

23 (c) Any group member ~~or qualifying eligible individual~~ whose coverage has been  
24 terminated and who has been continuously covered under the group contract or group plan,  
25 and under any contract or plan providing similar benefits which it replaces, for at least six  
26 months immediately prior to such termination, shall be entitled to have his or her coverage  
27 and the coverage of his or her eligible dependents continued under the contract or plan.  
28 Such coverage must continue for the fractional policy month remaining, if any, at  
29 termination plus three additional policy months upon payment of the premium by cash,  
30 certified check, or money order, at the option of the employer, to the policyholder or  
31 employer, at the same rate for active group members set forth in the contract or plan, on  
32 a monthly basis in advance as such premium becomes due during this coverage period.  
33 Such premium payment must include any portion of the premium paid by a former  
34 employer or other person if such employer or other person no longer contributes premium  
35 payments for this coverage. At the end of such period, the group member shall have the  
36 same conversion rights that were available on the date of termination of coverage in  
37 accordance with the conversion privileges contained in the group contract or group plan.

1 (d)(1) A group member shall not be entitled to have coverage continued if: (A)  
 2 termination of coverage occurred because the employment of the group member was  
 3 terminated for cause; (B) termination of coverage occurred because the group member  
 4 failed to pay any required contribution; or (C) any discontinued group coverage is  
 5 immediately replaced by similar group coverage including coverage under a health  
 6 benefits plan as defined in the federal Employee Retirement Income Security Act of  
 7 1974, 29 U.S.C. Section 1001, et seq. Further, a group member shall not be entitled to  
 8 have coverage continued if the group contract or group plan was terminated in its entirety  
 9 or was terminated with respect to a class to which the group member belonged. This  
 10 subsection shall not affect conversion rights available to a qualifying eligible individual  
 11 under any contract or plan.

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

23 (e) If the group contract or group plan terminates while any group member ~~or qualifying~~  
 24 ~~eligible individual~~ is covered or whose coverage is being continued, the group  
 25 administrator, as prescribed by the insurer, must notify each such group member ~~or~~  
 26 ~~qualifying eligible individual~~ that he or she must exercise his or her conversion rights  
 27 within:

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

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

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

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

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

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

24 ~~(A) Solely for purposes of this subsection, the claims experience produced by all~~  
25 ~~groups covered under comprehensive major medical or hospitalization accident and~~  
26 ~~sickness insurance for each insurer shall be fully pooled to determine the group pool~~  
27 ~~rate. Except to the extent that the claims experience of an individual group affects the~~  
28 ~~overall experience of the group pool, the claims experience produced by any individual~~  
29 ~~group of each insurer shall not be used in any manner for enhanced conversion policy~~  
30 ~~rating purposes;~~

31 ~~(B) Each insurer's group pool shall consist of each insurer's total claims experience~~  
32 ~~produced by all groups in this state, regardless of the marketing mechanism or~~  
33 ~~distribution system utilized in the sale of the group insurance from which the qualifying~~  
34 ~~eligible individual is converting. The pool shall include the experience generated under~~  
35 ~~any medical expense insurance coverage offered under separate group contracts and~~  
36 ~~contracts issued to trusts, multiple employer trusts, or association groups or trusts,~~  
37 ~~including trusts or arrangements providing group or group-type coverage issued to a~~

1 trust or association or to any other group policyholder where such group or group-type  
 2 contract provides coverage, primarily or incidentally, through contracts issued or issued  
 3 for delivery in this state or provided by solicitation and sale to Georgia residents  
 4 through an out-of-state multiple employer trust or arrangement; and any other  
 5 group-type coverage which is determined to be a group shall also be included in the  
 6 pool for enhanced conversion policy rating purposes; and

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

16 (3) Any group member who is not a qualifying eligible individual and whose insurance  
 17 under the group policy has been terminated for any reason, including failure of the  
 18 employer to pay premiums to the insurer, other than eligibility for medicare (reaching a  
 19 limiting age for coverage under the group policy) or failure of the group member to pay  
 20 a required premium contribution, and who has been continuously covered under the  
 21 group contract or group plan, and under any contract or plan providing similar benefits  
 22 which it replaces, for at least six months immediately prior to termination shall be  
 23 entitled, without evidence of insurability, to convert to individual or group coverage  
 24 covering such group member and any eligible dependents who were covered under the  
 25 group member's coverage under the group contract or group plan. Such conversion  
 26 coverage must be, at the option of the individual, retroactive to the date of termination  
 27 of the group coverage or the date on which continuation or COBRA coverage ended,  
 28 whichever is later. The premium of the basic converted policy shall be determined in  
 29 accordance with the insurer's table of premium rates applicable to the age and  
 30 classification of risks of each person to be covered under that policy and to the type and  
 31 amount of coverage provided. This form of conversion coverage shall be known as the  
 32 'Basic Conversion Option'; and

33 ~~(4)(2)~~ Nothing in this Code section shall be construed to prevent an insurer from offering  
 34 additional options to ~~qualifying eligible individuals~~ or group members.

35 (h) Each group certificate issued to each group member or ~~qualifying eligible individual~~,  
 36 in addition to setting forth any conversion rights, shall set forth the continuation right in a  
 37 separate provision bearing its own caption. The provisions shall clearly set forth a full

1 description of the continuation and conversion rights available, including all requirements,  
 2 limitations, and exceptions, the premium required, and the time of payment of all premiums  
 3 due during the period of continuation or conversion.

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

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

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

#### 22 **SECTION 4.**

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

#### 26 "CHAPTER 29A

27 33-29A-1.

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

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

1 33-29A-2.

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

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

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

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

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

9 (5) 'Creditable coverage' and 'eligible individual' have the same meaning as specified in  
10 Sections 2701 and 2741 of the federal Public Health Service Act, 42 U.S.C.A. Sections  
11 300gg and 300gg-41, except that a person shall not be an eligible individual under this  
12 chapter if such person is eligible for or has declined any continuation or conversion  
13 coverage or has terminated any such coverage prior to its exhaustion.

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

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

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

20 (9) 'Health insurance' means any hospital or medical expense incurred policy, nonprofit  
21 health care services plan contract, health maintenance organization, subscriber contract,  
22 or any other health care plan or arrangement that pays for or furnishes medical or health  
23 care services, whether by insurance or otherwise, when sold to an individual or as a group  
24 policy. This term does not include limited benefit insurance policies. For the purposes  
25 of this Code section, the term 'limited benefit insurance' means accident and sickness  
26 insurance designed, advertised, and marketed to supplement major medical insurance.  
27 The term 'limited benefit insurance' includes accident only, CHAMPUS supplement,  
28 dental, disability income, fixed indemnity, long-term care, medicare supplement,  
29 specified disease, vision, limited benefit, or credit insurance; coverage issued as a  
30 supplement to liability insurance; insurance arising out of a workers' compensation or  
31 similar law; automobile medical-payment insurance; or insurance under which benefits  
32 are payable with or without regard to fault and which is statutorily required to be  
33 contained in any liability insurance policy or equivalent self-insurance, and includes any  
34 other accident and sickness insurance other than basic hospital expense, basic  
35 medical-surgical expense, and comprehensive major medical insurance coverage.

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

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

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

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

13 (14) 'Insurer' means any entity that is authorized in this state to write health insurance or  
14 that provides health insurance in this state. For the purposes of this chapter, the term  
15 'insurer' includes an insurance company; nonprofit health care services plan; health care  
16 corporation or surviving health care corporation as defined in Code Section 33-20-3;  
17 fraternal benefits society; health maintenance organization; any other entity providing a  
18 plan of health insurance or health benefits subject to state insurance regulation;  
19 association plans; and any stop-loss plan providing stop-loss coverage to a health insurer  
20 or health plan in Georgia.

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

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

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

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

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

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

31 (21) 'Resident' means:

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

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

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

4 (22) 'Third-party administrator' as used in this chapter shall have the same meaning as  
5 the term 'administrator' as defined in Code Section 33-23-100.

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

9 33-29A-3.

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

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

18 (c) The Commissioner shall appoint:

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

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

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

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

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

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

1 organization is as an insured or person who has coverage through a plan provided by the  
2 corporation or organization.

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

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

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

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

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

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

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

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

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

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

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

22 33-29A-4.

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

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

27 (1) Operation of the pool;

28 (2) Selecting an administrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

26 33-29A-5.

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

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

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

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

- 1 (3) Sue and be sued, including taking any legal actions necessary or proper to recover  
2 or collect assessments due the pool;
  - 3 (4) Institute any legal action necessary to avoid payment of improper claims against the  
4 pool or the coverage provided by or through the pool, to recover any amounts erroneously  
5 or improperly paid by the pool, to recover any amount paid by the pool as a mistake of  
6 fact or law, and to recover other amounts due the pool;
  - 7 (5) Establish appropriate rates, rate schedules, rate adjustments, expense allowance,  
8 agents' referral fees, and claim reserve formulas and perform any actuarial function  
9 appropriate to the operation of the pool;
  - 10 (6) Adopt policy forms, endorsements, and riders and applications for coverage;
  - 11 (7) Issue insurance policies subject to this chapter and the plan of operation;
  - 12 (8) Appoint appropriate legal, actuarial, and other committees that are necessary to  
13 provide technical assistance in operating the pool and performing any of the functions of  
14 the pool;
  - 15 (9) Employ and set the compensation of any persons necessary to assist the pool in  
16 carrying out its responsibilities and functions;
  - 17 (10) Contract for stop-loss insurance for risks incurred by the pool;
  - 18 (11) Borrow money as necessary to implement the purposes of the pool;
  - 19 (12) Issue additional types of health insurance policies to provide optional coverages  
20 which comply with applicable provisions of state and federal law;
  - 21 (13) Provide for and employ cost containment measures and requirements including, but  
22 not limited to, preadmission screening, second surgical opinion, concurrent utilization  
23 case management, disease-state management, and other risk reduction practices for the  
24 purpose of maximizing effectiveness and cost savings to the pool, its insureds, and  
25 payers;
  - 26 (14) Design, utilize, contract, or otherwise arrange for delivery of cost-effective health  
27 care services, including establishing or contracting with preferred provider organizations  
28 and health maintenance organizations;
  - 29 (15) Provide for reinsurance on either a facultative or treaty basis, or both; and
  - 30 (16) Develop through research and surveys of insurers offering individual health  
31 insurance coverage in this state reasonable guidelines for acceptance of risk in the  
32 individual health insurance market.
- 33 (c) The board shall promulgate a list of medical or health conditions for which a person  
34 shall be eligible for pool coverage without applying for health insurance. The list shall be  
35 effective on the first day of the operation of the pool and may be amended from time to  
36 time as may be appropriate and as treatment outcomes and disease state management  
37 practices change due to advances in medicine.

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

6 33-29A-6.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 33-29A-7.

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

7 33-29A-8.

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

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

21 (c) All rates and rate schedules shall be submitted to the Commissioner for approval, and  
22 the Commissioner must approve the rates and rate schedules of the pool before use by the  
23 pool. The Commissioner in evaluating the rates and rate schedule of the pool shall  
24 consider the factors provided for in this Code section.

25 33-29A-9.

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

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

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

33 (3) Diagnosis of the individual with one of the medical or health conditions listed by the  
34 board in accordance with subsection (c) of Code Section 33-29A-5. A person diagnosed

1 with one or more of these conditions shall be eligible for a pool coverage without  
2 applying for other health insurance coverage;

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

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

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

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

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

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

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

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

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

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

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

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

36 (5) Has premiums that are paid for or reimbursed under any government sponsored  
37 program or by any government agency or health care provider, except as an otherwise

1 qualifying full-time employee, or dependent thereof, of a government agency or health  
2 care provider, except as provided in paragraph (6) of subsection (a) of this Code section;

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

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

8 (e) Pool coverage shall cease:

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

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

15 (3) Upon the death of the covered person;

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

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

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

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

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

26 33-29A-10.

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

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

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

32 (3) The applicable schedules of benefits; and

33 (4) Any exclusions to coverage and other limitations.

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

36 (1) All required or applicable definitions;

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

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

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

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

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

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

19 33-29A-11.

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

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

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

33 (d) An eligible individual who is eligible for the credit for health insurance under Section  
34 35 of the federal Internal Revenue Code of 1986 shall be eligible for coverage without  
35 regard to the 12 month preexisting conditions limitation only if he or she had three months

1 of prior creditable coverage as of the date on which the individual seeks to enroll in pool  
2 coverage, not counting any period prior to a 63 day break in coverage.

3 33-29A-12.

4 (a) The General Assembly shall appropriate the funds necessary to carry out the powers  
5 and duties of the pool.

6 (b) If the General Assembly should fail in any year to appropriate sufficient funds  
7 necessary to carry out the powers and duties of the pool, the board, by July 1 of that year,  
8 shall assess insurers in accordance with subsection (c) of this Code section an amount  
9 necessary for the continued operation of the pool for the next fiscal year. Assessments  
10 shall be due not less than 30 days after the end of each calendar quarter and shall accrue  
11 interest at a rate not to exceed 12 percent per annum on and after the due date.

12 (c) Each insurer shall be assessed in an amount established by the risk pool board not to  
13 exceed \$2.00 per covered person insured by each insurer, or 3 percent of total premium,  
14 including aggregate and specific premium, whichever is less, per month excluding persons  
15 insured under limited benefit insurance policies as defined in paragraph (9) of  
16 subsection (a) of Code Section 33-29A-2. Health insurance and health plans established  
17 by federal, state, or local governments shall not be included in such assessments.

18 (d) To the extent not otherwise prohibited by law, each insurer may itemize the cost of this  
19 assessment in statements or invoices to employers or insureds.

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

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

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

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

6 (i) Each insurer and excess or stop-loss carrier assessed under this Code section shall be  
7 allowed a tax credit to the extent of that insurer's or excess or stop-loss carrier's liability  
8 to pay state premium tax as required under subsection (b) of Code Section 33-8-4.

9 (j) Notwithstanding other limitations, each insurer's and excess or stop-loss carrier's  
10 assessment shall not exceed that insurer's or excess or stop-loss carrier's net premium tax  
11 due for the previous calendar year.

12 (k) If the board has established or is in the process of establishing through legislation or  
13 regulation an alternative funding mechanism other than assessments of insurers for future  
14 anticipated deficits of the pool as a result of recommendations pursuant to subsection (g)  
15 of Code Section 33-29A-4, such funding mechanism shall be used in lieu of assessments  
16 of insurers as soon as is reasonably practicable, but not beyond 24 months after the  
17 deadline provided in such Code section for such recommendations. Nothing in this  
18 subsection shall be interpreted to convey authority to the board to take any actions not  
19 expressly authorized by law.

20  
21 33-29A-13.

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

27 33-29A-14.

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

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

33 33-29A-15.

34 Notwithstanding other changes in law contained in this chapter, coverage for persons  
35 eligible as a result of the federal Health Insurance Portability and Accountability Act of

1 1996, P. L. 104-191, shall continue to be issued health insurance coverage through this  
 2 state's 'Georgia Health Insurance Assignment System,' 'Georgia Health Benefits  
 3 Assignment System,' or 'Enhanced Conversion Options,' under rules and procedures  
 4 established under this chapter or under Code Section 33-24-21.1 prior to July 1, 2005, until  
 5 December 31, 2005, or such time as the pool is able to issue coverage and pay claims to  
 6 eligible individuals as defined in Code Section 33-29A-2, whichever occurs later.

7 33-29A-16.

8 Coverages available under the Georgia Health Insurance Risk Pool must be made available  
 9 not later than January 1, 2006, unless the board with the agreement of the Commissioner  
 10 determines that reasonably sufficient funds necessary to issue coverage and pay claims are  
 11 not available to the pool as provided in Code Section 33-29A-12."

#### 12 **SECTION 5.**

13 Said title is further amended by striking paragraph (2) of subsection (b) of Code Section  
 14 33-30-15, relating to continuation of similar coverage, and inserting in lieu thereof a new  
 15 paragraph (2) to read as follows:

16 "(2) Once such creditable coverage terminates, including termination of such creditable  
 17 coverage after any period of continuation of coverage required under Code Section  
 18 33-24-21.1 or the provisions of Title X of the Omnibus Budget Reconciliation Act of  
 19 1986, the insurer must ~~offer a conversion policy~~ provide notice of eligibility for coverage  
 20 under the state's alternative mechanism of the availability of individual health insurance  
 21 coverage as provided under Chapter 29A of this title, as contemplated by Section 2741  
 22 of the federal Public Health Service Act, 42 U.S.C. Section 300gg-41, to the eligible  
 23 employee, member, subscriber, enrollee, or dependent."

#### 24 **SECTION 6.**

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

#### 27 **SECTION 7.**

28 Sections 1, 3, and 5 of this Act shall become effective on January 1, 2006. The remainder  
 29 of this Act shall become effective on July 1, 2005.

#### 30 **SECTION 8.**

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