

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 Assignment Pool Underwriting Authority; to provide alternative
3 mechanism coverage for the availability of individual health insurance; to provide
4 definitions; to provide for an assignment pool underwriting board; to provide for powers,
5 duties, and authority of the board; to provide for the selection of an administrator or
6 administrators; to provide for the duties of the Commissioner of Insurance with respect to the
7 board and assignment pool; to provide for the establishment of rates; to provide for eligibility
8 for and termination of coverage; to provide for minimum assignment pool benefits; to
9 provide for certain exclusions for preexisting conditions; to provide for funding; to provide
10 for assessments under certain circumstances; to provide for complaint procedures; to provide
11 for audits; to provide for certain reports; to provide for applicability; to provide for related
12 matters; to repeal the Georgia High Risk Health Insurance Plan; to provide effective dates;
13 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 revising 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, as follows:
18

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

1 ~~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 insured."

7 SECTION 2.

8 Said title is further amended by revising Code Section 33-24-21.1, relating to group accident
 9 and sickness contracts, as follows:

10 "33-24-21.1.

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

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

14 (A) Medicare or Medicaid;

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

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

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

21 (E) A conversion policy;

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

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

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

27 (I) A state health benefits risk pool;

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

29 (K) A public health plan; or

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

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

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

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

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

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

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

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

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

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

17 (6) 'Qualifying eligible individual' means:

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

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

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

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

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

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

36 (c) Any group member or qualifying eligible individual whose coverage has been
37 terminated and who has been continuously covered under the group contract or group plan,

1 and under any contract or plan providing similar benefits which it replaces, for at least six
2 months immediately prior to such termination, shall be entitled to have his or her coverage
3 and the coverage of his or her eligible dependents continued under the contract or plan.
4 Such coverage must continue for the fractional policy month remaining, if any, at
5 termination plus three additional policy months upon payment of the premium by cash,
6 certified check, or money order, at the option of the employer, to the policyholder or
7 employer, at the same rate for active group members set forth in the contract or plan, on
8 a monthly basis in advance as such premium becomes due during this coverage period.
9 Such premium payment must include any portion of the premium paid by a former
10 employer or other person if such employer or other person no longer contributes premium
11 payments for this coverage. At the end of such period, the group member shall have the
12 same conversion rights that were available on the date of termination of coverage in
13 accordance with the conversion privileges contained in the group contract or group plan.

14 (d)(1) A group member shall not be entitled to have coverage continued if: (A)
15 termination of coverage occurred because the employment of the group member was
16 terminated for cause; (B) termination of coverage occurred because the group member
17 failed to pay any required contribution; ~~or~~ (C) any discontinued group coverage is
18 immediately replaced by similar group coverage including coverage under a health
19 benefits plan as defined in the federal Employee Retirement Income Security Act of
20 1974, 29 U.S.C. Section 1001, et seq.; or (D) ~~Further, a group member shall not be~~
21 ~~entitled to have coverage continued~~ if the group contract or group plan was terminated
22 in its entirety or was terminated with respect to a class to which the group member
23 belonged. This subsection shall not affect conversion rights available to a qualifying
24 eligible individual under any contract or plan.

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

36 (e) If the group contract or group plan terminates while any group member or qualifying
37 eligible individual is covered or whose coverage is being continued, the group

1 administrator, as prescribed by the insurer, must notify each such group member or
 2 qualifying eligible individual that he or she must exercise his or her conversion rights and
 3 rights to alternative mechanism coverage for the availability of individual health insurance
 4 coverage, as contemplated by Section 2741 of the federal Public Health Service Act,
 5 42 U.S.C. Section 300gg-41, within:

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

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

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

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

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

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

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

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

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

32 ~~(3)~~(1) Any group member who is not a qualifying eligible individual and whose
 33 insurance under the group policy has been terminated for any reason, including failure
 34 of the employer to pay premiums to the insurer, other than eligibility for medicare
 35 (reaching a limiting age for coverage under the group policy) or failure of the group
 36 member to pay a required premium contribution, and who has been continuously covered
 37 under the group contract or group plan, and under any contract or plan providing similar

1 benefits which it replaces, for at least six months immediately prior to termination shall
 2 be entitled, without evidence of insurability, to convert to individual or group coverage
 3 covering such group member and any eligible dependents who were covered under the
 4 group member's coverage under the group contract or group plan. Such conversion
 5 coverage must be, at the option of the individual, retroactive to the date of termination
 6 of the group coverage or the date on which continuation or COBRA coverage ended,
 7 whichever is later. The premium of the basic converted policy shall be determined in
 8 accordance with the insurer's table of premium rates applicable to the age and
 9 classification of risks of each person to be covered under that policy and to the type and
 10 amount of coverage provided. This form of conversion coverage shall be known as the
 11 'Basic Conversion Option'; and

12 ~~(4)~~(2) Nothing in this Code section shall be construed to prevent an insurer from offering
 13 additional options to qualifying eligible individuals or group members.

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

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

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

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

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

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

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

22 (14) 'Insurance arrangement' or 'self-insurance arrangement' means a plan, program,
23 contract, or other arrangement through which health care services are provided by an
24 employer to its officers, employees, or other personnel, but does not include health care
25 services covered through an insurer.

26 (15) 'Insured' means a person who is a legal resident of this state and who is eligible to
27 receive benefits from the assignment pool. The term 'insured' may include dependents
28 and family members.

29 (16) 'Managed care organization' means a health maintenance organization or a nonprofit
30 health care corporation.

31 (17) 'Market share' means the percentage of the total number of covered persons living
32 in Georgia included in health insurance and health plans insured, reinsured, and
33 administered by a payor.

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

36 (19) 'Payor' means any entity that is authorized in this state to write health insurance or
37 that provides health insurance in this state. For the purposes of this chapter, the term

1 'payor' includes an insurance company; nonprofit health care services plan; health care
 2 corporation or surviving health care corporation as defined in Code Section 33-20-3;
 3 fraternal benefits society; health maintenance organization; any other entity providing a
 4 plan of health insurance or health benefits subject to state insurance regulation;
 5 association plans; and any administrator paying or processing health benefit claims in
 6 Georgia.

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

8 (21) 'Plan administrator' means a payor selected by the Georgia Assignment Pool
 9 Underwriting Authority to provide administrative services or accept assignments of
 10 insureds as defined in paragraph (15) of this subsection.

11 (22) 'Plan of operation' means the plan of operation of the assignment pool and includes
 12 the articles, bylaws, and operating rules of the assignment pool that are adopted by the
 13 board.

14 (23) 'Resident' means an individual who has been legally domiciled in Georgia for a
 15 minimum of 24 months; provided, however, that, for a federally defined eligible
 16 individual, there shall be no such time period requirement to establish residency.

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

20 33-29A-3.

21 (a) There is created a body corporate to be known as the 'Georgia Assignment Pool
 22 Underwriting Authority' which shall be deemed to be a public corporation. The Georgia
 23 Assignment Pool Underwriting Authority shall have perpetual existence, and any change
 24 in the name or composition of the assignment pool or Georgia Assignment Pool
 25 Underwriting Authority shall in no way impair the obligations of any contracts existing
 26 under this chapter.

27 (b) The Commissioner, the Speaker of the House of Representatives, and the Senate
 28 Committee on Assignments shall each appoint two members of the authority for staggered
 29 four-year terms as provided by this Code section. One of the authority members appointed
 30 by each of the above persons or officers shall have a two-year initial term and one shall
 31 have a four-year initial term as designated by the person or officer making such
 32 appointment at the time of such appointment. Thereafter, successors to such members shall
 33 be appointed to and serve four-year terms.

34 (c) Such appointees shall be persons affiliated with payors admitted and authorized to
 35 write health insurance in this state or who are otherwise familiar with health insurance
 36 matters.

1 (d) The Governor shall appoint three members for staggered four-year terms as provided
 2 by this subsection. One appointee shall be a person representing the medical provider
 3 community, such as a physician licensed to practice medicine in this state, who shall serve
 4 a four-year initial term and the other two appointees shall be persons representing
 5 consumers. One of the authority members representing consumers appointed by the
 6 Governor shall have a two-year initial term, and one shall have a four-year initial term as
 7 designated by the Governor at the time of such appointment. Thereafter, successors to such
 8 members shall be appointed to and serve four-year terms.

9 (e) The appointed members of the authority shall elect one of their own members to serve
 10 as chairperson.

11 (f) If a vacancy occurs on the authority, the person or officer who made the appointment
 12 shall fill the vacancy for the unexpired term with a person who has the appropriate
 13 qualifications to fill that position on the authority.

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

17 33-29A-4.

18 (a) The initial members of the Georgia Assignment Pool Underwriting Authority shall
 19 submit to the Commissioner a plan of operation for the assignment pool that will assure the
 20 fair, reasonable, and equitable administration of the assignment pool.

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

23 (1) Operation of the assignment pool;

24 (2) Selecting a plan administrator or multiple plan administrators;

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

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

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

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

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

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

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

6 (e) If the initial members of the authority fail to submit a suitable plan of operation within
 7 180 days following the appointment of the initial members, the Commissioner, after notice
 8 and hearing, may adopt all necessary and reasonable rules to provide a plan for the
 9 assignment pool. The rules adopted under this subsection shall continue in effect until the
 10 initial members submit, and the Commissioner approves, a plan of operation as provided
 11 under this Code section.

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

15 33-29A-5.

16 (a) The Georgia Assignment Pool Underwriting Authority is authorized to exercise any
 17 of the authority that a corporation in this state may exercise under the laws of this state.

18 (b) As part of its authority, the Georgia Assignment Pool Underwriting Authority shall
 19 have the authority to:

20 (1) Develop a means in this chapter referred to as the assignment pool, through the
 21 assignment of risks to provide health benefits coverage to persons who are eligible for
 22 that coverage under this chapter;

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

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

29 (4) Institute any legal action necessary to recover any amounts erroneously or improperly
 30 paid by the assignment pool, to recover any amounts paid by the assignment pool as a
 31 mistake of fact or law, and to recover other amounts due the assignment pool;

32 (5) Establish appropriate rates, rate schedules, rate adjustments, expense allowance, and
 33 agents' referral fees, and perform any actuarial function appropriate to the operation of
 34 the assignment pool;

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

1 (7) Develop a means for plan administrators to issue insurance policies subject to this
2 chapter and the plan of operation;

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

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

8 (10) Borrow money as necessary to implement the purposes of the assignment pool; and

9 (11) Require plan administrators to employ cost containment measures and requirements,
10 including, but not limited to, preadmission screening, second surgical opinion, concurrent
11 utilization case management, disease-state management, and other risk reduction
12 practices for the purpose of maximizing effectiveness and cost savings to the assignment
13 pool, its insureds, and payers. Plan administrators shall report at least annually on these
14 programs and document savings and improved health outcomes for eligible individuals.

15 (c) Not later than June 30 of each year, the board shall make an annual report to the
16 Governor, the Senate Insurance and Labor Committee, the House Committee on Insurance,
17 and the Commissioner. The report shall summarize the activities of the assignment pool
18 in the preceding calendar year, including information regarding net written and earned
19 premiums, plan enrollment, administration expenses, and paid and incurred losses of plan
20 administrators on behalf of persons eligible for coverage under the assignment pool.

21 (d) The board shall establish a methodology to assure that the widest practicable and
22 equitable distribution of risk among payors is achieved and that a variety of plan design
23 offerings are available through plan administrators.

24 (e) The board shall establish in its plan of operation means by which to compensate plan
25 administrators for accepting assignments from the assignment pool.

26 33-29A-6.

27 (a) After completing a competitive bidding process as provided by the plan of operation,
28 the board may select one or more payors or plan administrators certified by the board to
29 administer the assignment pool and offer assignment pool coverage.

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

32 (1) A payor's or plan administrator's proven ability to handle accident and sickness
33 insurance;

34 (2) The efficiency of a payor's or plan administrator's claims paying procedures;

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

1 (4) A payor's or plan administrator's ability to administer the assignment pool in a
 2 cost-efficient manner; and

3 (5) The financial condition and stability of the payor or plan administrator.

4 (c) The plan administrator shall perform such functions relating to the assignment pool as
 5 may be assigned to it, including:

6 (1) Providing health benefits coverage according to specifications adopted by the board
 7 to persons who are eligible for that coverage under this chapter;

8 (2) Performing eligibility and administrative claims payment functions for the
 9 assignment pool;

10 (3) Establishing a billing procedure for collection of premiums from persons insured by
 11 the assignment pool;

12 (4) Performing functions necessary to assuring timely payment of benefits to persons
 13 covered under the assignment pool, including:

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

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

17 (5) Submitting regular reports to the board relating to the operation of the assignment
 18 pool; and

19 (6) Determining after the close of each calendar year the net written and earned
 20 premiums, expenses of administration, and paid and incurred losses of the assignment
 21 pool for that calendar year and reporting such information to the board and the
 22 Commissioner on forms prescribed by the Commissioner.

23 33-29A-7.

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

29 33-29A-8.

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

33 (b) The Georgia Assignment Pool Underwriting Authority shall determine the standard
 34 risk rate by considering the premium rates charged by insurers offering health insurance
 35 coverage to individuals. The standard risk rate shall be established using reasonable

1 actuarial techniques and shall reflect anticipated experience and expenses for such
2 coverage. The initial assignment pool rate may not be less than 125 percent and may not
3 exceed 150 percent of rates established as applicable for individual standard rates.
4 Subsequent rates shall be established to provide fully for the expected costs of claims,
5 including recovery of prior losses, expenses of operation, investment income of claim
6 reserves, and any other cost factors subject to the limitations described in this subsection;
7 however, in no event shall assignment pool rates exceed 150 percent of rates applicable to
8 individual standard risks.

9 (c) All rates and rate schedules shall be submitted to the Commissioner for approval, and
10 the Commissioner must approve the rates and rate schedules of the plans offered by the
11 plan administrators on behalf of the assignment pool before assignment of risks to such
12 plan's use by the assignment pool. The Commissioner in evaluating the rates and rate
13 schedule of the assignment pool shall consider the factors provided for in this Code section.

14 33-29A-9.

15 (a) Any individual person who is and continues to be a legal resident of Georgia as defined
16 in paragraph (22) of subsection (a) of Code Section 33-29A-2 shall be eligible for coverage
17 from the assignment pool if evidence is provided of:

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

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

24 (3) In the case of an individual who is eligible for coverage under the federal Health
25 Insurance Portability and Accountability Act of 1996, P. L. 104-191, the individual's
26 maintenance of health insurance coverage for the previous 18 months with no gap in
27 coverage greater than 90 days of which the most recent coverage was through an
28 employer sponsored plan;

29 (4) In the case of an individual who is eligible for coverage under the federal Health
30 Insurance Portability and Accountability Act of 1996, P. L. 104-191, the individual's
31 maintenance of health insurance coverage through this state's 'Enhanced Conversion
32 Options,' 'Georgia Health Insurance Assignment System,' or 'Georgia Health Benefits
33 Assignment System' at a rate exceeding the assignment pool rate with no gap in coverage
34 since such coverage lapsed of more than 90 days; or

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

1 (b) Each dependent of a person who is eligible for coverage from the assignment pool shall
2 also be eligible for coverage from the assignment pool unless that person is enrolled in or
3 is eligible to enroll in any form of health insurance or insurance arrangement, whether
4 public or private. In the case of a child who is the primary insured, resident family
5 members shall also be eligible for coverage if they are the siblings, parents, or guardians
6 of the child.

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

10 (d) A person is not eligible for coverage from the assignment pool if the person:

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

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

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

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

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

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

24 (5) Has premiums that are paid for or reimbursed under any government sponsored
25 program or by any government agency or health care provider, except as an otherwise
26 qualifying full-time employee, or dependent thereof, of a government agency or health
27 care provider, except as provided in paragraph (6) of subsection (a) of this Code section;

28 (6) Has premiums that are paid for or reimbursed by a nongovernmental third-party
29 organization with interest in placing individuals in high risk pools or similar pools;

30 (7) Has had prior coverage with the assignment pool terminated for nonpayment of
31 premiums or fraud; or

32 (8) Has voluntarily terminated coverage outside the assignment pool within six months
33 of the date that application is made to the assignment pool unless the person demonstrates
34 a good faith reason for the termination. If a person otherwise eligible for assignment pool
35 coverage has declined or terminated COBRA continuation or other continuation or
36 conversion coverage, except for basic conversion coverage as provided in subsection (g)
37 of Code Section 33-24-21.1, such person is still eligible to apply for assignment pool

1 coverage, but a preexisting condition exclusion shall apply and last for a period of 18
2 months.

3 (e) Assignment pool coverage shall cease:

4 (1) On the date a person is no longer a resident of this state, except for a child who is a
5 dependent according to provisions of paragraph (3) of subsection (a) of Code Section
6 33-29-2 or paragraph (4) of Code Section 33-30-4 and who is financially dependent upon
7 the parent, a child for whom a person may be obligated to pay child support, or a child
8 of any age who is disabled and dependent upon the parent;

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

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

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

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

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

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

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

22 33-29A-10.

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

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

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

28 (3) The applicable schedules of benefits; and

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

30 (b) The benefits provisions of the assignment pool's health benefits coverages shall
31 include the following:

32 (1) All required or applicable definitions;

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

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

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

1 (c) The board may adjust deductibles and the time periods governing preexisting
2 conditions to preserve the financial integrity of the assignment pool. Plan administrators
3 may petition the board in a manner provided for in rules adopted by the board and
4 approved by the Commissioner to address solvency concerns and matters affecting the
5 financial integrity of coverage provided by plan administrators. If the board makes such
6 an adjustment, it shall report in writing that adjustment together with its reasons for the
7 adjustment to the Commissioner. The report shall be submitted not later than the thirtieth
8 day after the date the adjustment is made.

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

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

19 (f) Notwithstanding other provisions of this Code section and as long as the minimum
20 standards set forth in this Code section are met, the board and plan administrators may
21 offer additional major medical plans of coverage to eligible individuals that reflect those
22 otherwise available to the private health insurance market, including, but not limited to,
23 high deductible health plans (HDHP), health savings account eligible health plans (HSA),
24 and other such plans as may be designed in the future to meet the need for affordable
25 coverage for eligible individuals.

26 33-29A-11.

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

32 (b) The preexisting conditions limitation provided in this Code section shall be reduced
33 by aggregated creditable coverage that was in effect up to a date not more than 90 days
34 before application for coverage in the assignment pool.

35 (c) An eligible individual who is eligible for enrollment in the assignment pool as a result
36 of the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191,

1 and has 18 months of prior creditable coverage, the most recent of which is employer
2 sponsored coverage, shall be eligible for coverage without regard to the 12-month
3 preexisting conditions limitation.

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

9 33-29A-12.

10 (a) Payors shall participate in the assignment pool by accepting direct assignments of
11 eligible individuals for coverage or by contributing to the cost of claims beyond premiums
12 collected by plan administrators that accept direct assignment of risks from the assignment
13 pool.

14 (b) The board with review and approval of the Commissioner shall develop an accounting
15 method to estimate future and determine actual claims of payors accepting direct
16 assignment of risks from the assignment pool along with administrative costs of the
17 assignment pool and plan administrators and collect assessments from all payors using an
18 equitable formula based on market share.

19 (c) If the claims or anticipated claims of payors exceed premiums collected from
20 subscribers, the board, by July 1 of that year, shall assess payors in accordance with this
21 subsection an amount necessary for the continued operation of the assignment pool for the
22 next fiscal year. Assessments shall be due not less than 30 days after the end of each
23 calendar quarter and shall accrue interest at a rate not to exceed 12 percent per annum on
24 and after the due date. Each payor shall be assessed an amount established by the board
25 not to exceed \$2.00 per covered person per payor per month, excluding persons covered
26 under limited benefit insurance policies as defined in paragraph (11) of subsection (a) of
27 Code Section 33-29A-2. Health insurance and health plans established by federal, state,
28 or local governments shall not be included in such assessments unless such state or local
29 government has contracted with payors to provide insurance, stop-loss insurance, or plan
30 administrator services.

31 (d) Plan administrators accepting direct assignment of risks from the assignment pool shall
32 be allowed credit for actual claims of eligible individuals that exceed assessments that
33 would otherwise be payable based on market share.

34 (e) To the extent not otherwise prohibited by law, each payor may itemize the cost of this
35 assessment in statements or invoices to employers or covered persons.

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

9 (g) Each payor's assessment may be verified by the board based on annual statements and
10 other reports deemed to be necessary by the board. The board may use any reasonable
11 method of estimating the number of covered persons of a payor if the specific number is
12 unknown.

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

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

22 (j) The funding mechanism outlined in this Code section shall be modified only by general
23 law.

24 (k) Notwithstanding other provisions of this chapter, a payor may accept, with board and
25 Commissioner approval, direct assignments based on market share from the assignment
26 pool without regard to recovery for claims as long as the payor does not attempt to
27 discriminate or select which risks it will accept from the assignment pool. In addition, a
28 payor meeting the qualifications of this subsection may seek approval to market new
29 benefit plans that include, but are not limited to:

30 (1) Product or benefits designs to offer affordable coverage options to eligible
31 individuals; or

32 (2) Risk reductions methodologies through disease-state management.

33 (l) Any plans offered as provided in subsection (k) of this Code section shall be approved
34 as suitable for the purposes of this chapter by relevant federal authorities prior to
35 enrollment of eligible individuals.

1 (m) Payors accepting direct assignment of risks as provided in subsection (k) of this Code
2 section shall not be subject to assessments and their market share shall not be included in
3 market share calculations for the purpose of assessments.

4 (n) The Commissioner and the board shall determine the period or periods of time plans
5 authorized for assignments under subsection (k) of this Code section shall be offered except
6 that no payor shall be permitted to elect to change its manner of participation in the
7 assignment pool more than once in a two-year period.

8
9 33-29A-13.

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

16 33-29A-14.

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

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

22 33-29A-15.

23 Notwithstanding other changes in law contained in this chapter, persons eligible as a result
24 of the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191,
25 shall continue to be issued health insurance coverage through this state's 'Georgia Health
26 Insurance Assignment System,' 'Georgia Health Benefits Assignment System,' or
27 'Enhanced Conversion Options,' under rules and procedures established under this chapter
28 or under Code Section 33-24-21.1 prior to July 1, 2007, until December 31, 2007, or such
29 time as the assignment pool is able to issue coverage to eligible individuals, whichever
30 occurs later.

31 33-29A-16.

32 Coverages available under the assignment pool must be made available not later than
33 January 1, 2008, except as provided in Code Section 33-29A-15."

SECTION 4.

Said title is further amended by revising paragraph (2) of subsection (b) of Code Section 33-30-15, relating to continuation of similar coverage, as follows:

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

SECTION 5.

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

SECTION 6.

This Act shall become effective on July 1, 2007.

SECTION 7.

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