

## Senate Bill 28

By: Senators Hill of the 32nd, Thomas of the 54th, Rogers of the 21st, Goggans of the 7th, Hudgens of the 47th and others

## A BILL TO BE ENTITLED

## AN ACT

1 To provide a short title; to comprehensively revise the laws of Georgia concerning the  
2 provision of health insurance; to amend Title 33 of the Official Code of Georgia Annotated,  
3 relating to insurance, so as to provide for the development of consumer driven health  
4 insurance plans by the Commissioner of Insurance; to provide for exemptions for certain  
5 health insurance plans from premium taxes; to allow such plans to include wellness and  
6 health promotion programs; to provide that such programs shall not be considered unfair  
7 trade practices; to provide for the deductibility of certain health insurance premiums for state  
8 income tax purposes; to provide that preferred provider arrangements shall not have  
9 differences in coinsurance percentages applicable to benefit levels for services provided by  
10 preferred and nonpreferred providers which differ by more than 40 percentage points; to  
11 provide that preferred provider arrangements shall not have a coinsurance percentage  
12 applicable to benefit levels for services provided by nonpreferred providers which exceeds  
13 50 percent of the benefit levels under the policy for such services; to provide that an insured  
14 under a group accident and sickness policy may include dependents up to age 27 or until two  
15 years after ceasing to be a dependent, whichever is earlier; to provide that employers who  
16 employ persons who also work for other employers may enter into arrangements to  
17 contribute to the employees' health care coverage under such other employers; to provide for  
18 the promulgation of rules and regulations; to provide for related matters; to create the  
19 Georgia Health Security Underwriting Authority; to provide alternative mechanism coverage  
20 for the availability of individual health insurance; to provide definitions; to provide for an  
21 assignment group underwriting board; to provide for powers, duties, and authority of the  
22 board; to provide for the selection of an administrator or administrators; to provide for the  
23 duties of the Commissioner of Insurance with respect to the board and assignment group; to  
24 provide for the establishment of rates; to provide for eligibility for and termination of  
25 coverage; to provide for minimum assignment group benefits; to provide for certain  
26 exclusions for preexisting conditions; to provide for funding; to provide for complaint  
27 procedures; to provide for audits; to provide for certain reports; to provide for related  
28 matters; to repeal the Georgia High Risk Health Insurance Plan; to provide for legislative

1 findings; to provide for the creation of the Georgia Health Insurance Exchange; to provide  
2 for definitions; to provide for the selection, filling of vacancies, terms of office, and powers  
3 and responsibilities of a board of directors; to provide for the selection of officers of the  
4 board of directors; to provide for an exchange director and staff; to provide for enrollment  
5 and coverage election of eligible individuals; to provide for the participation of plans in the  
6 exchange; to provide underwriting rules; to provide for certain continuation of coverage; to  
7 provide for the resolution of certain disputes; to provide for participating employer plans and  
8 agreements; to provide for commissions for insurance producers using the exchange; to  
9 provide certain forms and require certain information to be filed concerning insurance  
10 coverage for employees; to require certain individuals to prove ability to pay for medical  
11 expenses; to provide for escrow accounts for such individuals; to provide for related matters;  
12 to amend Title 45 of the Official Code of Georgia Annotated, relating to public officers and  
13 employees, so as to provide that the Board of Community Health shall establish certain  
14 health insurance plans for state employees; to provide that the board shall provide for certain  
15 incentives with regard to such plans; to authorize selected out-of-state insurers to offer health  
16 insurance plans in Georgia; to provide for certain notices; to authorize the Commissioner of  
17 Insurance to adopt certain rules and regulations; to amend Chapter 4 of Title 26 of the  
18 Official Code of Georgia Annotated, relating to pharmacists and pharmacies, so as to require  
19 pharmacies to submit certain performance and cost data to the Department of Community  
20 Health; to amend Title 31 of the Official Code of Georgia Annotated, relating to health, so  
21 as to provide for the establishment of a website to provide consumers with information on  
22 the cost and quality of health care in Georgia; to provide for the submission of data elements  
23 from health care facilities and pharmacies; to provide for rules and regulations; to provide  
24 for the establishment of the Georgia Patient Safety Corporation; to provide for its  
25 membership and duties; to provide for the establishment of a central data base of electronic  
26 medical records; to provide for grants, subsidies, and other incentives for certain individuals  
27 to obtain health care coverage; to require health care facilities to submit certain performance  
28 and cost data to the Department of Community Health; to provide that health records are the  
29 property of the patient; to amend Article 1 of Chapter 18 of Title 45 of the Official Code of  
30 Georgia Annotated, relating to the state employees' health insurance plan, so as to provide  
31 incentives for electronic prescribing and electronic submission of claims; to amend Article  
32 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, known as the "Georgia  
33 Medical Assistance Act of 1977," so as to provide incentives for electronic prescribing and  
34 electronic submission of claims; to provide that a health care entity which is not in  
35 compliance with certain data reporting requirements is not eligible to provide Medicaid  
36 services; to provide for related matters; to create the Georgia Health Care Overview  
37 Committee; to provide for its composition, officers, duties, and powers; to provide for

1 cooperation by certain entities with such committee; to provide for certain expenditures of  
 2 funds by such committee; to provide for related matters; to amend Titles 33 and 48 of the  
 3 Official Code of Georgia Annotated, relating, respectively, to insurance and revenue and  
 4 taxation, so as to provide for additional exemptions for certain health plans with respect to  
 5 state and local insurance premium taxes; to provide for related matters; to provide for a sales  
 6 tax exemption for a limited period of time with respect to certain sales of tangible personal  
 7 property or services to a qualified small business; to provide that the taxable net income of  
 8 any taxpayer of this state shall not include premiums paid for high deductible health plans  
 9 established and used with a health savings account; to provide for income tax credits with  
 10 respect to certain qualified health insurance expenses or certain contributions related thereto;  
 11 to provide for an income tax credit with respect to qualified health information technology  
 12 expenses; to provide for procedures, conditions, and limitations; to provide for powers,  
 13 duties, and authority of the state revenue commissioner with respect to the foregoing; to  
 14 provide for the obtaining and maintaining of certain creditable health insurance coverage as  
 15 a condition of claiming certain exemptions and receiving refunds; to provide for alternate  
 16 bonding requirements; to provide for other matters relative to the foregoing; to provide  
 17 effective dates; to provide for applicability; to provide for an automatic repeals under certain  
 18 circumstances; to repeal conflicting laws; and for other purposes.

19 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

20 **PART I.**  
 21 **SECTION 1-1.**

22 This Act shall be known and may be cited as the "Insuring Georgia's Families Act."

23 **PART II.**  
 24 **SECTION 2-1.**

25 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
 26 striking Chapter 51 in its entirety and inserting in lieu thereof a new Chapter 51 to read as  
 27 follows:

28 "Chapter 51

29 33-51-1.

30 This chapter shall be known and may be cited as the 'Georgia Consumer Driven Health  
 31 Insurance Plan.'

1 33-51-2.

2 It is the intent of this chapter to authorize the Commissioner of Insurance to establish  
3 guidelines for plan designs for the development of health insurance products which will be  
4 affordable to Georgians and to increase the availability of health insurance coverage by  
5 encouraging the promotion of these types of plans by accident and sickness insurers  
6 licensed to transact such insurance in this state. It is the intent of this chapter that plan  
7 designs include high deductible health insurance plans as required under the rules of the  
8 federal Internal Revenue Service related to the establishment of health savings accounts.

9 33-51-3.

10 The Commissioner shall develop guidelines for consumer driven health insurance plans  
11 which are designed to qualify under federal and state requirements as high deductible  
12 health insurance plans for use with health savings accounts and which shall include, but  
13 shall not be limited to, nominal copayment provisions, reasonable lifetime benefit  
14 maximums, and choices of deductible amounts and other policy provisions and limits  
15 which comply with federal requirements under the applicable provisions of the federal  
16 Internal Revenue Code for high deductible health insurance plans sold in connection with  
17 health savings accounts.

18 33-51-4.

19 (a) The Commissioner shall be authorized to request information and data from any  
20 available source and to request the assistance of accident and sickness insurers and  
21 providers of health care services in order to develop guidelines for consumer driven health  
22 insurance plans.

23 (b) The Commissioner shall be authorized to encourage and promote the marketing of  
24 consumer driven health insurance plans by accident and sickness insurers in this state.

25 (c) The Commissioner shall be authorized to promulgate such rules and regulations as he  
26 or she deems necessary and appropriate for the design, promotion, and regulation of these  
27 products, including rules and regulations for the expedited review of standardized policies  
28 and rates by insurers, advertisements and solicitations, and other matters deemed relevant  
29 by the Commissioner.

30 33-51-5.

31 (a) Health insurance policies sold under this chapter shall be exempt from any and all  
32 otherwise applicable premium taxes under Code Section 33-8-4.

1 (b) Health insurance policies sold under this chapter shall be exempt from any and all  
 2 otherwise applicable county and municipal taxes under Code Section 33-8-8.1 or 33-8-8.2,  
 3 as applicable, depending on the type of insurer.

4 33-51-6.

5 Policies sold under this chapter may be designed with out of network differentials that  
 6 exceed the normal maximum differential allowed under paragraph (3) of subsection (b) of  
 7 Code Section 33-30-23 or the coinsurance limitation applicable to nonpreferred providers  
 8 under paragraph (4) of subsection (b) of Code Section 33-30-23 so long as the percentage  
 9 reimbursement for nonpreferred providers for out of network benefits is at least 50 percent.

10 33-51-7.

11 (a) Insurers are allowed to include wellness and health promotion programs in policies  
 12 designed and sold under this chapter in keeping with federal requirements under high  
 13 deductible health insurance plans, provided that such programs are approved by the  
 14 Commissioner of Insurance.

15 (b) Insurers which include and operate wellness and health promotion programs in their  
 16 high deductible health insurance policies in keeping with federal requirements shall not be  
 17 considered to be engaging in unfair trade practices under Code Section 33-6-4 with respect  
 18 to references to the practices of illegal inducements, unfair discrimination, or rebating.

19 33-51-8.

20 Effective January 1, 2008, and applicable to all taxable years beginning on and after  
 21 January 1, 2008, health insurance premiums for individuals who purchase qualified policies  
 22 under this chapter shall be fully deductible from the gross income of those individuals on  
 23 Georgia state income tax returns."

24 **PART III.**

25 **SECTION 3-1.**

26 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
 27 revising subsection (b) of Code Section 33-30-23, relating to standards for preferred provider  
 28 arrangements, to read as follows:

29 "(b) Such arrangements shall not:

- 30 (1) Unfairly deny health benefits for medically necessary covered services;  
 31 (2) Have differences in benefit levels payable to preferred providers compared to other  
 32 providers which unfairly deny benefits for covered services;

1 (3) Have differences in coinsurance percentages applicable to benefit levels for services  
 2 provided by preferred and nonpreferred providers which differ by more than ~~30~~ 40  
 3 percentage points;

4 (4) Have a coinsurance percentage applicable to benefit levels for services provided by  
 5 nonpreferred providers which exceeds ~~40~~ 50 percent of the benefit levels under the policy  
 6 for such services;

7 (5) Have an adverse effect on the availability or the quality of services; and

8 (6) Be a result of a negotiation with a primary care physician to become a preferred  
 9 provider unless that physician shall be furnished, beginning on and after January 1, 2001,  
 10 with a schedule showing common office based fees payable for services under that  
 11 arrangement."

12 **PART IV.**

13 **SECTION 4-1.**

14 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
 15 revising paragraph (4) of Code Section 33-30-4, relating to required provisions of group  
 16 accident and sickness policies generally, to read as follows:

17 "(4) A provision that, with respect to termination of benefits for, or coverage of, any  
 18 person who is a dependent child of an insured, the child shall continue to be insured up  
 19 to and including age ~~25~~ 27 or until two years after such child's status as a dependent ends,  
 20 whichever is earlier, so long as the coverage of the member continues in effect; and the  
 21 child remains a dependent of the insured parent or guardian, ~~and the child, in each~~  
 22 ~~calendar year since reaching any age specified for termination of benefits as a dependent,~~  
 23 ~~has been enrolled for five calendar months or more as a full-time student at a~~  
 24 ~~postsecondary institution of higher learning or, if not so enrolled, would have been~~  
 25 ~~eligible to be so enrolled and was prevented from being so enrolled due to illness or~~  
 26 ~~injury.~~ This paragraph shall not apply to group policies under which an employer  
 27 provides coverage for dependents of its employees and pays the entire cost of the  
 28 coverage without any charge to the employee or dependents; and".

29 **SECTION 4-2.**

30 Said title is further amended by revising paragraph (8) of subsection (b) of Code Section  
 31 33-30-6, relating to required provisions of blanket accident and sickness policies, to read as  
 32 follows:

33 "(8) A provision that, with respect to termination of benefits for, or coverage of, any  
 34 person who is a dependent child of an insured, the child shall continue to be insured up

1 to and including age ~~25~~ 27 or until two years after such child's status as a dependent ends,  
 2 whichever is earlier, so long as the coverage of the insured parent or guardian continues  
 3 in effect; and the child remains a dependent of the parent or guardian, ~~and the child, in~~  
 4 ~~each calendar year since reaching any age specified for termination of benefits as a~~  
 5 ~~dependent, has been enrolled for five months or more as a full-time student at a~~  
 6 ~~postsecondary institution of higher learning or, if not so enrolled, would have been~~  
 7 ~~eligible to be so enrolled and was prevented from being so enrolled due to illness or~~  
 8 ~~injury."~~

9 **PART V.**

10 **SECTION 5-1.**

11 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
 12 adding a new Code Section 33-30-16 to read as follows:

13 "33-30-16.

14 (a) Employers who employ persons who are also employed by other employers shall be  
 15 authorized to enter into arrangements with such other employers to provide group health  
 16 insurance coverage for such employees by contributing to the cost of such health care  
 17 insurance provided by such other employers.

18 (b) The commissioner shall promulgate such rules and regulations as necessary to regulate  
 19 and enable such contributions to group health care insurance coverage by additional  
 20 employers of an insured."

21 **PART VI.**

22 **SECTION 6-1.**

23 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
 24 revising subparagraph (b)(15)(D) of Code Section 33-6-4, relating to the enumeration of  
 25 unfair methods of competition and unfair or deceptive acts or practices, to read as follows:

26 "(D) It is unfairly discriminatory to terminate group coverage for a ~~subject of family~~  
 27 ~~violence~~ dependent because coverage was originally issued in the name of the  
 28 ~~perpetrator of the family violence~~ insured and (i) the ~~perpetrator~~ insured has divorced,  
 29 separated from, or lost custody of the ~~subject of family violence, or the perpetrator's~~  
 30 dependent; and (ii) the insured's coverage has terminated voluntarily or involuntarily.  
 31 If termination results from an act or omission of the ~~perpetrator~~ insured, the ~~subject of~~  
 32 ~~family violence~~ dependent shall be deemed a qualifying eligible individual under Code  
 33 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 6-2.**

8 Said title is further amended by revising Code Section 33-24-21.1, relating to group accident  
 9 and sickness contracts, to read 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 Option.'

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.

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

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

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

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

18 (16) 'Limited benefit insurance' means accident and sickness insurance designed,  
19 advertised, and marketed to supplement major medical insurance. The term 'limited  
20 benefit insurance' includes accident only, CHAMPUS supplement, dental, disability  
21 income, fixed indemnity, long-term care, medicare supplement, specified disease, vision,  
22 limited benefit, or credit insurance; coverage issued as a supplement to liability  
23 insurance; insurance arising out of a workers' compensation or similar law; automobile  
24 medical-payment insurance; or insurance under which benefits are payable with or  
25 without regard to fault and which is statutorily required to be contained in any liability  
26 insurance policy or equivalent self-insurance, and includes any other accident and  
27 sickness insurance other than basic hospital expense, basic medical-surgical expense, and  
28 comprehensive major medical insurance coverage.

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

31 (18) '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 (19) '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 (20) '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 (21) 'Physician' means a person licensed to practice medicine in Georgia.

8 (22) 'Plan administrator' means a payor selected by the Georgia Health Security  
9 Underwriting Authority to provide administrative services or accept assignments of  
10 insureds.

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

14 (24) '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 Health Security  
22 Underwriting Authority' which shall be deemed to be a public corporation. The Georgia  
23 Health Security Underwriting Authority shall have perpetual existence, and any change in  
24 the name or composition of the assignment group or Georgia Health Security Underwriting  
25 Authority shall in no way impair the obligations of any contracts existing under this  
26 chapter.

27 (b) The authority shall be governed by a board of directors whose members shall be  
28 appointed as follows:

29 (1) The Commissioner, the Speaker of the House of Representatives, and the Senate  
30 Committee on Assignments shall each appoint two members of the board for staggered  
31 four-year terms. One of the board members appointed by each of the above persons or  
32 officers shall have a two-year initial term and one shall have a four-year initial term as  
33 designated by the person or officer making such appointment at the time of such  
34 appointment. Thereafter, successors to such members shall be appointed to and serve  
35 four-year terms. Such appointees shall be persons affiliated with payors admitted and

1 authorized to write health insurance in this state or who are otherwise familiar with health  
2 insurance matters; and

3 (2) The Governor shall appoint one person representing the medical provider  
4 community, such as a physician licensed to practice medicine in this state, who shall  
5 serve a four-year initial term.

6 (c) The appointed members of the board shall elect one of their own members to serve as  
7 chairperson.

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

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

14 33-29A-4.

15 (a) The initial members of the board of directors of the Georgia Health Security  
16 Underwriting Authority shall submit to the Commissioner a plan of operation for the  
17 assignment group that will assure the fair, reasonable, and equitable administration of the  
18 assignment group.

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

21 (1) Operation of the assignment group;

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

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

24 (4) Handling, accounting, and auditing of money and other assets of the assignment  
25 group;

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

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

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

34 (c) After notice and hearing, the Commissioner shall approve the plan of operation if the  
35 Commissioner determines that the plan is suitable to assure the fair, reasonable, and  
36 equitable administration of the assignment group.

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

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

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

12 33-29A-5.

13 (a) The Georgia Health Security Underwriting Authority is authorized to exercise any of  
14 the authority that a corporation in this state may exercise under the laws of this state.

15 (b) The Georgia Health Security Underwriting Authority shall have the power to:

16 (1) Develop a means, in this chapter referred to as the assignment group, through the  
17 assignment of risks to provide health benefits coverage to persons who are eligible for  
18 that coverage under this chapter;

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

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

25 (4) Institute any legal action necessary to recover any amounts erroneously or improperly  
26 paid by the assignment group, to recover any amounts paid by the assignment group as  
27 a mistake of fact or law, and to recover other amounts due the assignment group;

28 (5) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, and  
29 agents' referral fees and to perform any actuarial function appropriate to the operation of  
30 the assignment group;

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

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

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

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

3 (10) Borrow money as necessary to implement the purposes of the assignment group;  
4 and

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

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

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

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

22 33-29A-6.

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

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

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

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

31 (3) An estimate of total charges for administering the assignment group;

32 (4) A payor's or plan administrator's ability to administer the assignment group in a  
33 cost-efficient manner; and

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

35 (c) The plan administrator shall perform such functions relating to the assignment group  
36 as may be assigned to it, including:

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

3 (2) Performing eligibility and administrative claims payment functions for the  
4 assignment group;

5 (3) Establishing a billing procedure for collection of premiums from persons insured by  
6 the assignment group;

7 (4) Performing functions necessary to assuring timely payment of benefits to persons  
8 covered under the assignment group, including:

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

11 (B) Evaluating the eligibility of each claim for payment by the assignment group;

12 (5) Submitting regular reports to the board relating to the operation of the assignment  
13 group; and

14 (6) Determining after the close of each calendar year the net written and earned  
15 premiums, expenses of administration, and paid and incurred losses of the assignment  
16 group for that calendar year and reporting such information to the board and the  
17 Commissioner on forms prescribed by the Commissioner.

18 33-29A-7.

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

24 33-29A-8.

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

28 (b) The Georgia Health Security Underwriting Authority shall determine the standard risk  
29 rate by considering the premium rates charged by insurers offering health insurance  
30 coverage to individuals. The standard risk rate shall be established using reasonable  
31 actuarial techniques and shall reflect anticipated experience and expenses for such  
32 coverage. The initial assignment group rate may not be less than 125 percent and may not  
33 exceed 200 percent of rates established as applicable for individual standard rates.  
34 Subsequent rates shall be established to provide fully for the expected costs of claims,  
35 including recovery of prior losses, expenses of operation, investment income of claim

1 reserves, and any other cost factors subject to the limitations described in this subsection;  
2 however, in no event shall assignment group rates exceed 200 percent of rates applicable  
3 to individual standard risks.

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

10 (d) No information submitted by an applicant in connection with an application for  
11 insurance under this chapter shall be submitted or released to a medical information bureau.

12 33-29A-9.

13 (a) Any individual person who is and continues to be a legal resident of Georgia as defined  
14 in paragraph (24) of subsection (a) of Code Section 33-29A-2 shall be eligible for coverage  
15 from the assignment group if evidence is provided of:

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

20 (2) A refusal by an insurer to issue insurance except at a rate exceeding the assignment  
21 group rate;

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

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

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

35 (b) Each dependent of a person who is eligible for coverage from the assignment group  
36 shall also be eligible for coverage from the assignment group unless that person is enrolled

1 in or is eligible to enroll in any form of health insurance or insurance arrangement, whether  
2 public or private. In the case of a child who is the primary insured, resident family  
3 members shall also be eligible for coverage if they are the siblings, parents, or guardians  
4 of the child.

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

8 (d) A person is not eligible for coverage from the assignment group if the person:

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

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

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

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

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

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

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

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

28 (7) Has had prior coverage with the assignment group terminated for nonpayment of  
29 premiums or fraud; or

30 (8) Has voluntarily terminated coverage outside the assignment group within six months  
31 of the date that application is made to the assignment group unless the person  
32 demonstrates a good faith reason for the termination. If a person otherwise eligible for  
33 assignment group coverage has declined or terminated COBRA continuation or other  
34 continuation or conversion coverage, except for basic conversion coverage as provided  
35 in subsection (g) of Code Section 33-24-21.1, such person is still eligible to apply for  
36 assignment group coverage, but a preexisting condition exclusion shall apply and last for  
37 a period of 18 months.

- 1 (e) Assignment group coverage shall cease:
- 2 (1) On the date a person is no longer a resident of this state, except for a child who is a  
3 dependent according to provisions of paragraph (3) of subsection (a) of Code Section  
4 33-29-2 or paragraph (4) of Code Section 33-30-4 and who is financially dependent upon  
5 the parent, a child for whom a person may be obligated to pay child support, or a child  
6 of any age who is disabled and dependent upon the parent;
- 7 (2) On the date a person requests coverage to end;
- 8 (3) Upon the death of the covered person;
- 9 (4) On the date state law requires cancellation of the policy;
- 10 (5) At the option of the assignment group, 30 days after the assignment group sends to  
11 the person any inquiry concerning the person's eligibility, including an inquiry  
12 concerning the person's residence, to which the person does not reply;
- 13 (6) On the thirty-first day after the day on which a premium payment for assignment  
14 group coverage becomes due if the payment is not made before that date; or
- 15 (7) At such time as the person ceases to meet the eligibility requirements of this Code  
16 section.
- 17 (f) A person who ceases to meet the eligibility requirements of this Code section may have  
18 his or her coverage terminated by the payor or plan administrator at the end of the policy  
19 period.

20 33-29A-10.

- 21 (a) The assignment group shall offer assignment group coverage consistent with major  
22 medical expense coverage to each eligible person who is not eligible for medicare. The  
23 board, with the approval of the Commissioner, shall establish:
- 24 (1) The coverages to be provided by the assignment group;
- 25 (2) At least two health benefit products to be offered by the assignment group, one of  
26 which shall be a plan utilizing a high deductible health plan (HDHP) that is health  
27 savings account (HSA) eligible and one of which shall be a managed care plan. All  
28 health benefit products offered shall require participation by the insureds in disease and  
29 health management programs and shall provide varying benefits based upon the insureds'  
30 compliance with such programs;
- 31 (3) The applicable schedules of benefits; and
- 32 (4) Any exclusions to coverage and other limitations.
- 33 (b) The benefits provisions of the assignment group's health benefits coverages shall  
34 include the following:
- 35 (1) All required or applicable definitions;
- 36 (2) A list of any exclusions or limitations to coverage;

1 (3) A description of covered services required under the assignment group; and

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

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

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

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

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

28 33-29A-11.

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

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

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

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

11 33-29A-12.

12 (a) Plan administrators shall participate in the assignment group by accepting direct  
13 assignments of eligible individuals for coverage.

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 group along with administrative costs of the  
17 assignment group and plan administrators.

18 (c) The General Assembly shall provide an initial appropriation in order to carry out the  
19 administrative powers and duties of the assignment group.

20 (d) The board, after completing its duties under subsection (b) of this Code section, shall  
21 report to the Governor, the House Committee on Insurance, the Senate Insurance and Labor  
22 Committee, the House Committee on Appropriations, and the Senate Appropriations  
23 Committee the anticipated operational costs for the assignment group in its first two years  
24 of making assignments of risks as provided in this chapter and shall request such  
25 appropriations as may be necessary to carry out the board's duties.

26 (e) The board shall evaluate the impact of tax reduction strategies and incentives, high  
27 deductible health plans, mandatory disease management programs, and other risk-reduction  
28 methodologies in reducing claims and present recommendations to the Governor, the  
29 House Committee on Insurance, the Senate Insurance and Labor Committee, the House  
30 Committee on Appropriations, and the Senate Appropriations Committee for funding the  
31 future operational expenses of the assignment group.

32 (f) The funding mechanism outlined in this Code section shall be modified only by general  
33 law.

34 (g) The board shall have authority to evaluate and apply for all grants and resources, public  
35 and private, for which it may qualify to execute its powers and duties under this chapter,  
36 including, but not limited to, start-up funds for state high risk pools under the federal

1 Deficit Reduction Act of 2005 or related legislation to extend such funding and funds as  
2 they are available for expansion of coverage to persons eligible for federal health coverage  
3 tax credits.

4 (h) If any source of funding for the assignment group should cease, the board is authorized  
5 to take actions including, but not limited to, implementing a moratorium on enrollment of  
6 nonfederally eligible individuals, ceding assignment or conversion of coverage to federally  
7 eligible individuals to currently operating federally approved programs, and taking ratings  
8 and benefit design actions not otherwise prohibited by law to preserve the financial  
9 integrity of the assignment group and its plan administrators."

10  
11 33-29A-13.

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

18 33-29A-14.

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

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

24 33-29A-15.

25 Until December 31, 2007, or such time as the assignment group is able to issue coverage  
26 to eligible individuals, whichever occurs later, and notwithstanding other changes in law  
27 contained in this chapter, persons eligible as a result of the federal Health Insurance  
28 Portability and Accountability Act of 1996, P. L. 104-191, shall continue to be issued  
29 health insurance coverage through this state's 'Georgia Health Insurance Assignment  
30 System,' 'Georgia Health Benefits Assignment System,' or 'Enhanced Conversion Options'  
31 under rules and procedures established under this chapter or under Code Section  
32 33-24-21.1 prior to July 1, 2007.

1 33-29A-16.

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

4 **SECTION 6-4.**

5 Said title is further amended by revising paragraph (2) of subsection (b) of Code Section  
6 33-30-15, relating to continuation of similar coverage, to read as follows:

7 "(2) Once such creditable coverage terminates, including termination of such creditable  
8 coverage after any period of continuation of coverage required under Code Section  
9 33-24-21.1 or the provisions of Title X of the Omnibus Budget Reconciliation Act of  
10 1986, the insurer must ~~offer a conversion policy~~ provide notice of eligibility for coverage  
11 under the state's alternative mechanism for the availability of individual health insurance  
12 coverage as provided under Chapter 29A of this title, as contemplated by Section 2741  
13 of the federal Public Health Service Act, 42 U.S.C. Section 300gg-41, to the eligible  
14 employee, member, subscriber, enrollee, or dependent."

15 **SECTION 6-5.**

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

18 **PART VII.**

19 **SECTION 7-1.**

20 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
21 adding a new Chapter 62 to read as follows:

22 **"CHAPTER 62**

23 33-62-1.

24 As used in this chapter, the term:

25 (1) 'Applicant' means an individual seeking to participate in the Georgia Health  
26 Insurance Exchange.

27 (2) 'Carrier' means any person or organization subject to the authority of the  
28 Commissioner that provides one or more health benefit plans or insurance in this state  
29 and includes an insurer, a hospital and medical services corporation, a fraternal benefit  
30 society, a health maintenance organization, and a multiple employer welfare arrangement.

1 (3) 'COBRA' means the Consolidated Omnibus Budget Reconciliation Act of 1985,  
2 approved April 7, 1986 (100 Stat. 231; 29 U.S.C. Section 1161, et seq.).

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

4 (5) 'Creditable coverage' means continual coverage of the applicant under any of the  
5 following health plans with no lapse in coverage of more than 63 days immediately prior  
6 to the date of application:

7 (A) A group health plan;

8 (B) Health insurance coverage;

9 (C) Part A or Part B of Title XVIII of the Social Security Act, approved July 30, 1965  
10 (79 Stat. 291; 42 U.S.C. Section 1395c, et seq.; or 42 U.S.C. Section 1395j, et seq.,  
11 respectively);

12 (D) Title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 291; 42  
13 U.S.C. Section 1396, et seq.), other than coverage consisting solely of benefits under  
14 Section 1928;

15 (E) Chapter 55 of Title 10 of the United States Code (10 U.S.C. Section 1071, et seq.);

16 (F) A medical care program of the Indian Health Service or of a tribal organization;

17 (G) A state health benefits risk pool;

18 (H) A health plan offered under Chapter 89 of Title 5 of the United States Code (5  
19 U.S.C. Section 8901, et seq.);

20 (I) A public health plan (as defined in federal or state regulation);

21 (J) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.  
22 Section 2504(e)); or

23 (K) Any other qualifying coverage required by HIPAA, as it may be amended, or  
24 regulations under that Act.

25 Creditable coverage does not include coverage consisting solely of coverage of excepted  
26 benefits.

27 (6) 'Dependent' means:

28 (A) The spouse of the principal insured; or

29 (B)(i) An individual who is related to the principal insured by birth, marriage, or  
30 adoption; and

31 (ii) Who also meets the definition of a dependent as set forth in the United States  
32 Internal Revenue Code (26 U.S.C. Section 152).

33 (7) 'Eligible individual' means an individual who is eligible to participate in the Georgia  
34 Health Insurance Exchange by reason of meeting one or more of the following  
35 qualifications:

36 (A) The individual is a Georgia resident, meaning that the individual is and continues  
37 to be legally domiciled and physically residing on a permanent and full-time basis in

1 a place of permanent habitation in Georgia that remains the person's principal residence  
2 and from which the person is absent only for temporary or transitory purposes. A  
3 person who is a full-time student attending an institution outside of Georgia may  
4 maintain his or her Georgia residency.

5 (B) The individual is not a Georgia resident but is employed, at least 20 hours a week  
6 on a regular basis, at a Georgia location by a bona fide employer, and the individual's  
7 employer does not offer a group health insurance plan, or the individual is not eligible  
8 to participate in any group health insurance plan offered by the individual's employer;

9 (C) The individual, whether a resident or not, is enrolled in, or eligible to enroll in, a  
10 participating employer plan;

11 (D) The individual is self-employed in Georgia and, if a nonresident self-employed  
12 individual, the individual's principal place of business is in Georgia;

13 (E) The individual is a full-time student attending an institution of higher education  
14 located in Georgia; or

15 (F) The individual, whether a resident or not, is a dependent of another individual who  
16 is an eligible individual.

17 (8) 'Employer' means any individual, partnership, association, corporation, business trust,  
18 or person or group of persons employing one or more persons and filing payroll tax  
19 information on such person or persons.

20 (9) 'Excepted benefits' means coverage such as Medicare Supplement Insurance;  
21 specified disease insurance; dental only or vision only insurance; accident only insurance;  
22 hospital confinement indemnity coverage; coverage issued as a supplement to liability  
23 insurance; long-term care insurance; workers compensation insurance; loss of income  
24 insurance; coverage for medical expenses included as part of any auto, property, casualty  
25 or other liability insurance; and credit or disability insurance.

26 (10) 'Exchange' means the Georgia Health Insurance Exchange established by this  
27 chapter.

28 (11) 'Federal health coverage tax credit eligible individual' means any individual who is  
29 eligible for benefits under section 201 of the Trade Act of 2002, approved August 6, 2002  
30 (116 Stat. 933; 26 U.S.C. Section 35(c) (2003)), as amended.

31 (12) 'HIPAA' means the Health Insurance Portability and Accountability Act of 1996,  
32 approved August 21, 1996 (Pub. L. 104-191; 110 Stat. 1136).

33 (13) 'Participating employer plan' means a group health plan, as defined in federal law  
34 (Section 706 of ERISA (29 U.S.C. Section 1186)), that is sponsored by an employer and  
35 for which the plan sponsor has entered into an agreement with the Georgia Health  
36 Insurance Exchange, in accordance with the provisions of Code Section 33-62-11, for the

1 Georgia Health Insurance Exchange to offer and administer health insurance benefits for  
2 enrollees in the plan.

3 (14) 'Participating individual' means a person who has been determined by the Georgia  
4 Health Insurance Exchange to be, and continues to remain, an eligible individual for  
5 purposes of obtaining coverage under participating insurance plans offered through the  
6 Georgia Health Insurance Exchange.

7 (15) 'Participating insurance plan' means a health benefit plan offered through the  
8 Georgia Health Insurance Exchange.

9 (16) 'Plan year' means the period of time during which the insured is covered under a  
10 health benefit plan, as stipulated in the contract governing the plan.

11 (17) 'Preexisting conditions provision' means a provision in a health benefit plan that  
12 limits, denies, or excludes benefits for a period of time for an enrollee for expenses or  
13 services related to a medical condition that was present before the date the coverage  
14 commenced, whether or not any medical advice, diagnosis, care, or treatment was  
15 recommended or received before that date. The time period for a preexisting conditions  
16 provision begins when an application for insurance is made or when an applicant is in a  
17 waiting period for coverage under any plan. Genetic information shall not be treated as  
18 a preexisting condition in the absence of a diagnosis of the condition related to such  
19 information.

20 (18) 'Producer' means a person required to be licensed in Georgia to sell, solicit, or  
21 negotiate insurance.

22 (19) 'Rate' means the premiums or fees charged by a health benefit plan for coverage  
23 under the plan.

24 (20) 'Self-funded health benefit plan' means a health insurance plan, not subject to  
25 regulation by this state or any other state, that is paid in whole or in part by the employer  
26 from its own assets or from a funded welfare benefit plan, provided that such plan does  
27 not shift any risk or liability for benefit payments to an insurer or other carrier other than  
28 through reinsurance or stop-loss coverage.

29 33-62-2.

30 (a) There is hereby chartered and established by the State of Georgia the Georgia Health  
31 Insurance Exchange as a body corporate and an independent instrumentality of the State  
32 of Georgia, created to effectuate public purposes provided for in this chapter, but with a  
33 legal existence separate from that of the State of Georgia.

34 (b) The Georgia Health Insurance Exchange is hereby recognized as a not for profit  
35 corporation in accordance with the provisions of the laws of Georgia and shall seek

1 recognition of the same status by the United States in accordance with the provisions of the  
2 United States Internal Revenue Code (26 U.S.C. Section 501(c)).

3 (c) The Georgia Health Insurance Exchange is created for the limited purpose of providing  
4 the residents of Georgia, and such other individuals as may, from time to time, also be  
5 eligible to participate, with greater access to, and choice and portability of, health insurance  
6 products.

7 (d) The Georgia Health Insurance Exchange shall operate in accordance with all  
8 requirements and restrictions set forth in this chapter and all other applicable laws of  
9 Georgia and the United States.

10 (e) All eligible individuals shall be permitted to obtain health insurance benefits through  
11 the Georgia Health Insurance Exchange, subject to the provisions of this chapter.

12 33-62-3.

13 (a) The exchange shall be governed by a board of directors. The board of directors shall  
14 consist of three members appointed by the Governor, three members appointed by the  
15 Senate Committee on Assignments, and three members appointed by the Speaker of the  
16 House of Representatives. The initial appointees to the board of directors shall be  
17 appointed to terms of office beginning July 1, 2007. Each appointing authority shall  
18 designate one of the authority's initial appointees to serve a term of office ending on  
19 June 30, 2009; one appointee to serve a term of office ending on June 30, 2010; and one  
20 appointee to serve a term of office ending on June 30, 2011. Thereafter, successors shall  
21 be appointed by the appropriate appointing authority for three-year terms of office  
22 beginning on July 1 following the expiration of the previous member's term of office and  
23 ending on June 30 three years later.

24 (b) Vacancies on the board of directors shall be filled by appointment by the appropriate  
25 appointing authority for the unexpired term of office. Members shall be eligible to succeed  
26 themselves in office.

27 (c) The board of directors shall at its initial meeting and the first meeting of each calendar  
28 year thereafter select from among its members a chairperson and a vice chairperson. The  
29 board of directors shall also select at the same times a secretary who shall not be required  
30 to be a member of the board of directors.

31 (d) The board of directors shall appoint an exchange director, who shall:

- 32 (1) Be a full-time employee of the Georgia Health Insurance Exchange;
  - 33 (2) Administer all of the Georgia Health Insurance Exchange's activities and contracts;
  - 34 (3) Supervise the staff of the Georgia Health Insurance Exchange; and
  - 35 (4) Perform such other functions and duties as directed by the board of directors
- 36 consistent with this chapter.

1 (e) The exchange director shall serve at the pleasure of the board of directors.

2 (f) The board of directors shall be authorized to employ staff and other professionals to  
3 assist the board in carrying out the provisions of this chapter.

4 33-62-4.

5 (a) The exchange shall:

6 (1) Publicize the existence of the exchange and disseminate information on eligibility  
7 requirements and enrollment procedures for the exchange;

8 (2) Establish and administer procedures for enrolling eligible individuals in the  
9 exchange, including:

10 (A) Creating a standard application form to collect information necessary to determine  
11 the eligibility and previous coverage history of an applicant; and

12 (B) Preparing and distributing certificate of eligibility forms and application forms to  
13 insurance producers and the general public;

14 (3) Establish and administer a website at which individuals can examine the various  
15 health insurance options available to them and which contains a program or programs  
16 designed to assist individuals, after inputting basic information about themselves and any  
17 covered dependents, in determining the cost of the various health insurance options  
18 available to them and which health insurance options provide the best coverages at the  
19 least cost for the individuals;

20 (4) Establish and administer procedures for the election of coverage by participating  
21 individuals, in accordance with Code Section 33-62-6, during open season periods and  
22 outside of open season periods upon the occurrence of any qualifying event specified in  
23 subsection (d) of Code Section 33-62-6, including preparing and distributing to  
24 participating individuals:

25 (A) Descriptions of the coverage, benefits, limitations, copayments, and premiums for  
26 all participating plans; and

27 (B) Forms and instructions for electing coverage and arranging payment for coverage;

28 (5) Collect and transmit to the applicable participating plans all premium payments or  
29 contributions made by or on behalf of participating individuals, including developing  
30 mechanisms to:

31 (A) Receive and process automatic payroll deductions for participating individuals  
32 enrolled in participating employer plans;

33 (B) Enable participating individuals to pay, in whole or part, for coverage through the  
34 exchange by electing to assign to the exchange any federal earned income tax credit  
35 payments due the participating individual; and

- 1 (C) Receive and process any federal or state tax credits or other premium support  
 2 payments for health insurance as may be established by law;
- 3 (6) Upon request, issue certificates of previous coverage in accordance with the  
 4 provisions of HIPAA to all such individuals who cease to be covered by a participating  
 5 insurance plan;
- 6 (7) Establish procedures to account for all funds received and disbursed by the exchange,  
 7 including:
- 8 (A) Maintaining a separate, segregated management account for the receipt and  
 9 disbursement of monies allocated to fund the administration of the exchange; and
- 10 (B) Maintaining a separate, segregated operations account for:
- 11 (i) The receipt of all premium payments or contributions made by or on behalf of  
 12 participating individuals; and
- 13 (ii) The distribution of premium payments to participating plans and of commissions  
 14 or payments to licensed insurance producers and such other organizations as are  
 15 permitted under Code Section 33-62-12 to receive payments for their services in  
 16 enrolling eligible individuals or groups in the exchange; and
- 17 (8) Submit to the Commissioner, following the end of each plan year, the report of an  
 18 independent audit of the exchange's accounts for the plan year.

19 33-62-5.

20 The exchange shall have the power to:

- 21 (1) Contract with vendors to perform one or more of the functions specified in Code  
 22 Section 33-62-4;
- 23 (2) Contract with private or public social service agencies to administer application,  
 24 eligibility verification, enrollment, and premium payments for specified groups or  
 25 populations of eligible individuals or participating individuals;
- 26 (3) Contract with employers to act as the plan administrator for participating employer  
 27 plans, subject to the provisions of Code Section 33-62-11, and to undertake the  
 28 obligations required by federal law of a plan administrator;
- 29 (4) Set and collect fees from participating individuals, participating employer plans, and  
 30 participating insurance plans sufficient to fund the cost of administering the exchange;
- 31 (5) Seek and directly receive grant funding from the United States government,  
 32 departments or agencies of this state, county or municipal governments, or private  
 33 philanthropic organizations to defray the costs of operating the exchange;
- 34 (6) Establish and administer rules and procedures governing the operations of the  
 35 exchange;
- 36 (7) Establish one or more service centers within this state to facilitate enrollment;

1 (8) Sue and be sued or otherwise take any necessary or proper legal action; and

2 (9) Establish bank accounts and borrow money.

3 33-62-6.

4 (a) Any eligible individual may apply to participate in the exchange. An employer; a labor  
5 union; and an educational, professional, civic, trade, church, or social organization that has  
6 eligible individuals as employees or members may apply on behalf of those eligible  
7 persons. Upon determination by the exchange that an individual is eligible in accordance  
8 with the provisions of this chapter to participate in the exchange, he or she may enroll, or,  
9 when applicable, be enrolled by that individual's parent or legal guardian, in a participating  
10 insurance plan offered through the exchange during the next open season period or, when  
11 applicable, at such other times as are specified in subsection (d) of this Code section.

12 (b) From November 1 to November 30 of each year, the exchange shall administer an open  
13 season during which any eligible individual may enroll in any health benefit plan offered  
14 through the exchange, subject to the provisions of Code Section 33-62-8, without a waiting  
15 period, and may not be declined coverage.

16 (c) The first 90 days after the exchange begins to accept applications shall be considered  
17 the initial open season.

18 (d) An eligible individual may enroll in a health benefit plan offered through the exchange,  
19 subject to the provisions of Code Section 33-62-8, without a waiting period, and may not  
20 be declined coverage, at a time other than the annual open season for any of the following  
21 reasons, provided the individual does so within 63 days of the triggering event:

22 (1) The individual loses coverage in an existing health insurance plan due to the death  
23 of a spouse, parent, or legal guardian;

24 (2) The individual or a covered dependent loses coverage in an existing health insurance  
25 plan due to a change in the individual's employment status;

26 (3) The individual or a covered dependent loses coverage in an existing health insurance  
27 plan because of a divorce, separation, or other change in familial status;

28 (4) The individual loses coverage in an existing health insurance plan because he or she  
29 achieves an age at which coverage lapses under that plan;

30 (5) The individual or a covered dependent becomes newly eligible by becoming a  
31 resident of Georgia or the individual's place of employment has been changed to  
32 Georgia;

33 (6) The individual becomes newly eligible by becoming the spouse or dependent, by  
34 reason of birth, adoption, court order, or a change in custody arrangement, of an eligible  
35 individual;

1 (7) The individual becomes subject to a court order requiring him or her to provide  
2 health insurance coverage to certain dependents or enters into a new arrangement for the  
3 custody of dependents that requires him or her to provide health insurance for those  
4 dependents; or

5 (8) The individual loses coverage in a plan offered through the exchange by reason of  
6 the plan terminating participation in the exchange prior to the end of the plan year.

7 33-62-7.

8 (a) No health benefit plan may be offered through the exchange unless the Commissioner  
9 has first certified to the exchange that:

10 (1) The carrier seeking to offer the plan is licensed to issue health insurance in this state  
11 and is in good standing; and

12 (2) The plan meets the requirements of this Code section, and the plan and the carrier are  
13 in compliance with all other applicable health insurance laws of this state.

14 (b) No plan shall be certified that excludes from coverage any individual otherwise  
15 determined by the exchange as meeting the eligibility requirements for participating  
16 individuals.

17 (c) The certification of plans to be offered through the exchange shall not be subject to any  
18 state law requiring competitive bidding.

19 (d) Each certification shall be valid for a uniform term of at least one year but may be  
20 made automatically renewable from term to term in the absence of notice of either:

21 (1) Withdrawal by the Commissioner; or

22 (2) Discontinuation of participation in the exchange by the plan or carrier.

23 (e) Certification of a plan may be withdrawn only after notice to the carrier and  
24 opportunity for hearing. The Commissioner may, however, decline to renew the  
25 certification of any carrier at the end of a certification term.

26 (f) Each plan certified by the Commissioner as eligible to be offered through the exchange  
27 shall contain a detailed description of benefits offered, including maximums, limitations,  
28 exclusions, and other benefit limits.

29 (g) Each plan certified by the Commissioner as eligible to be offered through the exchange  
30 shall provide, subject to the plan's deductibles and coinsurance or copayment schedule,  
31 major medical coverage that includes the following:

32 (1) Hospital benefits;

33 (2) Surgical benefits;

34 (3) In-hospital medical benefits;

35 (4) Ambulatory patient benefits;

36 (5) Prescription drug benefits; and

1 (6) Mental health benefits.

2 (h) Carriers shall offer plans through the exchange at standard rates based on age,  
3 geography, and family composition and that are determined to be actuarially sound in the  
4 judgment of the Commissioner.

5 (i) The rates determined for the first plan year for which the plan is offered through the  
6 exchange may be adjusted by the carrier for subsequent plan years based on experience and  
7 any later modifications to plan benefits, provided that any adjustments in rates shall be  
8 made in advance of the plan year for which they will apply and on a basis which, in the  
9 judgment of the Commissioner, is consistent with the general practice of carriers that issue  
10 health benefit plans to large employers.

11 (j) The exchange shall not decline or refuse to offer, or otherwise restrict the offering to  
12 any participating individual, any plan that has obtained, in a timely fashion in advance of  
13 the annual open season, certification by the Commissioner in accordance with the  
14 provisions of this Code section.

15 (k) The Exchange shall not sponsor any insurance or benefit plan, or contract with any  
16 carrier to offer any insurance or benefit plan, as a participating plan that has not first been  
17 certified by the Commissioner in accordance with the provisions of this Code section.

18 (l) The exchange shall not impose on any participating plan, or on any carrier or plan  
19 seeking to participate in the exchange, any terms or conditions, including any requirements  
20 or agreements with respect to rates or benefits beyond, or in addition to, those terms and  
21 conditions established and imposed by the Commissioner in certifying plans under the  
22 provisions of this Code section.

23 (m) The Commissioner shall establish and administer regulations and procedures for  
24 certifying plans to participate in the exchange in accordance with the provisions of this  
25 Code section.

26 33-62-8.

27 The following rules shall govern the imposition by carriers of any preexisting condition  
28 provisions and rating surcharges with respect to any participating individual covered by  
29 any participating insurance plan:

30 (1) *Current participants.* Except as otherwise specified in paragraphs (3) and (4) of this  
31 Code section, during any open season, a participating individual who elects to choose a  
32 different participating insurance plan or plan option for the next plan year shall not be  
33 subject to any preexisting condition provisions and shall be charged the standard rate of  
34 the new participating insurance plan or plan option for persons of the participating  
35 individual's age and geographic area, and the same criteria shall apply to any election by

1 a participating individual of coverage for any dependent who is also a participating  
2 individual;

3 (2) *New participants with creditable coverage.* A new participating individual with 18  
4 or more months of creditable coverage who enrolls in a participating insurance plan shall  
5 not be subject to any preexisting condition provisions and shall be charged the applicable  
6 age and geography adjusted standard rate for the participating insurance plan;

7 (3) *New participants with partial creditable coverage.* A new participating individual  
8 with creditable coverage of between two and 17 months may enroll in a participating  
9 insurance plan, but the participating individual may be subject to one or more preexisting  
10 condition provisions, for a period not to exceed 12 months, the number of such months  
11 to be reduced by the number of months of creditable coverage, or may be charged a  
12 premium not to exceed 125 percent of the otherwise applicable age and geography  
13 adjusted standard rate for the participating insurance plan, or both, and any such rate  
14 surcharge shall not be applied during the third or subsequent years of the individual's  
15 enrollment in any participating insurance plan;

16 (4) *New participants without creditable coverage.* A new participating individual with  
17 two months or less of creditable coverage may enroll in a participating insurance plan,  
18 but the participating individual may be subject to one or more preexisting condition  
19 provisions, for a period not to exceed 12 months, the number of such months to be  
20 reduced by the number of months of creditable coverage, or may be charged a premium  
21 not to exceed 150 percent of the otherwise applicable age and geography adjusted  
22 standard rate for the participating insurance plan, or both, and any such rate surcharge  
23 shall not be applied during the third or subsequent years of the individual's enrollment  
24 in any participating insurance plan;

25 (5) *Newly eligible dependents.* In cases where an individual is enrolled in a plan offered  
26 through the exchange as a newly eligible dependent of a participating individual by  
27 reason of birth, adoption, court order, or a change in custody arrangement, either during  
28 open season or outside of open season in accordance with paragraph (6) of subsection (d)  
29 of Code Section 33-62-6, a carrier shall not impose any preexisting condition provisions  
30 or any change in the rate charged to the participating individual, except for such  
31 difference, if any, in the participating insurance plan's standard rates that reflect the  
32 addition of a new dependent to the participating individual's coverage;

33 (6) *Creditable coverage.* Periods of creditable coverage with respect to an individual  
34 shall be established through presentation of certifications or in such other manner as may  
35 be specified in federal or state law;

36 (7) *Waiver of preexisting condition exclusion.* For new participating individuals without  
37 creditable coverage, or with only limited creditable coverage as defined in paragraphs (3)

1 and (4) of this Code section, a carrier may elect to waive the imposition of preexisting  
 2 condition provisions and instead extend the applicable rate surcharge for an additional  
 3 year beyond the time provided for in those paragraphs; and

4 (8) *Federal health coverage tax credit eligible individuals*. For purposes of this Code  
 5 section, any federal health coverage tax credit eligible individual shall be deemed to have  
 6 18 months of creditable coverage.

7 33-62-9.

8 (a) Any participating individual may continue to participate in any participating insurance  
 9 plan as long as the individual remains an eligible individual, subject to the carrier's rules  
 10 regarding cancellation for nonpayment of premiums or fraud, and shall not be cancelled or  
 11 nonrenewed because of any change in employer or employment status, marital status,  
 12 health status, age, membership in any organization, or other change that does not affect  
 13 eligibility as defined in this chapter.

14 (b) A participating individual who is not a resident of this state and who ceases to be an  
 15 eligible individual due to a qualifying event shall be deemed to remain an eligible  
 16 individual and shall be deemed to remain a participating individual for a period not to  
 17 exceed 36 months from the date of the qualifying event if:

18 (1) The qualifying event consists of a loss of eligible individual status due to:

19 (A) Voluntary or involuntary termination of employment for reasons other than gross  
 20 misconduct; or

21 (B) Loss of qualified dependent status for any reason; and

22 (2) The participating individual elects to remain a participating individual and notifies  
 23 the exchange of such election within 63 days of the qualifying event.

24 33-62-10.

25 (a) The Commissioner shall establish procedures for resolving disputes arising from the  
 26 operation of the exchange in accordance with the provisions of this chapter, including  
 27 disputes with respect to:

28 (1) The eligibility of an individual to participate in the exchange;

29 (2) The imposition of a coverage surcharge on a participating individual by a  
 30 participating plan; and

31 (3) The imposition of a preexisting condition provision on a participating individual by  
 32 a participating plan.

33 (b) In cases where a carrier, in accordance with the provisions of this chapter, imposes a  
 34 preexisting condition exclusion or a premium surcharge in connection with enrollment of  
 35 a participating individual in a participating insurance plan offered by the carrier, and the

1 participating individual disputes the imposition of such an exclusion or surcharge, the  
2 participating individual may request that the Commissioner issue a determination as to the  
3 validity or extent of such exclusion or surcharge under the provisions of this chapter. The  
4 Commissioner, or his or her designee, shall issue such a determination within 30 days of  
5 the request being filed with the Department of Insurance. If either the participating  
6 individual or the carrier disagrees with the outcome, he or she may submit a request for a  
7 hearing to the Commissioner in accordance with Chapter 13 of Title 50.

8 33-62-11.

9 (a) Any employer may apply to the exchange to be the sponsor of a participating employer  
10 plan.

11 (b) Any employer seeking to be the sponsor of a participating employer plan shall, as a  
12 condition of participation in the exchange, enter into a binding agreement with the  
13 exchange, which shall include the following conditions:

14 (1) The sponsoring employer designates the exchange director to be the plan's  
15 administrator for the employer's group health plan, and the exchange director agrees to  
16 undertake the obligations required of a plan administrator under federal law;

17 (2) Only the coverage and benefits offered by participating insurance plans shall  
18 constitute the coverage and benefits of the participating employer plan;

19 (3) Any individuals eligible to participate in the exchange by reason of their eligibility  
20 for coverage under the employer's participating employer plan, regardless of whether any  
21 such individuals would otherwise qualify as eligible individuals if not enrolled in the  
22 participating employer plan, may elect coverage under any participating insurance plan,  
23 and neither the employer nor the exchange shall limit such individuals' choice of  
24 coverage from among all the participating insurance plans;

25 (4) The employer reserves the right to offer benefits supplemental to the benefits offered  
26 through the exchange, but any supplemental benefits offered by the employer shall  
27 constitute a separate plan or plans under federal law for which the exchange director shall  
28 not be the plan administrator and for which neither the exchange director nor the  
29 exchange shall be responsible in any manner;

30 (5) The employer agrees that, for the term of the agreement, the employer will not offer  
31 to individuals eligible to participate in the exchange by reason of their eligibility for  
32 coverage under the employer's participating employer plan any separate or competing  
33 group health plan offering the same or substantially similar benefits as those provided by  
34 participating insurance plans through the exchange, regardless of whether any such  
35 individuals would otherwise qualify as eligible individuals if not enrolled in the  
36 participating employer plan;

1 (6) The employer reserves the right to determine the criteria for eligibility, enrollment,  
2 and participation in the participating employer plan and the terms and amounts of the  
3 employer's contributions to that plan, so long as for the term of the agreement with the  
4 exchange, the employer agrees not to alter or amend any criteria or contribution amounts  
5 at any time other than during an annual period designated by the exchange for  
6 participating employer plans to make such changes in conjunction with the exchange's  
7 annual open season;

8 (7) The employer agrees to make available to the exchange any of the employer's  
9 documents, records, or information, including copies of the employer's federal and state  
10 tax and wage reports, that the Commissioner reasonably determines are necessary for the  
11 exchange to verify:

12 (A) That the employer is in compliance with the terms of its agreement with the  
13 Exchange governing the employer's sponsorship of a participating employer plan;

14 (B) That the participating employer plan is in compliance with applicable laws relating  
15 to employee welfare benefit plans, particularly those relating to nondiscrimination in  
16 coverage; and

17 (C) The eligibility, under the terms of the employer's plan, of those individuals  
18 enrolled in the participating employer plan; and

19 (8) The employer agrees to also sponsor a 'cafeteria plan' as permitted under federal law  
20 (26 U.S.C. Section 125) for all employees eligible for coverage under the employer's  
21 participating employer plan.

22 (c) The exchange may not enter into any agreement with any employer with respect to any  
23 employer participating plan if such agreement does not, at a minimum, incorporate the  
24 conditions specified in subsection (b) of this Code section.

25 (d) The exchange may not enter into any agreement with any employer with respect to any  
26 participating employer plan to provide the participating employer plan with any additional  
27 or different services or benefits not otherwise provided or offered to all other participating  
28 employer plans.

29 (e) Beginning with the first plan year following the establishment of the exchange, the  
30 State of Georgia through the Department of Community Health shall enter into an  
31 agreement with the exchange to be the sponsor of a participating employer plan on behalf  
32 of any person eligible for health insurance benefits paid in whole or in part by the State of  
33 Georgia by reason of current or past employment by the state or by reason of being a  
34 dependent of such person.

1 33-62-12.

2 (a) In cases when a producer licensed in this state enrolls an eligible individual or group  
3 in the exchange, the plan chosen by each individual shall pay the producer a commission  
4 on premium either in an amount determined by the board of directors of the exchange or  
5 in the amount or amounts voluntarily agreed to by the various carriers and producers.

6 (b) In cases when a membership organization enrolls its eligible members, or the eligible  
7 members of its member entities, in the exchange, the plan chosen by each individual shall  
8 pay the organization a fee equal to the commission specified in subsection (a) of this Code  
9 section. Nothing in this Code section shall be deemed either to require a membership  
10 organization that enrolls persons in the exchange to be licensed by this state as an insurance  
11 producer or to permit such an organization to provide any other services requiring licensure  
12 as an insurance producer without first obtaining such license.

13 33-62-13.

14 (a) Each employer in the State of Georgia shall annually file with the Commissioner a  
15 form for each employee employed within this state indicating the health insurance coverage  
16 status of the employee and the employee's dependents, including the source of coverage  
17 and the name of the insurer or plan sponsor, and, if no coverage is indicated:

18 (1) The employee's election, in lieu of insurance coverage, to post a bond or establish  
19 an account in accordance with Code Section 33-66-15;

20 (2) The employee's election to apply or not apply for coverage through the exchange;  
21 and

22 (3) The employee's election to be considered or not to be considered for any publicly  
23 financed health insurance program or premium subsidy program administered by this  
24 state.

25 (b) Each form shall be signed by the individual to whom it pertains.

26 (c) Each self-employed individual in this state shall annually file the same form with the  
27 Commissioner.

28 (d) The commissioner of human resources shall annually file the same form with the  
29 Commissioner of Insurance on behalf of all individuals receiving benefits under the  
30 Medicaid and PeachCare programs, excepting such individuals who are also covered by  
31 Part A or Part B of Title XVIII of the federal Social Security Act (79 Stat. 291; 42 U.S.C.  
32 Section 1395c, et seq., or 1395j, et seq., respectively).

33 (e) For purposes of this Code section, health insurance coverage shall not include any  
34 coverage consisting solely of one or more excepted benefits.

35 (f) The Commissioner shall prepare and distribute such forms.

1 33-62-14.

2 (a) A carrier shall not issue or renew an individual health benefit plan, other than through  
3 the exchange established under Code Section 33-62-2, after the first day of the plan year  
4 following the first regular open season conducted by the exchange in accordance with Code  
5 Section 33-62-6.

6 (b) A carrier shall not issue or renew a group health benefit plan to a small employer with  
7 50 or fewer employees, other than through the exchange established under Code  
8 Section 33-62-2, after the first day of the plan year following the first regular open season  
9 conducted by the exchange in accordance with Code Section 33-62-6.

10 (c) Subsections (a) and (b) of this Code section shall not apply to any health benefit plan  
11 that consists solely of one or more excepted benefits.

12 33-62-15.

13 (a) Effective January 1, 2008, the following individuals who are over the age of 18 and  
14 have not yet attained the age of 65 and whose annual gross income exceeds 300 percent of  
15 the federal poverty level for the immediately preceding calendar year shall offer proof of  
16 their ability to pay for medical care for themselves and their dependents:

17 (1) Residents of Georgia; or

18 (2) Within 63 days of establishing residency, individuals who become residents of  
19 Georgia.

20 (b) Individuals subject to the requirement in subsection (a) of this Code section shall be  
21 deemed to be in compliance with said requirement if they:

22 (1) Indicated coverage under any health benefit plan in accordance with Code  
23 Section 33-62-13;

24 (2) Demonstrate proof of financial security in accordance with subsection (c) of this  
25 Code section; or

26 (3) Demonstrate proof of coverage under a high deductible major medical health  
27 insurance plan.

28 (c) Pursuant to paragraph (2) of subsection (b) of this Code Section, individuals electing  
29 to demonstrate proof of financial security to pay for medical expenditures shall present to  
30 the commissioner of revenue a bond in the amount of \$10,000.00 or shall deposit with the  
31 commissioner of revenue \$10,000.00 in an escrow account that shall bear interest at a rate  
32 established by the commissioner of revenue.

33 (d) If, in any calendar year, an individual subject to the requirement in subsection (a) of  
34 this Code section fails to comply with said requirement, the commissioner of revenue shall  
35 establish an escrow account in the name of said individual and:

1 (1) Shall retain and deposit in said account all such funds as may be owed to said  
2 individual by the State of Georgia, including, but not limited to, any overpayment by said  
3 individual of any taxes imposed by the State of Georgia;

4 (2) Shall obtain an order for the attachment of the wages of said individual to satisfy the  
5 requirements of this Code section; or

6 (3) Both paragraphs (1) and (2) of this subsection.

7 (e) With respect to any escrow account established in accordance with this Code section,  
8 either by reason of an individual making the election specified in subsection (c) of this  
9 Code section or by reason of an individual being subject to subsection (d) of this Code  
10 section:

11 (1) The amount deposited, retained, or collected shall not exceed \$10,000.00 in the  
12 aggregate for any such individual;

13 (2) Nothing in this Code section shall be construed to authorize the commissioner of  
14 revenue to retain any amount for such purposes that otherwise would be paid to a  
15 claimant agency or agencies of the State of Georgia as debts;

16 (3) Moneys shall be disbursed by the commissioner of revenue only to pay for medical  
17 claims for health care services provided to the individual during the period when the  
18 individual was not in compliance with subsection (a) of this Code section;

19 (4) The commissioner of revenue shall close the account and remit the remaining funds  
20 to the individual within six months of receiving notification that the individual has:

21 (A) Elected to comply with the requirement of subsection (a) of this Code section by  
22 submitting proof of insurance coverage in accordance with paragraph (1) of  
23 subsection (b) of this Code section; or

24 (B) Is no longer subject to subsection (a) of this Code section by reason of no longer  
25 being a resident of this state; and

26 (5) If the commissioner of revenue determines that an individual for whom an account  
27 has been established has not been a resident of this state for a consecutive period of 36  
28 months or more, the commissioner of revenue shall close the account and remit the  
29 remaining funds to the individual or, if the commissioner of revenue cannot locate the  
30 individual, shall dispose of the funds in accordance with the provisions of law concerning  
31 unclaimed property.

32 (f) Any judgment payable by an individual to a hospital, physician, or other health care  
33 provider for charges incurred during a period when the individual failed to comply with  
34 subsection (a) of this Code section shall include an order permitting the attachment of the  
35 wages of such individual to satisfy such judgment."

1 **PART VIII.**

2 **SECTION 8-1.**

3 Title 45 of the Official Code of Georgia Annotated, relating to public officers and employees,  
4 is amended by revising Code Section 45-18-2, relating to the authority of the Board of  
5 Community Health to establish health insurance plans, to read as follows:

6 "45-18-2.

7 (a)(1) The board is authorized to establish a health insurance plan for employees of the  
8 state and to adopt and promulgate rules and regulations for its administration, subject to  
9 the limitations contained in this article. The health insurance plan ~~may~~ shall provide for  
10 group hospitalization and surgical and medical insurance against the financial costs of  
11 hospitalization, surgery, and medical treatment and care and may also include, among  
12 other things, prescribed drugs, medicines, prosthetic appliances, hospital inpatient and  
13 outpatient service benefits, dental benefits, vision care benefits, and medical expense  
14 indemnity benefits, including major medical benefits.

15 (2) Among the health insurance plans offered, the board shall provide for the availability  
16 of a high deductible health plan (HDHP) that is health savings account (HSA) eligible.

17 (3) The board shall provide incentives for state employees who participate in health  
18 insurance plans offered by the board to undertake health management and disease  
19 management programs including, but not limited to, health management credits and  
20 disease management credits.

21 (4) If there is a generic drug available, any prescription drug program offered by the  
22 board to state employees shall provide for full reimbursement for such drug and shall  
23 provide that the insured may obtain the brand name drug only upon the payment of the  
24 difference between the cost for such brand name drug and the cost of such generic drug.

25 (b) If a retiring or retired employee or the beneficiary of such retiring or retired employee  
26 exercises eligibility under board regulations to continue coverage under the plan and the  
27 retiring or retired employees or the beneficiary is eligible to participate in the insurance  
28 program operated by or on behalf of the federal government under the provisions of 42  
29 U.S.C.A. 1395, as amended, the coverage available under the health insurance plan shall  
30 be subordinated to the coverage available under such federal program. The board is  
31 authorized to promulgate regulations to establish the premium paid by the retired employee  
32 or beneficiary to reflect the subordination of coverage."

**PART IX.**  
**SECTION 9-1.**

3 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is revised by  
4 adding a new Chapter 63 to read as follows:

"CHAPTER 63

6 33-63-1.

7 The General Assembly recognizes the need for individuals, employers, and other  
8 purchasers of health insurance coverage in this state to have the opportunity to choose  
9 health insurance plans that are more affordable and flexible than existing market policies  
10 offering accident and sickness insurance coverage. Therefore, the General Assembly seeks  
11 to increase the availability of health insurance coverage by allowing insurers authorized to  
12 engage in the business of insurance in selected states to issue accident and sickness policies  
13 in Georgia.

14 33-63-2.

15 The selected out-of-state insurers shall not be required to offer or provide state mandated  
16 health benefits required by Georgia law or regulations in health insurance policies sold to  
17 Georgia residents.

18 33-63-3.

19 (a) Each written application for participation in an out-of-state health benefit plan shall  
20 contain the following language in boldface type at the beginning of the document:

21 "This policy is primarily governed by the laws of (insert state where the master policy is  
22 filed); therefore, all of the rating laws applicable to policies filed in this state do not apply  
23 to this policy, which may result in increases in your premium at renewal that would not  
24 be permissible in a Georgia-approved policy. Any purchase of individual health  
25 insurance should be considered carefully since future medical conditions may make it  
26 impossible to qualify for another individual health policy. For information concerning  
27 individual health coverage under a Georgia-approved policy, please consult your  
28 insurance agent or the Georgia Department of Insurance.'

29 (b) Each out-of-state health benefit plan shall contain the following language in boldface  
30 type at the beginning of the document:

31 'The benefits of this policy providing your coverage are governed primarily by the laws  
32 of a state other than Georgia. While this health benefit plan may provide you a more

1 affordable health insurance policy, it may also provide fewer health benefits than those  
 2 normally included as state mandated health benefits in policies in Georgia. Please consult  
 3 your insurance agent to determine which state mandated health benefits are excluded  
 4 under this policy.'

5 33-63-4.

6 The Commissioner shall be authorized to conduct market conduct and solvency  
 7 examinations of all out-of-state companies seeking to offer health benefit plans in this state  
 8 or who have been given approval to offer health benefit plans in this state. Such  
 9 examinations shall be conducted in the same manner and under the same terms and  
 10 conditions as for companies located in this state.

11 33-63-5.

12 The Commissioner shall adopt rules and regulations necessary to implement this chapter,  
 13 including, but not limited to, determining which health insurance companies located in  
 14 other states shall be authorized to offer plans to Georgia residents and determining the  
 15 manner of approving the health benefit plans offered by such companies."

16 **PART X.**

17 **SECTION 10-1.**

18 Chapter 4 of Title 26 of the Official Code of Georgia Annotated, relating to pharmacists and  
 19 pharmacies, is amended in Article 6, relating to pharmacies, by adding a new Code section  
 20 to the end of such article to read as follows:

21 "26-4-119.

22 (a) All pharmacies licensed under this article shall submit outcome data as well as pricing  
 23 information to the Department of Community Health as specified by such department  
 24 pursuant to Code Section 31-5A-7. Such data shall be submitted at least annually or more  
 25 frequently, as specified by the Department of Community Health.

26 (b) No pharmacy or its employees or agents shall be held liable for civil damages or  
 27 subject to criminal penalties either for the reporting of patient data to the Department of  
 28 Community Health or for the release of such data by the department pursuant to Code  
 29 Section 31-5A-7."

30 **SECTION 10-2.**

31 Title 31 of the Official Code of Georgia Annotated, relating to health, is amended by adding  
 32 to the end of Chapter 5A, relating to the Department of Community Health, new Code  
 33 sections to read as follows:

1 "31-5A-7.

2 (a) The department shall provide for the establishment of a website to be known as  
3 'www.georgiahealthcare.com' or a similar name, as determined by the department, for the  
4 purpose of providing consumers information on the cost and quality of health care in  
5 Georgia. The consumer information shall include:

6 (1) Performance and outcome data and pricing comparisons for selected medical  
7 conditions, surgeries, and procedures in hospitals and ambulatory surgical centers in  
8 Georgia to assist consumers in choosing a health care facility that best serves their needs;  
9 and

10 (2) Cost comparison information on certain prescription drugs at different pharmacies in  
11 Georgia.

12 Subject to appropriations by the General Assembly, the website shall be developed, hosted,  
13 and maintained by a private or other entity selected through a request for proposals process.

14 Such website shall be operational and available to the public no later than January 1, 2008.

15 (b) The department shall adopt rules and regulations establishing the data elements  
16 required to be submitted by health care facilities and pharmacies in order to obtain  
17 information relating to number of hospitalizations at a facility for a certain procedure,  
18 average lengths of stay, readmission rates, mortality rates, complication/infection rates,  
19 facility profiles, average charges, and wholesale and retail prices for certain prescription  
20 drugs to populate the website established pursuant to subsection (a) of this Code section.  
21 The data shall include, but not be limited to, case mix data; patient admission and discharge  
22 data; hospital emergency department data, which shall include the number of patients  
23 treated in the emergency department of a licensed hospital reported by patient acuity level;  
24 data on hospital acquired infections as specified by rule; data on complications; data on  
25 readmissions, with patient and provider specific identifiers included; actual charge data by  
26 diagnostic groups; financial data; accounting data; operating expenses; expenses incurred  
27 for rendering services to patients who cannot or do not pay; interest charges; depreciation  
28 expenses based on the expected useful life of the property and equipment involved; and  
29 demographic data. Data may be obtained from documents such as, but not limited to,  
30 leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and  
31 related diagnostic information. Reported data elements shall be reported in accordance  
32 with rules and regulations established by the department. The department shall promulgate  
33 standards for the electronic format of data and may require such data to be submitted in  
34 accordance with interoperability agreements. Data submitted shall be certified by the chief  
35 executive officer or an appropriate and duly authorized representative or employee of the  
36 licensed facility that the information submitted is true and accurate. Specifications for data  
37 to be collected under this Code section shall be developed by the department with input

1 from the Georgia Patient Safety Corporation established pursuant to Code Section 31-5A-8,  
2 affected entities, consumers, purchasers, and such other interested parties as may be  
3 determined by the department.

4 (c) The department shall determine which medical conditions and procedures, performance  
5 outcomes, and patient charge data to include on the website. When determining which  
6 conditions and procedures to include, the department shall consider such factors as volume,  
7 severity of the illness, urgency of admission, individual and societal costs, whether the  
8 condition is acute or chronic, variation in costs, variation in outcomes, and magnitude of  
9 variations and other relevant information. When determining which performance outcomes  
10 to include, the department shall consider such factors as volume of cases, average patient  
11 charges, average lengths of stay, complication rates, mortality rates, and infection rates,  
12 among others, which shall be adjusted for case mix and severity, if applicable; provided,  
13 however, the department may also consider such additional measures that are adopted by  
14 the federal Centers for Medicare and Medicaid Studies, the National Quality Forum, the  
15 Joint Commission on Accreditation of Healthcare Organizations, the federal Agency for  
16 Healthcare Research and Quality, or a similar national entity that establishes standards to  
17 measure the performance of health care providers or by other states. Performance outcome  
18 indicators shall be risk adjusted or severity adjusted, as applicable, using nationally  
19 recognized risk adjustment methodologies, consistent with the standards of the Agency for  
20 Healthcare Research and Quality and as selected by the department. When determining  
21 which patient charge data to include, the department shall consider such measures as  
22 average charge, average net revenue per adjusted patient day, average cost per adjusted  
23 patient day, and average cost per admission, among others.

24 (d) The department shall identify those prescription drugs for which price information  
25 shall be collected. Such information shall include recent average wholesale prices and  
26 retail prices. If a prescription drug is available in a generic form, price data shall be  
27 reported for the generic drug and its brand name equivalent.

28 (e) The website shall be designed and operated to allow consumers to conduct an  
29 interactive search that allows them to view and compare the information for specific health  
30 care facilities and pharmacies. Such information shall be made available by geographic  
31 area and by provider. The website shall include such additional information as is  
32 determined necessary by the department to ensure that the website enhances informed  
33 decision making among consumers, including definitions of all of the data and terms,  
34 descriptions of each procedure, appropriate guidance on how to use the data, and an  
35 explanation of why the data may vary between health care facilities. The department may  
36 include a notice on the website that the pricing information is based on a compilation of  
37 charges for the average patient and that each patient's bill may vary from the average

1 depending on the severity of illness, length of stay, and other factors. This notice may  
2 include a statement indicating that, at certain facilities, the charges may be negotiable for  
3 certain patients based upon the patient's ability to pay.

4 (f) Portions of patient records obtained or generated by the department containing the  
5 name, residence or business address, telephone number, social security or other identifying  
6 number, or photograph of any person or the spouse, relative, or guardian of such person,  
7 or any other identifying information which is patient specific or otherwise identifies the  
8 patient, either directly or indirectly, are confidential and exempt from the provisions of  
9 Article 4 of Chapter 18 of Title 50, relating to inspection of public records.

10 (g) The department shall cooperate with local health agencies and the Department of  
11 Human Resources with regard to health care data collection and dissemination and shall  
12 cooperate with state agencies in any efforts to establish an integrated health care data base.

13 (h) The department shall be authorized to establish rules and regulations to implement the  
14 provisions of this Code section.

15 31-5A-8.

16 (a) There is created a body corporate and politic to be known as the Georgia Patient Safety  
17 Corporation which shall be deemed to be an instrumentality of the state, and not a state  
18 agency, and a public corporation. Venue for the corporation shall be in Fulton County.

19 (b) The purpose of the corporation is to serve as a learning organization dedicated to  
20 assisting health care providers in this state to improve the quality and safety of health care  
21 rendered and to reduce harm to patients. The corporation shall promote the development  
22 of a culture of patient safety in the health care system in this state. The corporation shall  
23 not regulate health care providers in this state. In fulfilling its purpose, the corporation shall  
24 work with a consortium of patient safety centers and other patient safety programs.

25 (c) The corporation shall be governed by a board of directors composed of 13 members  
26 appointed by the Governor as follows:

27 (1) One representative from the board of regents affiliated with a medical school in  
28 Georgia;

29 (2) Two representatives with expertise in patient safety issues for the health insurer and  
30 health maintenance organization with the largest market shares, respectively, as measured  
31 by premiums written in this state for the most recent calendar year;

32 (3) One representative of an authorized medical malpractice insurer in this state;

33 (4) Two representatives of hospitals in this state;

34 (5) Four physicians;

35 (6) One nurse;

36 (7) One dentist; and

1 (8) One pharmacist.

2 Members shall be residents of the State of Georgia, shall be prominent persons in their  
3 businesses or professions, and shall not have been convicted of any felony offense.

4 Members shall serve terms of five years, except that of the initial members appointed, five  
5 shall be appointed for initial terms of two years, four shall be appointed for initial terms of

6 four years, and four shall be appointed for initial terms of five years. Any vacancy  
7 occurring on the board shall be filled by the Governor by appointment for the unexpired

8 term. The members shall elect from their membership a chairperson and vice chairperson.

9 Upon approval by the chairperson, members of the board shall be reimbursed for actual and  
10 reasonable expenses incurred for each day's service spent in the performance of the duties

11 of the corporation. A majority of members in office shall constitute a quorum for the  
12 transaction of any business and for the exercise of any power or function of the

13 corporation.

14 (d) The department shall provide staff to assist the corporation in its establishment.

15 (e) The corporation shall be authorized to:

16 (1) Secure staff necessary to properly administer the corporation;

17 (2) Collect, analyze, and evaluate patient safety data and quality and patient safety  
18 indicators, medical malpractice closed claims, and adverse incidents reported to the

19 Department of Human Resources for the purpose of recommending changes in practices  
20 and procedures that may be implemented by health care practitioners and health care

21 facilities to improve health care quality and to prevent future adverse incidents.  
22 Notwithstanding any other provision of law, the Department of Human Resources shall

23 make available to the corporation any adverse incident report submitted pursuant to Code  
24 Section 31-8-93. To the extent that adverse incident reports submitted are considered

25 confidential and exempt from disclosure, the confidential and exempt status of such  
26 reports shall be maintained by the corporation;

27 (3) Establish a patient safety reporting system to: identify potential systemic problems  
28 that could lead to adverse incidents; enable publication of system-wide alerts of potential

29 harm; and facilitate development of both facility specific and state-wide options to avoid  
30 adverse incidents and improve patient safety. The reporting system shall record any

31 potentially harmful event that could have had an adverse result but, through chance or  
32 intervention, in which harm was prevented submitted by hospitals, birthing centers, and

33 ambulatory surgical centers and other providers. The reporting system shall be voluntary  
34 and anonymous and independent of mandatory reporting systems used for regulatory

35 purposes;

36 (4) Work collaboratively with the appropriate state agencies in the development of  
37 electronic health records;

- 1 (5) Provide for access to an active library of evidence based medicine and patient safety  
2 practices, together with the emerging evidence supporting their retention or modification,  
3 and make this information available to health care practitioners, health care facilities, and  
4 the public;
  - 5 (6) Develop and recommend core competencies in patient safety that can be incorporated  
6 into the undergraduate and graduate curricula in schools of medicine, nursing, and allied  
7 health in the state;
  - 8 (7) Develop and recommend programs to educate the public about the role of health care  
9 consumers in promoting patient safety;
  - 10 (8) Provide recommendations for interagency coordination of patient safety efforts in the  
11 state;
  - 12 (9) Assess the patient safety culture at volunteering hospitals and recommend methods  
13 to improve the working environment related to patient safety at these hospitals;
  - 14 (10) Inventory the information technology capabilities related to patient safety of health  
15 care facilities and health care practitioners and recommend a plan for expediting the  
16 implementation of patient safety technologies state wide;
  - 17 (11) Recommend continuing medical education regarding patient safety to practicing  
18 health care practitioners;
  - 19 (12) Study and facilitate the testing of alternative systems of compensating injured  
20 patients as a means of reducing and preventing medical errors and promoting patient  
21 safety;
  - 22 (13) Provide recommendations to the department on data elements to be collected from  
23 health care entities and on performance and outcome data and pricing information to be  
24 included on the department's website in accordance with Code Section 31-5A-7; and
  - 25 (14) Conduct other activities identified by the board of directors to promote patient  
26 safety in this state.
- 27 (f) The corporation shall submit an annual report to the Governor, President of the Senate,  
28 Speaker of the House of Representatives, and the chairpersons of the Health and Human  
29 Services Committees of the Senate and the House of Representatives.
- 30 (g) Subject to appropriations by the General Assembly, the corporation shall provide for  
31 the establishment of a central data base accessible through a website for the purpose of  
32 providing a clearing-house of electronic medical records accessible to health care  
33 providers, patients, and others as determined by the corporation. The data base shall  
34 include, at a minimum, vaccination records and prescription drug records. The corporation  
35 shall be authorized to coordinate with the Department of Human Resources, and the  
36 Department of Human Resources shall be authorized to share and release vaccination  
37 records maintained in the vaccination registry established pursuant to Code Section

1 31-12-3.1 to the corporation or its agent as long as any such release is in compliance with  
 2 the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191.  
 3 The corporation shall be authorized to issue a request for proposals to select a private or  
 4 other entity to develop, host, and maintain such data base and website.

5 31-5A-9.

6 Subject to appropriations by the General Assembly, the department shall be authorized to  
 7 provide grants, subsidies, and other incentives for individuals to obtain health care  
 8 coverage whose family income exceeds the income requirements for eligibility for health  
 9 services under Medicaid, but whose family income does not exceed 200 percent of the  
 10 federal poverty level and are not able to afford health insurance from their employers.  
 11 Such grants, subsidies, and other incentives may include, but not be limited to, programs  
 12 to provide preventive care for children, Pap smears, mammograms, prostate exams,  
 13 biannual physical exams, copayments for hospitals, coverage of deductibles, and outreach."

#### 14 **SECTION 10-3.**

15 Said title is further amended in Article 1 of Chapter 7, relating to regulation of hospitals and  
 16 related institutions, by adding to the end of such article a new Code section to read as  
 17 follows:

18 "31-7-17.

19 (a) For purposes of this Code section, 'health care facility' means all hospitals and  
 20 ambulatory surgical or obstetrical facilities, as such terms are defined in Code Section  
 21 31-6-2.

22 (b) All health care facilities licensed under this article which receive any state funds shall  
 23 submit performance and outcome data as well as pricing information to the Department of  
 24 Community Health as specified by such department pursuant to Code Section 31-5A-7.  
 25 Such data shall be submitted at least annually or more frequently, as specified by the  
 26 Department of Community Health.

27 (c) No health care facility or other reporting entity or its employees or agents shall be held  
 28 liable for civil damages or subject to criminal penalties either for the reporting of patient  
 29 data to the Department of Community Health or for the release of such data by such  
 30 department pursuant to Code Section 31-5A-7.

31 (d) A health care facility which is not in compliance with this Code section:

32 (1) May be subject to consequences pursuant to Code Section 49-4-158; and

33 (2) May be subject to having its certificate of need modified or sanctioned by the  
 34 Department of Community Health as may be authorized pursuant to Article 3 of Chapter  
 35 6 of this title."





1 Senate Committee on Assignments. The members of the committee shall serve two-year  
2 terms concurrent with their terms as members of the General Assembly. The chairperson  
3 of the committee shall be appointed by the Senate Committee on Assignments from the  
4 membership of the committee, and the vice chairperson of the committee shall be  
5 appointed by the Speaker of the House of Representatives from the membership of the  
6 committee. The chairperson and vice chairperson shall serve terms of two years concurrent  
7 with their terms as members of the General Assembly. Vacancies in an appointed  
8 member's position or in the offices of chairperson or vice chairperson shall be filled for the  
9 unexpired term in the same manner as the original appointment.

10 28-12-2.

11 The state auditor, the Attorney General, and all other agencies of state government, upon  
12 request by the committee, shall assist the committee in the discharge of its duties. The  
13 committee may employ not more than two staff members and may secure the services of  
14 independent accountants, engineers, and consultants.

15 28-12-3.

16 The Georgia Health Security Underwriting Authority, the Georgia Patient Safety  
17 Corporation, and the Georgia Health Insurance Exchange shall cooperate with the  
18 committee, its authorized personnel, the Attorney General, the state auditor, the state  
19 accounting officer, and other state agencies. The Georgia Health Security Underwriting  
20 Authority, the Georgia Patient Safety Corporation, and the Georgia Health Insurance  
21 Exchange shall submit to the committee such reports and data as the committee shall  
22 reasonably require of them. The Attorney General is authorized to bring appropriate legal  
23 actions to enforce any laws specifically or generally relating to the Georgia Health Security  
24 Underwriting Authority, the Georgia Patient Safety Corporation, and the Georgia Health  
25 Insurance Exchange.

26 28-12-4.

27 The committee shall:

28 (1) Evaluate the performance of the Georgia Health Security Underwriting Authority,  
29 the Georgia Patient Safety Corporation, and the Georgia Health Insurance Exchange  
30 consistent with the following criteria:

- 31 (A) Prudent, legal, and accountable expenditure of public funds;  
32 (B) Efficient operation; and  
33 (C) Performance of statutory responsibilities;

1 (2) Periodically inquire into and review the operations of the Georgia Health Security  
 2 Underwriting Authority, the Georgia Patient Safety Corporation, and the Georgia Health  
 3 Insurance Exchange as well as periodically review and evaluate the success with which  
 4 such entities are accomplishing their statutory duties and functions; and

5 (3) On or before the first day of January of each year, and at such other times as it deems  
 6 necessary, submit to the General Assembly a report of its findings and recommendations  
 7 based upon the review of the Georgia Health Security Underwriting Authority, the  
 8 Georgia Patient Safety Corporation, and the Georgia Health Insurance Exchange.

9 28-12-5.

10 (a) The committee is authorized to expend state funds available to the committee for the  
 11 discharge of its duties. Said funds may be used for the purposes of compensating staff,  
 12 paying for services of independent accountants, engineers, and consultants, and paying all  
 13 other necessary expenses incurred by the committee in performing its duties.

14 (b) The members of the committee shall receive the same compensation, per diem,  
 15 expenses, and allowances for their service on the committee as is authorized by law for  
 16 members of interim legislative study committees.

17 (c) The funds necessary for the purposes of the committee shall come from the funds  
 18 appropriated to and available to the legislative branch of government."

19 **PART XII.**

20 **SECTION 12-1.**

21 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
 22 adding new subsections (c) and (d) in Code Section 33-8-4, relating to amount and method  
 23 of computing tax on insurance premiums generally, to read as follows:

24 "(c) Insurers may claim an exemption from otherwise applicable state premium taxes as  
 25 provided for in subsection (a) of this Code section in an amount equal to 2 1/4 percent of  
 26 the premiums such insurers collect during the applicable tax year from Georgia residents  
 27 on premiums paid for high deductible health plans sold or maintained in connection with  
 28 a health savings account under the applicable provisions of Section 223 of the Internal  
 29 Revenue Code.

30 (d) Insurers may claim an exemption from otherwise applicable state premium taxes as  
 31 provided for in subsection (a) of this Code section in an amount equal to 2 1/4 percent of  
 32 the premiums such insurers collect during the applicable tax year from Georgia residents  
 33 on premiums paid for other health plans which are not otherwise exempt under subsection  
 34 (c) of this Code section."



1 participating employees or compensated individuals or \$500.00, whichever is less, if such  
2 contributions are made available to all of its employees and compensated individuals.

3 (c) In no event shall the total amount of the tax credit under this Code section for a taxable  
4 year exceed the taxpayer's income tax liability. Any unused tax credit shall be allowed the  
5 taxpayer against succeeding years' tax liability. No such credit shall be allowed the  
6 taxpayer against prior years' tax liability.

7 (d) The commissioner shall be authorized to promulgate any rules and regulations  
8 necessary to implement and administer the provisions of this Code section.

9 48-7-29.14.

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

11 (1) 'Qualified health insurance expense' means the expenditure of funds for health  
12 insurance premiums for high deductible health plans that include, at a minimum,  
13 catastrophic health care coverage, which are established and used with a health savings  
14 account under the applicable provisions of Section 223 of the Internal Revenue Code.

15 (2) 'Taxpayer' means an employee who is employed directly or a person who is paid  
16 compensation which is reported on Form 1099 at a business where 25 or fewer persons  
17 are employed or compensated by the employer.

18 (b) A taxpayer shall be allowed a credit against the tax imposed by Code Section 48-7-20  
19 for qualified health insurance expenses in an amount not to exceed the actual amount  
20 expended or \$250.00, whichever is less, if such health insurance is made available to all  
21 of the employees and compensated individuals of the employer.

22 (c) In no event shall the total amount of the tax credit under this Code section for a taxable  
23 year exceed the taxpayer's income tax liability. Any unused tax credit shall be allowed the  
24 taxpayer against succeeding years' tax liability. No such credit shall be allowed the  
25 taxpayer against prior years' tax liability.

26 (d) The commissioner shall be authorized to promulgate any rules and regulations  
27 necessary to implement and administer the provisions of this Code section."

## 28 **SECTION 12-5.**

29 Said title is further amended by adding a new Code section to read as follows:

30 "48-7-29.15.

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

32 (1) 'Qualified health information technology expense' means the expenditure of funds by  
33 a taxpayer for health information technology hardware or software used directly in the  
34 establishment and maintenance of electronic medical records accessible at a website

1 established by the Department of Community Health pursuant to Code Section 26-4-80  
2 or 31-33-9.

3 (2) 'Taxpayer' means a physician, pharmacy, or hospital which incurs qualified health  
4 information technology expenses.

5 (b) A taxpayer shall be allowed a credit against the tax imposed by Code Section 48-7-20  
6 or 48-7-21 for qualified health information technology expenses in an amount not to exceed  
7 the actual amount expended or \$5,000.00, whichever is less.

8 (c) In no event shall the total amount of the tax credit under this Code section for a taxable  
9 year exceed the taxpayer's income tax liability. Any unused tax credit shall be allowed the  
10 taxpayer against succeeding years' tax liability. No such credit shall be allowed the  
11 taxpayer against prior years' tax liability.

12 (d) The commissioner shall be authorized to promulgate any rules and regulations  
13 necessary to implement and administer the provisions of this Code section.

14 (e) This Code section shall be repealed by operation of law on January 1, 2009."

#### 15 **SECTION 12-6.**

16 Said title is further amended in Code Section 48-8-3, relating to exemptions from sales and  
17 use tax, by replacing "; or" at the end of paragraph (84) with a semicolon; by replacing the  
18 period at the end of paragraph (85) with "; or"; and by adding a new paragraph to read as  
19 follows:

20 "(86)(A) For the period commencing January 1, 2008, and ending on December 31,  
21 2011, sales of tangible personal property or services to a qualified small business.

22 (B) As used in this paragraph, the term 'qualified small business' means any small  
23 business located in this state which qualifies for and receives the state income tax credit  
24 with respect to qualified health insurance expenses pursuant to Code Section  
25 48-7-29.13.

26 (C) Any person making a sale of tangible personal property or services to a qualified  
27 small business shall collect the tax imposed on this sale unless the purchaser furnishes  
28 such person with an exemption determination letter issued by the commissioner  
29 certifying that the purchaser is entitled to purchase the tangible personal property or  
30 services without paying the tax.

31 (D) The commissioner is authorized to promulgate rules and regulations deemed  
32 necessary in order to administer and effectuate this paragraph."

**PART XIII.****SECTION 13-1.**

3 For the purpose of appointing the initial board of directors of the Georgia Health Insurance  
4 Exchange, Part VII of this Act shall become effective upon its approval by the Governor or  
5 upon its becoming law without such approval. For all other purposes, Part VII of this Act  
6 shall become effective on July 1, 2007. Part XII of this Act shall become effective on  
7 January 1, 2008, and Sections 12-4 and 12-5 of this Act shall be applicable to all taxable  
8 years beginning on or after January 1, 2008. The remaining parts of this Act shall become  
9 effective on July 1, 2007.

**SECTION 13-2.**

10  
11 All laws and parts of laws in conflict with this Act are repealed.