

Senate Bill 150

By: Senators Hill of the 32nd and Thomas of the 54th

A BILL TO BE ENTITLED

AN ACT

1 To amend Chapter 4 of Title 26 of the Official Code of Georgia Annotated, relating to  
2 pharmacists and pharmacies, so as to require pharmacies to submit certain performance and  
3 cost data to the Department of Community Health; to amend Title 31 of the Official Code  
4 of Georgia Annotated, relating to health, so as to provide for the establishment of a website  
5 to provide consumers with information on the cost and quality of health care in Georgia; to  
6 provide for the submission of data elements from health care facilities, pharmacies, nursing  
7 homes, and assisted living facilities; to provide for rules and regulations; to provide for the  
8 establishment of the Georgia Patient Safety Corporation; to provide for its membership and  
9 duties; to provide for the establishment of a central data base of electronic medical records;  
10 to provide for grants, subsidies, and other incentives for certain individuals to obtain health  
11 care coverage; to require health care facilities to submit certain performance and cost data  
12 to the Department of Community Health; to provide that health records are the property of  
13 the patient; to amend Title 28 of the Official Code of Georgia Annotated, relating to the  
14 General Assembly, so as to create the Georgia Health Care Overview Committee; to provide  
15 for its composition, officers, duties, and powers; to provide for cooperation by certain entities  
16 with such committee; to provide for certain expenditures of funds by such committee; to  
17 amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to  
18 comprehensively revise the laws of Georgia concerning the provision of health insurance;  
19 to provide that preferred provider arrangements shall not have differences in coinsurance  
20 percentages applicable to benefit levels for services provided by preferred and nonpreferred  
21 providers which differ by more than 40 percentage points; to provide that preferred provider  
22 arrangements shall not have a coinsurance percentage applicable to benefit levels for services  
23 provided by nonpreferred providers which exceeds 50 percent of the benefit levels under the  
24 policy for such services; to provide that an insured under a group accident and sickness  
25 policy may include dependents up to age 25 or until two years after ceasing to be a  
26 dependent, whichever is earlier; to provide that employers who employ persons who also  
27 work for other employers may enter into arrangements to contribute to the employees' health  
28 care coverage under such other employers; to provide for the promulgation of rules and

1 regulations; 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 authorize selected out-of-state insurers to offer health insurance  
 11 plans in Georgia; to provide for certain notices; to authorize the Commissioner of Insurance  
 12 to adopt certain rules and regulations; to provide for related matters; to amend Title 45 of the  
 13 Official Code of Georgia Annotated, relating to public officers and employees, so as to  
 14 provide that the Board of Community Health shall establish certain health insurance plans  
 15 for state employees; to provide that the board shall provide for certain incentives with regard  
 16 to such plans; to provide incentives for electronic prescribing and electronic submission of  
 17 claims; to amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia  
 18 Annotated, known as the "Georgia Medical Assistance Act of 1977," so as to provide  
 19 incentives for electronic prescribing and electronic submission of claims; to provide that a  
 20 health care entity which is not in compliance with certain data reporting requirements is not  
 21 eligible to provide Medicaid services; to provide for related matters; to provide effective  
 22 dates; to repeal conflicting laws; and for other purposes.

23 **BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:**

24 **SECTION 1.**

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

28 "26-4-119.

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

33 (b) No pharmacy or its employees or agents shall be held liable for civil damages or  
 34 subject to criminal penalties either for the reporting of patient data to the Department of

1 Community Health or for the release of such data by the department pursuant to Code  
2 Section 31-5A-7."

3 **SECTION 2.**

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

7 "31-5A-7.

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

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

15 (2) Cost comparison information on certain prescription drugs at different pharmacies in  
16 Georgia; and

17 (3) Cost comparison information on nursing homes and assisted living facilities in  
18 Georgia.

19 Subject to appropriations by the General Assembly, the website shall be developed, hosted,  
20 and maintained by a private or other entity selected through a request for proposals process.  
21 Such website shall be operational and available to the public no later than January 1, 2008.

22 (b) The department shall adopt rules and regulations establishing the data elements  
23 required to be submitted by health care facilities, pharmacies, nursing homes, and assisted  
24 living facilities in order to obtain information relating to number of hospitalizations at a  
25 facility for a certain procedure, average lengths of stay, readmission rates, mortality rates,  
26 complication/infection rates, facility profiles, average charges, and wholesale and retail  
27 prices for certain prescription drugs to populate the website established pursuant to  
28 subsection (a) of this Code section. The data shall include, but not be limited to, case mix  
29 data; patient admission and discharge data; hospital emergency department data, which  
30 shall include the number of patients treated in the emergency department of a licensed  
31 hospital reported by patient acuity level; data on hospital acquired infections as specified  
32 by rule; data on complications; data on readmissions, with patient and provider specific  
33 identifiers included; actual charge data by diagnostic groups; financial data; accounting  
34 data; operating expenses; expenses incurred for rendering services to patients who cannot  
35 or do not pay; interest charges; depreciation expenses based on the expected useful life of  
36 the property and equipment involved; and demographic data. Data may be obtained from

1 documents such as, but not limited to, leases, contracts, debt instruments, itemized patient  
2 bills, medical record abstracts, and related diagnostic information. Reported data elements  
3 shall be reported in accordance with rules and regulations established by the department.  
4 The department shall promulgate standards for the electronic format of data and may  
5 require such data to be submitted in accordance with interoperability agreements. Data  
6 submitted shall be certified by the chief executive officer or an appropriate and duly  
7 authorized representative or employee of the licensed facility that the information  
8 submitted is true and accurate. Specifications for data to be collected under this Code  
9 section shall be developed by the department with input from the Georgia Patient Safety  
10 Corporation established pursuant to Code Section 31-5A-8, affected entities, consumers,  
11 purchasers, and such other interested parties as may be determined by the department.

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

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

36 (e) The website shall be designed and operated to allow consumers to conduct an  
37 interactive search that allows them to view and compare the information for specific health

1 care facilities, pharmacies, nursing homes, and assisted living facilities. Such information  
2 shall be made available by geographic area and by provider. The website shall include  
3 such additional information as is determined necessary by the department to ensure that the  
4 website enhances informed decision making among consumers, including definitions of all  
5 of the data and terms, descriptions of each procedure, appropriate guidance on how to use  
6 the data, and an explanation of why the data may vary between facilities. The department  
7 may include a notice on the website that the pricing information is based on a compilation  
8 of charges for the average patient and that each patient's bill may vary from the average  
9 depending on the severity of illness, length of stay, and other factors. This notice may  
10 include a statement indicating that, at certain facilities, the charges may be negotiable for  
11 certain patients based upon the patient's ability to pay.

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

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

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

23 31-5A-8.

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

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

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

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

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

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

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

6 (5) Four physicians;

7 (6) One nurse;

8 (7) One dentist; and

9 (8) One pharmacist.

10 Members shall be residents of the State of Georgia, shall be prominent persons in their  
11 businesses or professions, and shall not have been convicted of any felony offense.  
12 Members shall serve terms of five years, except that of the initial members appointed, five  
13 shall be appointed for initial terms of two years, four shall be appointed for initial terms of  
14 four years, and four shall be appointed for initial terms of five years. Any vacancy  
15 occurring on the board shall be filled by the Governor by appointment for the unexpired  
16 term. The members shall elect from their membership a chairperson and vice chairperson.  
17 Upon approval by the chairperson, members of the board shall be reimbursed for actual and  
18 reasonable expenses incurred for each day's service spent in the performance of the duties  
19 of the corporation. A majority of members in office shall constitute a quorum for the  
20 transaction of any business and for the exercise of any power or function of the  
21 corporation.

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

23 (e) The corporation shall be authorized to:

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

25 (2) Collect, analyze, and evaluate patient safety data and quality and patient safety  
26 indicators, medical malpractice closed claims, and adverse incidents reported to the  
27 Department of Human Resources for the purpose of recommending changes in practices  
28 and procedures that may be implemented by health care practitioners and health care  
29 facilities to improve health care quality and to prevent future adverse incidents.  
30 Notwithstanding any other provision of law, the Department of Human Resources shall  
31 make available to the corporation any adverse incident report submitted pursuant to Code  
32 Section 31-8-93. To the extent that adverse incident reports submitted are considered  
33 confidential and exempt from disclosure, the confidential and exempt status of such  
34 reports shall be maintained by the corporation;

35 (3) Establish a patient safety reporting system to: identify potential systemic problems  
36 that could lead to adverse incidents; enable publication of system-wide alerts of potential  
37 harm; and facilitate development of both facility specific and state-wide options to avoid

1 adverse incidents and improve patient safety. The reporting system shall record any  
2 potentially harmful event that could have had an adverse result but, through chance or  
3 intervention, in which harm was prevented submitted by hospitals, birthing centers,  
4 ambulatory surgical centers, nursing homes, assisted living facilities, and other providers.  
5 The reporting system shall be voluntary and anonymous and independent of mandatory  
6 reporting systems used for regulatory purposes;

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

9 (5) Provide for access to an active library of evidence based medicine and patient safety  
10 practices, together with the emerging evidence supporting their retention or modification,  
11 and make this information available to health care practitioners, health care facilities, and  
12 the public;

13 (6) Develop and recommend core competencies in patient safety that can be incorporated  
14 into the undergraduate and graduate curricula in schools of medicine, nursing, and allied  
15 health in the state;

16 (7) Develop and recommend programs to educate the public about the role of health care  
17 consumers in promoting patient safety;

18 (8) Provide recommendations for interagency coordination of patient safety efforts in the  
19 state;

20 (9) Assess the patient safety culture at volunteering hospitals and recommend methods  
21 to improve the working environment related to patient safety at these hospitals;

22 (10) Inventory the information technology capabilities related to patient safety of health  
23 care facilities and health care practitioners and recommend a plan for expediting the  
24 implementation of patient safety technologies state wide;

25 (11) Recommend continuing medical education regarding patient safety to practicing  
26 health care practitioners;

27 (12) Study and facilitate the testing of alternative systems of compensating injured  
28 patients as a means of reducing and preventing medical errors and promoting patient  
29 safety;

30 (13) Provide recommendations to the department on data elements to be collected from  
31 health care entities and on performance and outcome data and pricing information to be  
32 included on the department's website in accordance with Code Section 31-5A-7; and

33 (14) Conduct other activities identified by the board of directors to promote patient  
34 safety in this state.

35 (f) The corporation shall submit an annual report to the Governor, President of the Senate,  
36 Speaker of the House of Representatives, and the chairpersons of the Health and Human  
37 Services Committees of the Senate and the House of Representatives.

1 (g) Subject to appropriations by the General Assembly, the corporation shall provide for  
 2 the establishment of a central data base accessible through a website for the purpose of  
 3 providing a clearing-house of electronic medical records accessible to health care  
 4 providers, patients, and others as determined by the corporation. The data base shall  
 5 include, at a minimum, vaccination records and prescription drug records. The corporation  
 6 shall be authorized to coordinate with the Department of Human Resources, and the  
 7 Department of Human Resources shall be authorized to share and release vaccination  
 8 records maintained in the vaccination registry established pursuant to Code Section  
 9 31-12-3.1 to the corporation or its agent as long as any such release is in compliance with  
 10 the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191.  
 11 The corporation shall be authorized to issue a request for proposals to select a private or  
 12 other entity to develop, host, and maintain such data base and website.

13 31-5A-9.

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

### 22 SECTION 3.

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

26 "31-7-17.

27 (a) For purposes of this Code section, 'health care facility' means all hospitals and  
 28 ambulatory surgical or obstetrical facilities, as such terms are defined in Code Section  
 29 31-6-2.

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

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

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

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

7 (2) May be subject to having its certificate of need modified or sanctioned by the  
 8 Department of Community Health as may be authorized pursuant to Article 3 of Chapter  
 9 6 of this title."

#### 10 SECTION 4.

11 Said title is further amended by revising subsection (b) of Code Section 31-33-3, relating to  
 12 costs of copying and mailing health records, as follows:

13 "(b) The rights granted to a patient or other person under this chapter are in addition to any  
 14 other rights such patient or person may have relating to access to a patient's records;  
 15 ~~however, nothing in this chapter shall be construed as granting to a patient or person any~~  
 16 ~~right of ownership in the records, as such records are owned by and are the property of the~~  
 17 ~~provider. A patient's records shall be deemed to be owned by the patient. A provider shall~~  
 18 furnish to any patient one copy of his or her medical records per calendar year, upon  
 19 request and without charge, in paper or electronic format at the provider's discretion."

#### 20 SECTION 5.

21 Title 28 of the Official Code of Georgia Annotated, relating to the General Assembly, is  
 22 amended by adding a new chapter to read as follows:

#### 23 "CHAPTER 12

24 28-12-1.

25 There is created as a joint committee of the General Assembly the Georgia Health Care  
 26 Overview Committee to be composed of five members of the House of Representatives  
 27 appointed by the Speaker of the House and five members of the Senate appointed by the  
 28 Senate Committee on Assignments. The members of the committee shall serve two-year  
 29 terms concurrent with their terms as members of the General Assembly. The chairperson  
 30 of the committee shall be appointed by the Senate Committee on Assignments from the  
 31 membership of the committee, and the vice chairperson of the committee shall be  
 32 appointed by the Speaker of the House of Representatives from the membership of the  
 33 committee. The chairperson and vice chairperson shall serve terms of two years concurrent

1 with their terms as members of the General Assembly. Vacancies in an appointed  
2 member's position or in the offices of chairperson or vice chairperson shall be filled for the  
3 unexpired term in the same manner as the original appointment.

4 28-12-2.

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

9 28-12-3.

10 The Georgia Patient Safety Corporation shall cooperate with the committee, its authorized  
11 personnel, the Attorney General, the state auditor, the state accounting officer, and other  
12 state agencies. The Georgia Patient Safety Corporation shall submit to the committee such  
13 reports and data as the committee shall reasonably require of it. The Attorney General is  
14 authorized to bring appropriate legal actions to enforce any laws specifically or generally  
15 relating to the Georgia Patient Safety Corporation.

16 28-12-4.

17 The committee shall:

18 (1) Evaluate the performance of the Georgia Patient Safety Corporation consistent with  
19 the following criteria:

20 (A) Prudent, legal, and accountable expenditure of public funds;

21 (B) Efficient operation; and

22 (C) Performance of statutory responsibilities;

23 (2) Periodically inquire into and review the operations of the Georgia Patient Safety  
24 Corporation as well as periodically review and evaluate the success with which such  
25 entity is accomplishing its statutory duties and functions; and

26 (3) On or before the first day of January of each year, and at such other times as it deems  
27 necessary, submit to the General Assembly a report of its findings and recommendations  
28 based upon the review of the Georgia Patient Safety Corporation.

29 28-12-5.

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

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

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

#### 6 SECTION 6.

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

10 "(b) Such arrangements shall not:

11 (1) Unfairly deny health benefits for medically necessary covered services;

12 (2) Have differences in benefit levels payable to preferred providers compared to other  
13 providers which unfairly deny benefits for covered services;

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

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

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

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

#### 25 SECTION 7.

26 Said title is further amended by revising paragraph (4) of Code Section 33-30-4, relating to  
27 required provisions of group accident and sickness policies generally, as follows:

28 "(4) A provision that, with respect to termination of benefits for, or coverage of, any  
29 person who is a dependent child of an insured, the child shall continue to be insured up  
30 to and including age 25 or until two years after such child's status as a dependent ends,  
31 whichever is earlier, so long as the coverage of the member continues in effect; and the  
32 child remains a dependent of the insured parent or guardian, ~~and the child, in each~~  
33 ~~calendar year since reaching any age specified for termination of benefits as a dependent,~~  
34 ~~has been enrolled for five calendar months or more as a full-time student at a~~  
35 ~~postsecondary institution of higher learning or, if not so enrolled, would have been~~

1 ~~eligible to be so enrolled and was prevented from being so enrolled due to illness or~~  
 2 ~~injury.~~ This paragraph shall not apply to group policies under which an employer  
 3 provides coverage for dependents of its employees and pays the entire cost of the  
 4 coverage without any charge to the employee or dependents; and”.

#### 5 **SECTION 8.**

6 Said title is further amended by revising paragraph (8) of subsection (b) of Code Section  
 7 33-30-6, relating to required provisions of blanket accident and sickness policies, as follows:

8 “(8) A provision that, with respect to termination of benefits for, or coverage of, any  
 9 person who is a dependent child of an insured, the child shall continue to be insured up  
 10 to and including age 25 or until two years after such child’s status as a dependent ends,  
 11 whichever is earlier, so long as the coverage of the insured parent or guardian continues  
 12 in effect; and the child remains a dependent of the parent or guardian, ~~and the child, in~~  
 13 ~~each calendar year since reaching any age specified for termination of benefits as a~~  
 14 ~~dependent, has been enrolled for five months or more as a full-time student at a~~  
 15 ~~postsecondary institution of higher learning or, if not so enrolled, would have been~~  
 16 ~~eligible to be so enrolled and was prevented from being so enrolled due to illness or~~  
 17 ~~injury.”~~

#### 18 **SECTION 9.**

19 Said title is further amended by adding a new Code Section 33-30-16 to read as follows:

20 “33-30-16.

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

25 (b) The commissioner shall promulgate such rules and regulations as necessary to regulate  
 26 and enable such contributions to group health care insurance coverage by additional  
 27 employers of an insured.”

#### 28 **SECTION 10.**

29 Said title is further amended by adding a new Chapter 62 to read as follows:

#### 30 “CHAPTER 62

31 33-62-1.

32 As used in this chapter, the term:

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

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

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

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

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

13 (A) A group health plan;

14 (B) Health insurance coverage;

15 (C) Part A or Part B of Title XVIII of the Social Security Act, approved July 30, 1965  
16 (79 Stat. 291; 42 U.S.C. Section 1395c, et seq.; or 42 U.S.C. Section 1395j, et seq.,  
17 respectively);

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

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

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

23 (G) A state health benefits risk pool;

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

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

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

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

31 Creditable coverage does not include coverage consisting solely of coverage of excepted  
32 benefits.

33 (6) 'Dependent' means:

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

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

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

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

6 (A) The individual is a Georgia resident, meaning that the individual is and continues  
7 to be legally domiciled and physically residing on a permanent and full-time basis in  
8 a place of permanent habitation in Georgia that remains the person's principal residence  
9 and from which the person is absent only for temporary or transitory purposes. A  
10 person who is a full-time student attending an institution outside of Georgia may  
11 maintain his or her Georgia residency.

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

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

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

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

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

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

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

33 (10) 'Exchange' means the Georgia Health Insurance Exchange established by this  
34 chapter.

35 (11) 'Federal health coverage tax credit eligible individual' means any individual who is  
36 eligible for benefits under section 201 of the Trade Act of 2002, approved August 6, 2002  
37 (116 Stat. 933; 26 U.S.C. Section 35(c) (2003)), as amended.

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

3 (13) 'Participating employer plan' means a group health plan, as defined in federal law  
4 (Section 706 of ERISA (29 U.S.C. Section 1186)), that is sponsored by an employer and  
5 for which the plan sponsor has entered into an agreement with the Georgia Health  
6 Insurance Exchange, in accordance with the provisions of Code Section 33-62-11, for the  
7 Georgia Health Insurance Exchange to offer and administer health insurance benefits for  
8 enrollees in the plan.

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

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

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

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

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

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

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

1 33-62-2.

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

6 (b) The Georgia Health Insurance Exchange is hereby recognized as a not for profit  
7 corporation in accordance with the provisions of the laws of Georgia and shall seek  
8 recognition of the same status by the United States in accordance with the provisions of the  
9 United States Internal Revenue Code (26 U.S.C. Section 501(c)).

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

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

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

19 33-62-3.

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

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

34 (c) The board of directors shall at its initial meeting and the first meeting of each calendar  
35 year thereafter select from among its members a chairperson and a vice chairperson. The

1 board of directors shall also select at the same times a secretary who shall not be required  
2 to be a member of the board of directors.

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

4 (1) Be a full-time employee of the Georgia Health Insurance Exchange;

5 (2) Administer all of the Georgia Health Insurance Exchange's activities and contracts;

6 (3) Supervise the staff of the Georgia Health Insurance Exchange; and

7 (4) Perform such other functions and duties as directed by the board of directors  
8 consistent with this chapter.

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

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

12 33-62-4.

13 (a) The exchange shall:

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

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

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

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

22 (3) Establish and administer a website at which individuals can examine the various  
23 health insurance options available to them and which contains a program or programs  
24 designed to assist individuals, after inputting basic information about themselves and any  
25 covered dependents, in determining the cost of the various health insurance options  
26 available to them and which health insurance options provide the best coverages at the  
27 least cost for the individuals;

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

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

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

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

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

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

9 (C) Receive and process any federal or state tax credits or other premium support  
 10 payments for health insurance as may be established by law;

11 (6) Upon request, issue certificates of previous coverage in accordance with the  
 12 provisions of HIPAA to all such individuals who cease to be covered by a participating  
 13 insurance plan;

14 (7) Establish procedures to account for all funds received and disbursed by the exchange,  
 15 including:

16 (A) Maintaining a separate, segregated management account for the receipt and  
 17 disbursement of monies allocated to fund the administration of the exchange; and

18 (B) Maintaining a separate, segregated operations account for:

19 (i) The receipt of all premium payments or contributions made by or on behalf of  
 20 participating individuals; and

21 (ii) The distribution of premium payments to participating plans and of commissions  
 22 or payments to licensed insurance producers and such other organizations as are  
 23 permitted under Code Section 33-62-12 to receive payments for their services in  
 24 enrolling eligible individuals or groups in the exchange; and

25 (8) Submit to the Commissioner, following the end of each plan year, the report of an  
 26 independent audit of the exchange's accounts for the plan year.

27 33-62-5.

28 The exchange shall have the power to:

29 (1) Contract with vendors to perform one or more of the functions specified in Code  
 30 Section 33-62-4;

31 (2) Contract with private or public social service agencies to administer application,  
 32 eligibility verification, enrollment, and premium payments for specified groups or  
 33 populations of eligible individuals or participating individuals;

34 (3) Contract with employers to act as the plan administrator for participating employer  
 35 plans, subject to the provisions of Code Section 33-62-11, and to undertake the  
 36 obligations required by federal law of a plan administrator;

- 1 (4) Set and collect fees from participating individuals, participating employer plans, and  
 2 participating insurance plans sufficient to fund the cost of administering the exchange;  
 3 (5) Seek and directly receive grant funding from the United States government,  
 4 departments or agencies of this state, county or municipal governments, or private  
 5 philanthropic organizations to defray the costs of operating the exchange;  
 6 (6) Establish and administer rules and procedures governing the operations of the  
 7 exchange;  
 8 (7) Establish one or more service centers within this state to facilitate enrollment;  
 9 (8) Sue and be sued or otherwise take any necessary or proper legal action; and  
 10 (9) Establish bank accounts and borrow money.

11 33-62-6.

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

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

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

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

- 31 (1) The individual loses coverage in an existing health insurance plan due to the death  
 32 of a spouse, parent, or legal guardian;  
 33 (2) The individual or a covered dependent loses coverage in an existing health insurance  
 34 plan due to a change in the individual's employment status;  
 35 (3) The individual or a covered dependent loses coverage in an existing health insurance  
 36 plan because of a divorce, separation, or other change in familial status;

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

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

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

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

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

15 33-62-7.

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

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

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

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

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

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

29 (1) Withdrawal by the Commissioner; or

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

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

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

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

- 4 (1) Hospital benefits;
- 5 (2) Surgical benefits;
- 6 (3) In-hospital medical benefits;
- 7 (4) Ambulatory patient benefits;
- 8 (5) Prescription drug benefits; and
- 9 (6) Mental health benefits.

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

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

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

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

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

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

1 33-62-8.

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

5 (1) *Current participants.* Except as otherwise specified in paragraphs (3) and (4) of this  
6 Code section, during any open season, a participating individual who elects to choose a  
7 different participating insurance plan or plan option for the next plan year shall not be  
8 subject to any preexisting condition provisions and shall be charged the standard rate of  
9 the new participating insurance plan or plan option for persons of the participating  
10 individual's age and geographic area, and the same criteria shall apply to any election by  
11 a participating individual of coverage for any dependent who is also a participating  
12 individual;

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

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

26 (4) *New participants without creditable coverage.* A new participating individual with  
27 two months or less of creditable coverage may enroll in a participating insurance plan,  
28 but the participating individual may be subject to one or more preexisting condition  
29 provisions, for a period not to exceed 12 months, the number of such months to be  
30 reduced by the number of months of creditable coverage, or may be charged a premium  
31 not to exceed 150 percent of the otherwise applicable age and geography adjusted  
32 standard rate for the participating insurance plan, or both, and any such rate surcharge  
33 shall not be applied during the third or subsequent years of the individual's enrollment  
34 in any participating insurance plan;

35 (5) *Newly eligible dependents.* In cases where an individual is enrolled in a plan offered  
36 through the exchange as a newly eligible dependent of a participating individual by  
37 reason of birth, adoption, court order, or a change in custody arrangement, either during

1 open season or outside of open season in accordance with paragraph (6) of subsection (d)  
 2 of Code Section 33-62-6, a carrier shall not impose any preexisting condition provisions  
 3 or any change in the rate charged to the participating individual, except for such  
 4 difference, if any, in the participating insurance plan's standard rates that reflect the  
 5 addition of a new dependent to the participating individual's coverage;

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

9 (7) *Waiver of preexisting condition exclusion.* For new participating individuals without  
 10 creditable coverage, or with only limited creditable coverage as defined in paragraphs (3)  
 11 and (4) of this Code section, a carrier may elect to waive the imposition of preexisting  
 12 condition provisions and instead extend the applicable rate surcharge for an additional  
 13 year beyond the time provided for in those paragraphs; and

14 (8) *Federal health coverage tax credit eligible individuals.* For purposes of this Code  
 15 section, any federal health coverage tax credit eligible individual shall be deemed to have  
 16 18 months of creditable coverage.

17 33-62-9.

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

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

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

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

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

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

1 33-62-10.

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

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

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

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

10 (b) In cases where a carrier, in accordance with the provisions of this chapter, imposes a  
11 preexisting condition exclusion or a premium surcharge in connection with enrollment of  
12 a participating individual in a participating insurance plan offered by the carrier, and the  
13 participating individual disputes the imposition of such an exclusion or surcharge, the  
14 participating individual may request that the Commissioner issue a determination as to the  
15 validity or extent of such exclusion or surcharge under the provisions of this chapter. The  
16 Commissioner, or his or her designee, shall issue such a determination within 30 days of  
17 the request being filed with the Department of Insurance. If either the participating  
18 individual or the carrier disagrees with the outcome, he or she may submit a request for a  
19 hearing to the Commissioner in accordance with Chapter 13 of Title 50.

20 33-62-11.

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

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

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

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

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

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

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

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

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

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

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

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

31 (8) The employer agrees to also sponsor a 'cafeteria plan' as permitted under federal law  
32 (26 U.S.C. Section 125) for all employees eligible for coverage under the employer's  
33 participating employer plan.

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

1 (d) The exchange may not enter into any agreement with any employer with respect to any  
 2 participating employer plan to provide the participating employer plan with any additional  
 3 or different services or benefits not otherwise provided or offered to all other participating  
 4 employer plans.

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

11 33-62-12.

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

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

23 33-62-13.

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

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

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

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

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

- 1 (c) Each self-employed individual in this state shall annually file the same form with the  
2 Commissioner.
- 3 (d) The commissioner of human resources shall annually file the same form with the  
4 Commissioner of Insurance on behalf of all individuals receiving benefits under the  
5 Medicaid and PeachCare programs, excepting such individuals who are also covered by  
6 Part A or Part B of Title XVIII of the federal Social Security Act (79 Stat. 291; 42 U.S.C.  
7 Section 1395c, et seq., or 1395j, et seq., respectively).
- 8 (e) For purposes of this Code section, health insurance coverage shall not include any  
9 coverage consisting solely of one or more excepted benefits.
- 10 (f) The Commissioner shall prepare and distribute such forms.

11 33-62-14.

- 12 (a) A carrier shall not issue or renew an individual health benefit plan, other than through  
13 the exchange established under Code Section 33-62-2, after the first day of the plan year  
14 following the first regular open season conducted by the exchange in accordance with Code  
15 Section 33-62-6.
- 16 (b) A carrier shall not issue or renew a group health benefit plan to a small employer with  
17 50 or fewer employees, other than through the exchange established under Code  
18 Section 33-62-2, after the first day of the plan year following the first regular open season  
19 conducted by the exchange in accordance with Code Section 33-62-6.
- 20 (c) Subsections (a) and (b) of this Code section shall not apply to any health benefit plan  
21 that consists solely of one or more excepted benefits."

22 **SECTION 11.**

23 Said title is further amended by adding a new Chapter 63 to read as follows:

24 "CHAPTER 63

25 33-63-1.

26 The General Assembly recognizes the need for individuals, employers, and other  
27 purchasers of health insurance coverage in this state to have the opportunity to choose  
28 health insurance plans that are more affordable and flexible than existing market policies  
29 offering accident and sickness insurance coverage. Therefore, the General Assembly seeks  
30 to increase the availability of health insurance coverage by allowing insurers authorized to  
31 engage in the business of insurance in selected states to issue accident and sickness policies  
32 in Georgia.

1 33-63-2.

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

5 33-63-3.

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

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

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

18 'The benefits of this policy providing your coverage are governed primarily by the laws  
19 of a state other than Georgia. While this health benefit plan may provide you a more  
20 affordable health insurance policy, it may also provide fewer health benefits than those  
21 normally included as state mandated health benefits in policies in Georgia. Please consult  
22 your insurance agent to determine which state mandated health benefits are excluded  
23 under this policy.'

24 33-63-4.

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

30 33-63-5.

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



1 "45-18-11.

2 (a) Any benefits payable under the plan may be made either directly to the attending  
3 physicians, hospitals, medical groups, or others furnishing the services upon which a claim  
4 is based or to the covered employee, upon presentation of valid bills for such services,  
5 subject to such provisions to facilitate payment as may be made by the board.

6 (b) The claims must be presented in writing to the board or its designee within two years  
7 from the date the service was rendered or else no benefits will be owed or paid.

8 (c) All drafts or checks issued by the board or the board's designee shall be void if not  
9 presented and accepted by the drawer's bank within six months of the date the draft or  
10 check was drawn. If the payee or member does not present the draft or check for  
11 acceptance during the seven years following the date the draft or check was issued, the  
12 draft or check will be void, funds will be retained in the insurance fund, and further  
13 payments for such claim will not be owed or paid.

14 (d) The board shall ensure that for claims submitted on or after July 1, 2007:

15 (1) Claims submitted electronically by a provider to the board, the department, or an  
16 agent thereof shall be paid or denied within 30 days; and

17 (2) Incentive payments of \$0.20 per prescription will be paid for each electronic data  
18 prescription drug order accepted and fulfilled by such pharmacist or pharmacy."

19 **SECTION 14.**

20 Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, known as the  
21 "Georgia Medical Assistance Act of 1977," is amended by revising Code Section 49-4-146,  
22 relating to time for action on claim, as follows:

23 "49-4-146.

24 (a) Except as provided in subsection (b), the ~~The~~ Department of Community Health,  
25 within three months of receiving a claim submitted on or after July 1, 1978, shall pay or  
26 deny the claim.

27 (b) For claims submitted on or after July 1, 2007:

28 (1) Claims submitted electronically by a provider to the Department of Community  
29 Health or its agent shall be paid or denied within 30 days; and

30 (2) Incentive payments of \$0.20 per prescription will be paid for each electronic data  
31 prescription drug order accepted and fulfilled by such pharmacist or pharmacy."

32 **SECTION 15.**

33 Said article is further amended by adding a new Code section to the end of such article, to  
34 read as follows:

1 "49-4-158.

2 A health care entity which is not in compliance with Code Section 31-7-17 shall not be  
3 eligible to be a provider of medical assistance pursuant to this article. No contract shall be  
4 entered into or renewed on or after January 1, 2008, between the department or a care  
5 management organization providing services under this article and a health care entity  
6 which is not in compliance with Code Section 31-7-17 for the purpose of providing  
7 services pursuant to this article."

8 **SECTION 16.**

9 For purposes of making appointments to the board of directors of the Georgia Health  
10 Insurance Exchange, this Act shall become effective upon its approval by the Governor or  
11 upon its becoming law without such approval. For all other purposes, this Act shall become  
12 effective on July 1, 2007.

13 **SECTION 17.**

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