Senate Bill 150
By: Senators Hill of the 32nd and Thomas of the 54th

A BILL TO BE ENTITLED
AN ACT

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

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regulations; to provide for the creation of the Georgia Health Insurance Exchange; to provide
for definitions; to provide for the selection, filling of vacancies, terms of office, and powers
and responsibilities of a board of directors; to provide for the selection of officers of the
board of directors; to provide for an exchange director and staff; to provide for enrollment
and coverage election of eligible individuals; to provide for the participation of plans in the
exchange; to provide underwriting rules; to provide for certain continuation of coverage; to
provide for the resolution of certain disputes; to provide for participating employer plans and
agreements; to provide for commissions for insurance producers using the exchange; to
provide certain forms and require certain information to be filed concerning insurance
coverage for employees; to authorize selected out-of-state insurers to offer health insurance
plans in Georgia; to provide for certain notices; to authorize the Commissioner of Insurance
to adopt certain rules and regulations; to provide for related matters; to amend Title 45 of the
Official Code of Georgia Annotated, relating to public officers and employees, so as to
provide that the Board of Community Health shall establish certain health insurance plans
for state employees; to provide that the board shall provide for certain incentives with regard
to such plans; to provide incentives for electronic prescribing and electronic submission of
claims; to amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia
Annotated, known as the "Georgia Medical Assistance Act of 1977," so as to provide
incentives for electronic prescribing and electronic submission of claims; to provide that a
health care entity which is not in compliance with certain data reporting requirements is not
eligible to provide Medicaid services; to provide for related matters; to provide effective
dates; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

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

"26-4-119.

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

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

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

SECTION 2.

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

"31-5A-7.

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

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

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

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

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

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

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documents such as, but not limited to, leases, contracts, debt instruments, itemized patient
bills, medical record abstracts, and related diagnostic information. Reported data elements
shall be reported in accordance with rules and regulations established by the department.
The department shall promulgate standards for the electronic format of data and may
require such data to be submitted in accordance with interoperability agreements. Data
submitted shall be certified by the chief executive officer or an appropriate and duly
authorized representative or employee of the licensed facility that the information
submitted is true and accurate. Specifications for data to be collected under this Code
section shall be developed by the department with input from the Georgia Patient Safety
Corporation established pursuant to Code Section 31-5A-8, affected entities, consumers,
purchasers, and such other interested parties as may be determined by the department.
(c) The department shall determine which medical conditions and procedures, performance
outcomes, and patient charge data to include on the website. When determining which
conditions and procedures to include, the department shall consider such factors as volume,
severity of the illness, urgency of admission, individual and societal costs, whether the
condition is acute or chronic, variation in costs, variation in outcomes, and magnitude of
variations and other relevant information. When determining which performance outcomes
to include, the department shall consider such factors as volume of cases, average patient
charges, average lengths of stay, complication rates, mortality rates, and infection rates,
among others, which shall be adjusted for case mix and severity, if applicable; provided,
however, the department may also consider such additional measures that are adopted by
the federal Centers for Medicare and Medicaid Studies, the National Quality Forum, the
Joint Commission on Accreditation of Healthcare Organizations, the federal Agency for
Healthcare Research and Quality, or a similar national entity that establishes standards to
measure the performance of health care providers or by other states. Performance outcome
indicators shall be risk adjusted or severity adjusted, as applicable, using nationally
recognized risk adjustment methodologies, consistent with the standards of the Agency for
Healthcare Research and Quality and as selected by the department. When determining
which patient charge data to include, the department shall consider such measures as
average charge, average net revenue per adjusted patient day, average cost per adjusted
patient day, and average cost per admission, among others.
(d) The department shall identify those prescription drugs for which price information
shall be collected. Such information shall include recent average wholesale prices and
retail prices. If a prescription drug is available in a generic form, price data shall be
reported for the generic drug and its brand name equivalent.
(e) The website shall be designed and operated to allow consumers to conduct an
interactive search that allows them to view and compare the information for specific health
care facilities, pharmacies, nursing homes, and assisted living facilities. Such information shall be made available by geographic area and by provider. The website shall include such additional information as is determined necessary by the department to ensure that the website enhances informed decision making among consumers, including definitions of all of the data and terms, descriptions of each procedure, appropriate guidance on how to use the data, and an explanation of why the data may vary between facilities. The department may include a notice on the website that the pricing information is based on a compilation of charges for the average patient and that each patient’s bill may vary from the average depending on the severity of illness, length of stay, and other factors. This notice may include a statement indicating that, at certain facilities, the charges may be negotiable for certain patients based upon the patient’s ability to pay.

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

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

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

31-5A-8.

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

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

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

(1) One representative from the board of regents affiliated with a medical school in Georgia;
(2) Two representatives with expertise in patient safety issues for the health insurer and health maintenance organization with the largest market shares, respectively, as measured by premiums written in this state for the most recent calendar year;
(3) One representative of an authorized medical malpractice insurer in this state;
(4) Two representatives of hospitals in this state;
(5) Four physicians;
(6) One nurse;
(7) One dentist; and
(8) One pharmacist.

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

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

(e) The corporation shall be authorized to:

(1) Secure staff necessary to properly administer the corporation;
(2) Collect, analyze, and evaluate patient safety data and quality and patient safety indicators, medical malpractice closed claims, and adverse incidents reported to the Department of Human Resources for the purpose of recommending changes in practices and procedures that may be implemented by health care practitioners and health care facilities to improve health care quality and to prevent future adverse incidents.

Notwithstanding any other provision of law, the Department of Human Resources shall make available to the corporation any adverse incident report submitted pursuant to Code Section 31-8-93. To the extent that adverse incident reports submitted are considered confidential and exempt from disclosure, the confidential and exempt status of such reports shall be maintained by the corporation;

(3) Establish a patient safety reporting system to: identify potential systemic problems that could lead to adverse incidents; enable publication of system-wide alerts of potential harm; and facilitate development of both facility specific and state-wide options to avoid
adverse incidents and improve patient safety. The reporting system shall record any potentially harmful event that could have had an adverse result but, through chance or intervention, in which harm was prevented submitted by hospitals, birthing centers, ambulatory surgical centers, nursing homes, assisted living facilities, and other providers. The reporting system shall be voluntary and anonymous and independent of mandatory reporting systems used for regulatory purposes;

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

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

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

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

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

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

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

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

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

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

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

(f) The corporation shall submit an annual report to the Governor, President of the Senate, Speaker of the House of Representatives, and the chairpersons of the Health and Human Services Committees of the Senate and the House of Representatives.
Subject to appropriations by the General Assembly, the corporation shall provide for the establishment of a central data base accessible through a website for the purpose of providing a clearing-house of electronic medical records accessible to health care providers, patients, and others as determined by the corporation. The data base shall include, at a minimum, vaccination records and prescription drug records. The corporation shall be authorized to coordinate with the Department of Human Resources, and the Department of Human Resources shall be authorized to share and release vaccination records maintained in the vaccination registry established pursuant to Code Section 31-12-3.1 to the corporation or its agent as long as any such release is in compliance with the federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191. The corporation shall be authorized to issue a request for proposals to select a private or other entity to develop, host, and maintain such data base and website.

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

### SECTION 3.

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

"31-7-17.

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

(b) All health care facilities licensed under this article which receive any state funds shall submit performance and outcome data as well as pricing information to the Department of Community Health as specified by such department pursuant to Code Section 31-5A-7. Such data shall be submitted at least annually or more frequently, as specified by the Department of Community Health."
(c) No health care facility or other reporting entity or its employees or agents shall be held liable for civil damages or subject to criminal penalties either for the reporting of patient data to the Department of Community Health or for the release of such data by such department pursuant to Code Section 31-5A-7.

(d) A health care facility which is not in compliance with this Code section:
   (1) May be subject to consequences pursuant to Code Section 49-4-158; and
   (2) May be subject to having its certificate of need modified or sanctioned by the Department of Community Health as may be authorized pursuant to Article 3 of Chapter 6 of this title.

SECTION 4.

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

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

SECTION 5.

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

"CHAPTER 12

28-12-1. There is created as a joint committee of the General Assembly the Georgia Health Care Overview Committee to be composed of five members of the House of Representatives appointed by the Speaker of the House and five members of the Senate appointed by the Senate Committee on Assignments. The members of the committee shall serve two-year terms concurrent with their terms as members of the General Assembly. The chairperson of the committee shall be appointed by the Senate Committee on Assignments from the membership of the committee, and the vice chairperson of the committee shall be appointed by the Speaker of the House of Representatives from the membership of the committee. The chairperson and vice chairperson shall serve terms of two years concurrent

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

28-12-2.
The state auditor, the Attorney General, and all other agencies of state government, upon request by the committee, shall assist the committee in the discharge of its duties. The committee may employ not more than two staff members and may secure the services of independent accountants, engineers, and consultants.

28-12-3.
The Georgia Patient Safety Corporation shall cooperate with the committee, its authorized personnel, the Attorney General, the state auditor, the state accounting officer, and other state agencies. The Georgia Patient Safety Corporation shall submit to the committee such reports and data as the committee shall reasonably require of it. The Attorney General is authorized to bring appropriate legal actions to enforce any laws specifically or generally relating to the Georgia Patient Safety Corporation.

28-12-4.
The committee shall:

(1) Evaluate the performance of the Georgia Patient Safety Corporation consistent with the following criteria:
   (A) Prudent, legal, and accountable expenditure of public funds;
   (B) Efficient operation; and
   (C) Performance of statutory responsibilities;

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

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

28-12-5.
(a) The committee is authorized to expend state funds available to the committee for the discharge of its duties. Said funds may be used for the purposes of compensating staff, paying for services of independent accountants, engineers, and consultants, and paying all other necessary expenses incurred by the committee in performing its duties.
(b) The members of the committee shall receive the same compensation, per diem, expenses, and allowances for their service on the committee as is authorized by law for members of interim legislative study committees.

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

SECTION 6.

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

"(b) Such arrangements shall not:

(1) Unfairly deny health benefits for medically necessary covered services;
(2) Have differences in benefit levels payable to preferred providers compared to other providers which unfairly deny benefits for covered services;
(3) Have differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers which differ by more than 30\% 40\%;
(4) Have a coinsurance percentage applicable to benefit levels for services provided by nonpreferred providers which exceeds 40\% 50\% percent of the benefit levels under the policy for such services;
(5) Have an adverse effect on the availability or the quality of services; and
(6) Be a result of a negotiation with a primary care physician to become a preferred provider unless that physician shall be furnished, beginning on and after January 1, 2001, with a schedule showing common office based fees payable for services under that arrangement."

SECTION 7.

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

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

SECTION 8.

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

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

SECTION 9.

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

"33-30-16. (a) Employers who employ persons who are also employed by other employers shall be authorized to enter into arrangements with such other employers to provide group health insurance coverage for such employees by contributing to the cost of such health care insurance provided by such other employers. (b) The commissioner shall promulgate such rules and regulations as necessary to regulate and enable such contributions to group health care insurance coverage by additional employers of an insured.”

SECTION 10.

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

"CHAPTER 62

33-62-1. As used in this chapter, the term:
(1) 'Applicant' means an individual seeking to participate in the Georgia Health Insurance Exchange.

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

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

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

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

(A) A group health plan;

(B) Health insurance coverage;

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

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

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

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

(G) A state health benefits risk pool;

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

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

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

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

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

(6) 'Dependent' means:

(A) The spouse of the principal insured; or

(B)(i) An individual who is related to the principal insured by birth, marriage, or adoption; and
(ii) Who also meets the definition of a dependent as set forth in the United States Internal Revenue Code (26 U.S.C. Section 152).

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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

(20) 'Self-funded health benefit plan' means a health insurance plan, not subject to regulation by this state or any other state, that is paid in whole or in part by the employer from its own assets or from a funded welfare benefit plan, provided that such plan does not shift any risk or liability for benefit payments to an insurer or other carrier other than through reinsurance or stop-loss coverage.
(a) There is hereby chartered and established by the State of Georgia the Georgia Health Insurance Exchange as a body corporate and an independent instrumentality of the State of Georgia, created to effectuate public purposes provided for in this chapter, but with a legal existence separate from that of the State of Georgia.
(b) The Georgia Health Insurance Exchange is hereby recognized as a not for profit corporation in accordance with the provisions of the laws of Georgia and shall seek recognition of the same status by the United States in accordance with the provisions of the United States Internal Revenue Code (26 U.S.C. Section 501(c)).
(c) The Georgia Health Insurance Exchange is created for the limited purpose of providing the residents of Georgia, and such other individuals as may, from time to time, also be eligible to participate, with greater access to, and choice and portability of, health insurance products.
(d) The Georgia Health Insurance Exchange shall operate in accordance with all requirements and restrictions set forth in this chapter and all other applicable laws of Georgia and the United States.
(e) All eligible individuals shall be permitted to obtain health insurance benefits through the Georgia Health Insurance Exchange, subject to the provisions of this chapter.

33-62-3.
(a) The exchange shall be governed by a board of directors. The board of directors shall consist of three members appointed by the Governor, three members appointed by the Senate Committee on Assignments, and three members appointed by the Speaker of the House of Representatives. The initial appointees to the board of directors shall be appointed to terms of office beginning July 1, 2007. Each appointing authority shall designate one of the authority’s initial appointees to serve a term of office ending on June 30, 2009; one appointee to serve a term of office ending on June 30, 2010; and one appointee to serve a term of office ending on June 30, 2011. Thereafter, successors shall be appointed by the appropriate appointing authority for three-year terms of office beginning on July 1 following the expiration of the previous member’s term of office and ending on June 30 three years later.
(b) Vacancies on the board of directors shall be filled by appointment by the appropriate appointing authority for the unexpired term of office. Members shall be eligible to succeed themselves in office.
(c) The board of directors shall at its initial meeting and the first meeting of each calendar year thereafter select from among its members a chairperson and a vice chairperson. The
board of directors shall also select at the same time a secretary who shall not be required to be a member of the board of directors.

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

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

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

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


(a) The exchange shall:

1. Publicize the existence of the exchange and disseminate information on eligibility requirements and enrollment procedures for the exchange;
2. Establish and administer procedures for enrolling eligible individuals in the exchange, including:
   (A) Creating a standard application form to collect information necessary to determine the eligibility and previous coverage history of an applicant; and
   (B) Preparing and distributing certificate of eligibility forms and application forms to insurance producers and the general public;
3. Establish and administer a website at which individuals can examine the various health insurance options available to them and which contains a program or programs designed to assist individuals, after inputting basic information about themselves and any covered dependents, in determining the cost of the various health insurance options available to them and which health insurance options provide the best coverages at the least cost for the individuals;
4. Establish and administer procedures for the election of coverage by participating individuals, in accordance with Code Section 33-62-6, during open season periods and outside of open season periods upon the occurrence of any qualifying event specified in subsection (d) of Code Section 33-62-6, including preparing and distributing to participating individuals:
   (A) Descriptions of the coverage, benefits, limitations, copayments, and premiums for all participating plans; and
   (B) Forms and instructions for electing coverage and arranging payment for coverage;
(5) Collect and transmit to the applicable participating plans all premium payments or contributions made by or on behalf of participating individuals, including developing mechanisms to:

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

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

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

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

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

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

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

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

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

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

33-62-5.

The exchange shall have the power to:

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

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

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

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

33-62-6.

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

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

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

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

(1) The individual loses coverage in an existing health insurance plan due to the death of a spouse, parent, or legal guardian;
(2) The individual or a covered dependent loses coverage in an existing health insurance plan due to a change in the individual’s employment status;
(3) The individual or a covered dependent loses coverage in an existing health insurance plan because of a divorce, separation, or other change in familial status;
(4) The individual loses coverage in an existing health insurance plan because he or she achieves an age at which coverage lapses under that plan;

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

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

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

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


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

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

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

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

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

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

(1) Withdrawal by the Commissioner; or

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

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

(f) Each plan certified by the Commissioner as eligible to be offered through the exchange shall contain a detailed description of benefits offered, including maximums, limitations, exclusions, and other benefit limits.
(g) Each plan certified by the Commissioner as eligible to be offered through the exchange shall provide, subject to the plan’s deductibles and coinsurance or copayment schedule, major medical coverage that includes the following:

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

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

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

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

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

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

(m) The Commissioner shall establish and administer regulations and procedures for certifying plans to participate in the exchange in accordance with the provisions of this Code section.
The following rules shall govern the imposition by carriers of any preexisting condition provisions and rating surcharges with respect to any participating individual covered by any participating insurance plan:

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

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

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

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

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

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

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

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


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

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

(1) The qualifying event consists of a loss of eligible individual status due to:
    (A) Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
    (B) Loss of qualified dependent status for any reason; and

(2) The participating individual elects to remain a participating individual and notifies the exchange of such election within 63 days of the qualifying event.
33-62-10. (a) The Commissioner shall establish procedures for resolving disputes arising from the operation of the exchange in accordance with the provisions of this chapter, including disputes with respect to:

(1) The eligibility of an individual to participate in the exchange;
(2) The imposition of a coverage surcharge on a participating individual by a participating plan; and
(3) The imposition of a preexisting condition provision on a participating individual by a participating plan.

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

33-62-11. (a) Any employer may apply to the exchange to be the sponsor of a participating employer plan.

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

(1) The sponsoring employer designates the exchange director to be the plan’s administrator for the employer’s group health plan, and the exchange director agrees to undertake the obligations required of a plan administrator under federal law;
(2) Only the coverage and benefits offered by participating insurance plans shall constitute the coverage and benefits of the participating employer plan;
(3) Any individuals eligible to participate in the exchange by reason of their eligibility for coverage under the employer’s participating employer plan, regardless of whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan, may elect coverage under any participating insurance plan, and neither the employer nor the exchange shall limit such individuals’ choice of coverage from among all the participating insurance plans;
(4) The employer reserves the right to offer benefits supplemental to the benefits offered through the exchange, but any supplemental benefits offered by the employer shall constitute a separate plan or plans under federal law for which the exchange director shall not be the plan administrator and for which neither the exchange director nor the exchange shall be responsible in any manner;

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

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

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

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

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

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

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

(c) The exchange may not enter into any agreement with any employer with respect to any employer participating plan if such agreement does not, at a minimum, incorporate the conditions specified in subsection (b) of this Code section.
(d) The exchange may not enter into any agreement with any employer with respect to any participating employer plan to provide the participating employer plan with any additional or different services or benefits not otherwise provided or offered to all other participating employer plans.

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

33-62-12.

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

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


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

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

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

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

(b) Each form shall be signed by the individual to whom it pertains.
(c) Each self-employed individual in this state shall annually file the same form with the Commissioner.

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

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

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

33-62-14.

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

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

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

SECTION 11.

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

"CHAPTER 63

33-63-1.

The General Assembly recognizes the need for individuals, employers, and other purchasers of health insurance coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. Therefore, the General Assembly seeks to increase the availability of health insurance coverage by allowing insurers authorized to engage in the business of insurance in selected states to issue accident and sickness policies in Georgia.
33-63-2.
The selected out-of-state insurers shall not be required to offer or provide state mandated health benefits required by Georgia law or regulations in health insurance policies sold to Georgia residents.

33-63-3.
(a) Each written application for participation in an out-of-state health benefit plan shall contain the following language in boldface type at the beginning of the document:

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

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

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

33-63-4.
The Commissioner shall be authorized to conduct market conduct and solvency examinations of all out-of-state companies seeking to offer health benefit plans in this state or who have been given approval to offer health benefit plans in this state. Such examinations shall be conducted in the same manner and under the same terms and conditions as for companies located in this state.

33-63-5.
The Commissioner shall adopt rules and regulations necessary to implement this chapter, including, but not limited to, determining which health insurance companies located in other states shall be authorized to offer plans to Georgia residents and determining the manner of approving the health benefit plans offered by such companies."

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SECTION 12.

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

"45-18-2.

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

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

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

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

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

SECTION 13.

Said title is further amended by revising Code Section 45-18-11, relating to the procedure for presentation of claims and payment of benefits, as follows:
"45-18-11.
(a) Any benefits payable under the plan may be made either directly to the attending physicians, hospitals, medical groups, or others furnishing the services upon which a claim is based or to the covered employee, upon presentation of valid bills for such services, subject to such provisions to facilitate payment as may be made by the board.
(b) The claims must be presented in writing to the board or its designee within two years from the date the service was rendered or else no benefits will be owed or paid.
(c) All drafts or checks issued by the board or the board’s designee shall be void if not presented and accepted by the drawer’s bank within six months of the date the draft or check was drawn. If the payee or member does not present the draft or check for acceptance during the seven years following the date the draft or check was issued, the draft or check will be void, funds will be retained in the insurance fund, and further payments for such claim will not be owed or paid.
(d) The board shall ensure that for claims submitted on or after July 1, 2007:
   (1) Claims submitted electronically by a provider to the board, the department, or an agent thereof shall be paid or denied within 30 days; and
   (2) Incentive payments of $0.20 per prescription will be paid for each electronic data prescription drug order accepted and fulfilled by such pharmacist or pharmacy."

SECTION 14.
Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, known as the "Georgia Medical Assistance Act of 1977," is amended by revising Code Section 49-4-146, relating to time for action on claim, as follows:
"49-4-146.
(a) Except as provided in subsection (b), the Department of Community Health, within three months of receiving a claim submitted on or after July 1, 1978, shall pay or deny the claim.
(b) For claims submitted on or after July 1, 2007:
   (1) Claims submitted electronically by a provider to the Department of Community Health or its agent shall be paid or denied within 30 days; and
   (2) Incentive payments of $0.20 per prescription will be paid for each electronic data prescription drug order accepted and fulfilled by such pharmacist or pharmacy."

SECTION 15.
Said article is further amended by adding a new Code section to the end of such article, to read as follows:
"49-4-158.

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

SECTION 16.

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

SECTION 17.

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