Senate Bill 151

By: Senator Hill of the 32nd

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to create the Georgia Health Security Underwriting Authority; to provide alternative mechanism coverage for the availability of individual health insurance; to provide definitions; to provide for an assignment group underwriting board; to provide for powers, duties, and authority of the board; to provide for the selection of an administrator or administrators; to provide for the duties of the Commissioner of Insurance with respect to the board and assignment group; to provide for the establishment of rates; to provide for eligibility for and termination of coverage; to provide for minimum assignment group benefits; to provide for certain exclusions for preexisting conditions; to provide for funding; to provide for complaint procedures; to provide for audits; to provide for certain reports; to provide for related matters; to repeal the Georgia High Risk Health Insurance Plan; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by revising subsection (b) of Code Section 33-6-4, relating to the enumeration of unfair methods of competition and unfair or deceptive acts or practices, by adding a new paragraph (13.1) to read as follows:

"(13.1) It is unfairly discriminatory to terminate group coverage for a dependent because coverage was originally issued in the name of the insured and (i) the insured has divorced, separated from, or lost custody of the dependent; and (ii) the insured´s coverage has terminated voluntarily or involuntarily. If termination results from an act or omission of the insured, the dependent shall be deemed a qualifying eligible individual under Code Section 33-24-21.1 or 33-29A-2 and may obtain continuation and alternative mechanism coverage for the availability of individual health insurance coverage, as contemplated by

Section 2741 of the federal Public Health Service Act, 42 U.S.C. Section 300gg-41, notwithstanding the act or omission of the insured;″.

SECTION 2.

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

″33-24-21.1.

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

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

(A) Medicare or Medicaid;

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

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

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

(E) A conversion policy;

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

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

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

(I) A state health benefits risk pool;

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

(K) A public health plan; or

(L) A Peace Corps Act health benefit plan.

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

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

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

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

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

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

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

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

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

(6) 'Qualifying eligible individual' means:

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

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

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

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

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

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

(c) Any group member or qualifying eligible individual whose coverage has been terminated and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage and the coverage of his or her eligible dependents continued under the contract or plan. Such coverage must continue for the fractional policy month remaining, if any, at

termination plus three additional policy months upon payment of the premium by cash, certified check, or money order, at the option of the employer, to the policyholder or employer, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. Such premium payment must include any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage. At the end of such period, the group member shall have the same conversion rights that were available on the date of termination of coverage in accordance with the conversion privileges contained in the group contract or group plan.

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

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

(e) If the group contract or group plan terminates while any group member or qualifying eligible individual is covered or whose coverage is being continued, the group administrator, as prescribed by the insurer, must notify each such group member or qualifying eligible individual that he or she must exercise his or her conversion rights and rights to alternative mechanism coverage for the availability of individual health insurance

coverage, as contemplated by Section 2741 of the federal Public Health Service Act, 42 U.S.C. Section 300gg-41, within:

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

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

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

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

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

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

~~(A) Solely for purposes of this subsection, the claims experience produced by all groups covered under comprehensive major medical or hospitalization accident and~~

~~sickness insurance for each insurer shall be fully pooled to determine the group pool rate. Except to the extent that the claims experience of an individual group affects the overall experience of the group pool, the claims experience produced by any individual group of each insurer shall not be used in any manner for enhanced conversion policy rating purposes;~~

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

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

~~(3)~~(1) Any group member who is not a qualifying eligible individual and whose insurance under the group policy has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than eligibility for medicare (reaching a limiting age for coverage under the group policy) or failure of the group member to pay a required premium contribution, and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group coverage covering such group member and any eligible dependents who were covered under the group member´s coverage under the group contract or group plan. Such conversion

coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The premium of the basic converted policy shall be determined in accordance with the insurer´s table of premium rates applicable to the age and classification of risks of each person to be covered under that policy and to the type and amount of coverage provided. This form of conversion coverage shall be known as the 'Basic Conversion ~~Option'; and~~ Option.'

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

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

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

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

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

SECTION 3.

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

"CHAPTER 29A

33-29A-1.

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

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

33-29A-2.

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

(1) 'Administrator' shall have the same meaning as the term 'administrator' as defined in Code Section 33-23-100.

(2) 'Assignment group' means the assignment group administered by the Georgia Health Security Underwriting Authority.

(3) 'Assignment group coverage' means coverage offered by plan administrators on behalf of the assignment group to eligible persons.

(4) 'Board' means the board of directors of the Georgia Health Security Underwriting Authority created under this chapter.

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

(6) 'Covered person' means any individual resident of this state, excluding dependents, who is eligible to receive benefits from any insurer.

(7) 'Creditable coverage' and 'eligible individual' have the same meanings as specified in Sections 270l and 2741 of the federal Public Health Service Act, 42 U.S.C. Sections 300gg and 300gg-41.

(8) 'Department' means the Department of Insurance.

(9) 'Dependent' shall have the same meaning as provided in paragraph (3) of subsection (a) of Code Section 33-29-2 or as qualified in paragraph (4) of Code Section 33-30-4.

(10) 'Family member' means a parent, grandparent, brother, or sister, whether such relationship is established by birth or by law.

(11) 'Health insurance' means any hospital or medical expense incurred policy, nonprofit health care services plan contract, health maintenance organization, subscriber contract, or any other health care plan or insurance arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise, when sold to an individual or as a group policy. This term does not include limited benefit insurance policies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33-29A-3.

(a) There is created a body corporate to be known as the 'Georgia Health Security Underwriting Authority' which shall be deemed to be a public corporation. The Georgia Health Security Underwriting Authority shall have perpetual existence, and any change in the name or composition of the assignment group or Georgia Health Security Underwriting Authority shall in no way impair the obligations of any contracts existing under this chapter.

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

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

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

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

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

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

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

33-29A-4.

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

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

(1) Operation of the assignment group;

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

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

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

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

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

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

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

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

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

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

33-29A-5.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33-29A-6.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33-29A-7.

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

33-29A-8.

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

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

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

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

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

33-29A-9.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Assignment group coverage shall cease:

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

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

(3) Upon the death of the covered person;

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

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

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

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

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

33-29A-10.

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

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

(2) At least two health benefit products to be offered by the assignment group, one of which shall be a plan utilizing a high deductible health plan (HDHP) that is health savings account (HSA) eligible and one of which shall be a managed care plan. All health benefit products offered shall require participation by the insureds in disease and health management programs and shall provide varying benefits based upon the insureds´ compliance with such programs;

(3) The applicable schedules of benefits; and

(4) Any exclusions to coverage and other limitations.

(b) The benefits provisions of the assignment group´s health benefits coverages shall include the following:

(1) All required or applicable definitions;

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

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

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

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

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

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

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

33-29A-11.

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

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

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

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

33-29A-12.

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

(b) The board with review and approval of the Commissioner shall develop an accounting method to estimate future and determine actual claims of payors accepting direct assignment of risks from the assignment group along with administrative costs of the assignment group and plan administrators.

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

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

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

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

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

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

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

33-29A-13.

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

33-29A-14.

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

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

33-29A-15.

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

33-29A-16.

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

SECTION 4.

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

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

SECTION 5.

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

SECTION 6.

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