

The Senate Insurance and Labor Committee offered the following substitute to SB 453:

A BILL TO BE ENTITLED
AN ACT

1 To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to
2 change certain provisions concerning use of the premium taxes; to change certain provisions
3 of the group accident and sickness contracts, conversion privilege, and continuation of right
4 provisions; to provide for the creation of the Georgia Individual High Risk Reinsurance Pool;
5 to provide for definitions; to provide for operation; to provide for powers and authority; to
6 provide for reinsurance; to provide for premium rates; to provide for assessments; to provide
7 for standards for agents; to provide for design of products; to make certain funding
8 provisions contingent upon passage of a constitutional amendment; to provide for an
9 effective date and applicability; to provide for related matters; to repeal the Commission on
10 the Georgia Health Insurance Risk Pool; to repeal conflicting laws; and for other purposes.

11 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

12 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
13 revising Code Section 33-8-4, relating to amount and method of computing tax on insurance
14 premiums generally, by adding a new subsection to read as follows:
15

16 "(a.1) One-fourth of 1 percent of premium taxes collected pursuant to this Code section
17 shall offset losses of the Georgia High Risk Individual Reinsurance Pool, as provided in
18 Code Section 33-29A-10."

SECTION 2.

19 Said title is further amended by revising Code Section 33-24-21.1, relating to group accident
20 and health contracts conversion privilege and continuation right provisions, by adding a new
21 subsection to read as follows:
22

23 "(m) Enhanced conversion option coverage for qualified eligible individuals as defined
24 under this Code section shall no longer be issued after eligible individuals under Article 1
25 of Chapter 29A of Title 33 is offered coverage through the Georgia high risk individual
26 reinsurance pool as provided in that chapter."

27 **SECTION 3.**

28 Said title is further amended by striking Article 2 of Chapter 29A, relating to the Commission
29 on the Georgia Health Insurance Risk Pool, and inserting a new article to read as follows:

30 "ARTICLE 2

31 33-29A-20.

32 (a) It is the intention of this article together with Code Section 33-24-21.1 to provide an
33 acceptable alternative mechanism for the availability of individual health insurance
34 coverage, as contemplated by Section 2741 of the federal Public Health Service Act, 42
35 U.S.C.A. Section 300gg-41. This article shall be construed and administered so as
36 accomplish such intention.

37 (b) As provided in subsection (m) in Code Section 33-24-21.1, enhanced conversion
38 option coverage for qualified eligible individuals as defined under that Code section shall
39 no longer be issued after eligible individuals under this article are offered coverage through
40 the Georgia High Risk Individual Reinsurance Pool as provided in this article.

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

44 33-29A-21.

45 (a) As used in this article, the terms:

46 (1) 'Agent' means a producer as defined in Code Section 33-23-1.

47 (2) 'Board' means the board of directors of the Georgia High Risk Individual Reinsurance
48 Pool established in this article.

49 (3) 'Carrier' means any entity that provides, or is authorized to provide, health insurance
50 in this state. For purposes of this article, carrier includes an insurance company, any
51 other entity providing reinsurance including excess or stop loss coverage, a hospital or
52 professional service corporation, a fraternal benefit society, a managed care organization,
53 any entity providing health insurance coverage or benefits to residents of this state as
54 certificate holders under a group policy issued or delivered outside of this state, and any
55 other entity providing a plan of health insurance or health benefits subject to state
56 insurance regulation.

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

58 (5) 'Creditable coverage' and 'eligible individual' have the same meaning as specified in
59 Sections 2701 and 2741 of the federal Public Health Service Act, 42 U.S.C.A. Sections
60 300gg and 300gg-41.

61 (6) 'Dependent' means a spouse, an unmarried child under the age of 21 years, an
 62 unmarried child who is a full-time student under the age of 25 years and who is
 63 financially dependent upon the parent, and an unmarried child of any age who is
 64 medically certified as disabled and dependent upon the parent.

65 (7) 'Eligible individual' means:

66 (A) A Georgia resident individual or dependent of a Georgia resident who is under the
 67 age of 65 years, is not eligible for coverage under a group health plan, Part A or Part
 68 B of Title XVIII of the Social Security Act (medicare), or a state plan under Title XIX
 69 (Medicaid) or any successor program, and who does not have other health insurance
 70 coverage;

71 (B) An individual who is legally domiciled in Georgia on the date of application to the
 72 pool and is eligible for the credit for health insurance costs under Section 35 of the
 73 Internal Revenue Code of 1986; or

74 (C) A Georgia resident individual or a dependent of a Georgia resident who is a
 75 federally eligible individual which means an individual who meets the eligibility
 76 criteria set forth in the federal Health Insurance Portability and Accountability Act of
 77 1996 Public Law 104-191, subsection (b) of Section 2741 (HIPAA).

78 Coverage provided under this article shall not be available to any individual who is
 79 covered under other health insurance coverage, except as provided in Code Section
 80 33-29A-12. For purposes of this article, to be eligible, an individual must also meet the
 81 requirements of Code Section 33-29A-12.

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

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

87 (10) 'Health benefit plan' means any hospital or medical policy or certificate, any
 88 subscriber contract provided by a hospital or professional service corporation, or health
 89 maintenance organization subscriber contract. Health benefit plan does not include
 90 policies or certificates of insurance for specific disease, hospital confinement indemnity,
 91 accident-only, credit, dental, vision, medicare supplement, long-term care, or disability
 92 income insurance, student health benefits only, coverage issued as a supplement to
 93 liability insurance, worker's compensation or similar insurance, automobile medical
 94 payment insurance, or nonrenewable short-term coverage issued for a period of 12
 95 months or less.

96 (11) 'Individual carrier' means a carrier that offers health benefit plans covering eligible
 97 individuals and their dependents.

98 (12) 'Individual HSA compatible health benefit plan' means a health savings account
 99 compatible health benefit plan accepted for use in the pool pursuant to Code Section
 100 33-29A-13.

101 (13) 'Individual health benefit plan' means a health benefit plan accepted for use in the
 102 pool pursuant to Code Section 33-29A-13.

103 (14) 'Managed care organization' means a health maintenance organization or a nonprofit
 104 health care corporation.

105 (15) 'Plan' or 'pool plan' means the individual or HSA compatible health benefit plan
 106 accepted for use in the pool pursuant to Code Section 33-29A-13.

107 (16) 'Plan of operation' means the plan of operation of the individual high risk
 108 reinsurance pool established pursuant to this article.

109 (17) 'Pool' means the Georgia Individual High Risk Reinsurance Pool created under
 110 Code Section 33-29A-4.

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

114 33-29A-22.

115 Each health insurer and managed care corporation which is licensed to and does offer
 116 health insurance coverage in this state shall as a condition of such licensure agree to
 117 participation in the Georgia individual high risk reinsurance pool as provided in this article.
 118 This Code section shall not apply to an entity which offers only excepted benefits as
 119 specified in Section 2791(c) of the federal Public Health Service Act, 42 U.S.C.A. Section
 120 300gg-91(c).

121 33-29A-23.

122 (a) There is hereby created an independent public body corporate and politic to be known
 123 as the Georgia individual high risk reinsurance pool. The pool will perform an essential
 124 governmental function in the exercise of powers conferred upon it in this article. The pool
 125 and any assessments imposed or collected pursuant to the operation of the pool shall at all
 126 times be free from taxation of every kind.

127 (b) The pool created by this article, shall operate subject to the supervision and control of
 128 the board. The board shall consist of ten members. Eight members shall be appointed by
 129 the commissioner and serve at the pleasure of the commissioner. The commissioner or his
 130 designated representative shall serve as an ex officio member of the board. In selecting the
 131 members of the board the commissioner shall appoint four members representing carriers,
 132 two agents, and two members representing consumer interests. One member shall be a

133 member of the Senate appointed by the President of the Senate and one member shall be
 134 a member of the House of Representatives appointed by the Speaker of the House.

135 (c) The initial nonlegislative board members shall be appointed as follows: two of the
 136 members to serve a term of two years; three of the members to serve a term of four years;
 137 and three of the members to serve a term of six years. Subsequent nonlegislative board
 138 members shall serve for a term of three years. Legislative members of the board shall serve
 139 for a term of two years. A vacancy in a legislative member's position on the board shall
 140 be filled in the same manner as the original appointment. All other vacancies on the board
 141 shall be filled by the commissioner. A nonlegislative board member may be removed by
 142 the commissioner for cause.

143 33-29A-24.

144 (a) The board shall submit to the commissioner a plan of operation and thereafter any
 145 amendments thereto necessary or suitable to assure the fair, reasonable, and equitable
 146 administration of the pool. The commissioner may, after notice and hearing, approve the
 147 plan of operation if the commissioner determines it to be suitable to assure the fair,
 148 reasonable and equitable administration of the pool, and to provide for the sharing of pool
 149 gains or losses on an equitable and proportionate basis in accordance with the provisions
 150 of this article. The plan of operation shall become effective upon written approval by the
 151 commissioner.

152 (b) If the board fails to submit a suitable plan of operation, the commissioner shall, after
 153 notice and hearing, adopt and promulgate a temporary plan of operation. The
 154 commissioner shall approve the plan of operation submitted by the board, or adopt a
 155 temporary plan of operation if the board fails to submit a suitable plan. The commissioner
 156 shall amend or rescind any plan adopted under the provisions of this Code section at the
 157 time a plan of operation is submitted by the board and approved by the commissioner.

158 (c) The plan of operation shall:

159 (1) Establish procedures for handling and accounting of pool assets and moneys and for
 160 an annual fiscal reporting to the commissioner;

161 (2) Establish procedures for selecting an administrator, and setting forth the powers and
 162 duties of the administrator;

163 (3) Establish procedures for entering into agreements with private reinsurance carriers
 164 to obtain reinsurance and to facilitate coordination and responsibility for claims between
 165 health insurers and reinsurance carriers in accordance with the provisions of this article;

166 (4) Establish procedures for collecting assessments from carriers to fund claims,
 167 administrative expenses, and any reinsurance costs incurred or estimated to be incurred
 168 by the pool; and

169 (5) Provide for any additional matters necessary for the implementation and
170 administration of the pool.

171 33-29A-25.

172 (a) The pool shall have the general powers and authority granted under the laws of this
173 state to insurance companies and managed care organizations licensed to transact business,
174 except the power to issue health benefit plans directly to individuals. In addition thereto,
175 the pool shall have the specific authority to:

176 (1) Enter into contracts as are necessary or proper to carry out the provisions and
177 purposes of this article, including the authority, with the approval of the commissioner,
178 to enter into contracts with similar programs of other states for the joint performance of
179 common functions or with persons or other organizations for the performance of
180 administrative functions;

181 (2) Sue or be sued, including taking any legal actions necessary or proper to recover any
182 assessments and penalties for, on behalf of, or against the pool or any carrier;

183 (3) Designate health benefit plans, which shall allow coordination of benefits, for which
184 reinsurance will be provided, and to obtain reinsurance policies, in accordance with the
185 requirements of this article;

186 (4) Establish rules, conditions, and procedures for obtaining reinsurance coverage under
187 the pool;

188 (5) Establish actuarial functions as appropriate for the operation of the pool;

189 (6) Assess carriers in accordance with the provisions of Code Section 33-29A-10, and
190 make advance interim assessments of carriers as may be reasonable and necessary for
191 organizational and interim operating expenses. Any interim assessments shall be credited
192 as offsets against any regular assessments due following the close of the fiscal year. In
193 no event shall any assessments of carriers begin before the latter of the establishment of
194 a plan of operation for the pool or January 1, 2011;

195 (7) Appoint appropriate legal, actuarial and other committees as necessary to provide
196 technical assistance in the operation of the pool, policy and other contract design, and any
197 other function within the authority of the pool;

198 (8) Borrow money to effect the purposes of the pool. Any notes or other evidence of
199 indebtedness of the pool not in default shall be legal investments for carriers and may be
200 carried as admitted assets; and

201 (9) Establish rules, policies and procedures as may be necessary or convenient for the
202 implementation of this article and the operation of the pool.

203 (b) Neither the board nor its employees shall be liable for any obligations of the pool. No
204 member or employee of the board shall be liable, and no cause of action of any nature may

205 arise against them, for any act or omission related to the performance of their powers and
206 duties under this article, unless such act or omission constitutes willful or wanton
207 misconduct. The board may provide for indemnification of, and legal representation for,
208 its members and employees.

209 (c) The board shall establish procedures for review of declinations of coverage by
210 individual health insurers to reasonably assure that no such insurer is overburdening the
211 pool with decline rates that are excessive in comparison to other health insurers issuing
212 similar coverages.

213 (d) No participation of a reinsuring carrier in the pool, no establishment of rates, forms or
214 procedures, and no other joint or collective action required under the provisions of this
215 article shall be grounds for any legal action, criminal or civil liability, or penalty against
216 the pool or any of its reinsuring carriers either jointly or separately.

217 33-29A-26.

218 (a) Any individual carrier issuing an individual health benefit plan as provided in this
219 article shall be reinsured by a reinsurance carrier to the level of coverage provided in the
220 plan and shall be liable to the reinsurance carrier for the reinsurance premium.

221 (b)(1) The pool shall not reimburse a reinsuring carrier with respect to the claims of a
222 reinsured individual or dependent until the carrier has incurred an initial level of claims
223 for such individual or dependent of the amount determined by the pool in accordance
224 with the provisions of this chapter in a calendar year for benefits covered by the pool. In
225 addition, the reinsuring carrier shall be responsible for a percentage determined by the
226 pool in accordance with the provisions of this chapter of a coinsurance retention limit
227 determined by the pool of benefit payments during a calendar year and the pool shall
228 reinsure the remainder.

229 (2) The board annually may adjust the initial level of claims and the maximum limit to
230 be retained by the carrier to reflect increases in costs and utilization within the standard
231 market for health benefit plans within the state. The adjustment shall not be less than the
232 annual change in the medical component of the 'Consumer Price Index for All Urban
233 Consumers' of the department of labor, bureau of labor statistics, unless the board
234 proposes and the commissioner approves a lower adjustment factor.

235 (c) A reinsuring carrier shall apply all managed care and claims handling techniques,
236 including utilization review, individual case management, preferred provider provisions,
237 wellness programs and other managed care provisions or methods of operation consistently
238 with respect to reinsured and nonreinsured business without regard to whether retention
239 limits established according to this chapter have been reached.

240 (d) Each carrier shall make a filing with the commissioner containing the carrier's earned
241 health insurance premium derived from health benefit plans delivered or issued for delivery
242 in this state in the previous calendar year.

243 (e) Each carrier shall file with the commissioner, in a form and manner to be prescribed
244 by the commissioner, an annual report. The report shall state the number of resident
245 persons insured under the carrier's health benefit plan, or through excess or stop loss
246 coverage.

247 33-29A-27.

248 (a) The board, as part of the plan of operation, shall establish a methodology for
249 determining premium rates to be charged by reinsuring carriers to reinsure individuals
250 under this article. The methodology shall include a system for classification of individuals
251 that reflects the types of case characteristics commonly used by individual carriers in the
252 state. The methodology shall provide for the development of base reinsurance premium
253 rates, subject to the approval of the commissioner, which shall be set at levels which
254 reasonably approximate gross premiums charged to individuals by individual carriers for
255 health benefit plans with benefits similar to the standard health benefit plan, adjusted to
256 reflect retention levels required under the provisions of this article. Reinsuring carriers
257 desiring to use their own methodologies and methods for determining reinsurance premium
258 rates for use as provided under this article shall submit such proposal to the board for
259 approval before using their own methodologies.

260 (b) The board periodically shall review the methodology established under the provisions
261 of this Code section, including the system of classification and any rating factors, to assure
262 that it reasonably reflects the claims experience of the pool. The board may propose
263 changes to the methodology which shall be subject to the approval of the commissioner.

264 (c) The board may consider adjustments to the premium rates charged for health plans
265 approved for use as provided by this chapter to reflect the use of effective cost containment
266 and managed care arrangements.

267 33-29A-28.

268 (a) The board shall establish premium rates for coverage under the individual and HSA
269 compatible health benefit plans for eligible individuals only. Such rates shall be required
270 to be established according to acceptable standards according to Section 2741 of the federal
271 Public Health Service Act, 42 U.S.C.A. Section 300gg-41.

272 (b) Separate schedules of premium rates based on age, individual tobacco use, geography
273 as defined by rule of the commissioner, gender and benefit plan design shall apply for
274 individual risks.

275 (c) The board, with the assistance of the commissioner and in accordance with appropriate
 276 actuarial principles, shall determine a standard risk rate by using the average rates that
 277 individual standard risks in this state are charged by at least five of the largest health
 278 insurance carriers providing individual health insurance coverage to residents of Georgia
 279 that is substantially similar to the coverage offered by each pool plan. In determining the
 280 average rate or charges of those health insurance carriers, the rates charged by those
 281 carriers shall be actuarially adjusted to determine the rate that would have been charged for
 282 benefits similar to those provided by each plan. The standard risk rates shall be established
 283 using reasonable actuarial techniques and shall reflect anticipated claims experience,
 284 expenses, and other appropriate risk factors for such coverage.

285 (d) Rates for plan coverage shall not be less than 150 percent nor more than 180 percent
 286 of rates established as applicable for individual standard risks pursuant to paragraph (3) of
 287 this Code section.

288 33-29A-29.

289 (a) Prior to March 1 of each year, the board shall determine and report to the commissioner
 290 the pool's net loss for the previous calendar year, including administrative expenses and
 291 incurred losses for the year, taking into account investment income and other appropriate
 292 gains and losses, and any premium tax funds appropriated to the pool pursuant to Code
 293 Section 33-8-4.

294 (b) After accounting for factors listed in subsection (a), any net loss for the year shall be
 295 recouped by assessments of carriers.

296 (c)(1) For the assessment of March 1, 2012, and prior to March 1 of each succeeding
 297 year, the board shall determine and file with the commissioner an estimate of the
 298 assessments needed to fund the losses incurred by the pool in the previous calendar year.

299 (2) The individual assessments shall be determined by multiplying net losses, if net
 300 earnings are negative, as defined by subsection (a) of this Code section, by a fraction, the
 301 numerator of which shall be the carrier's total premiums earned in the preceding calendar
 302 year from all health benefit plans and policies or certificates of insurance for specific
 303 disease, and hospital confinement indemnity in this state as reported in the carrier's
 304 reports filed pursuant to Code Section 33-29A-7 paragraphs (4) and (5) including
 305 reinsurance by way of excess or stop loss coverage, and the denominator of which shall
 306 be the total premiums earned in the preceding calendar year from all health benefit plans
 307 and policies or certificates of insurance for specific disease and hospital confinement
 308 indemnity in this state, including reinsurance by way of excess or stop loss coverage.

309 (d) If assessments exceed net losses of the pool, the excess shall be held at interest and
310 used by the board to offset future losses or to reduce pool premiums. As used in this
311 paragraph, 'future losses' includes reserves for incurred but not reported claims.

312 (e) Each carrier's proportion of the assessment shall be determined annually by the board
313 based on annual statements and other reports deemed necessary by the board and filed by
314 the carriers with the commissioner.

315 (f) The plan of operation shall provide for the imposition of an interest penalty for late
316 payment of assessments.

317 (g) A carrier may seek from the commissioner a deferment from all or part of an
318 assessment imposed by the board. The commissioner may defer all or part of the
319 assessment if the commissioner determines that the payment of the assessment would place
320 the carrier in a financially impaired condition. If all or part of an assessment against a
321 carrier is deferred the amount deferred shall be assessed against the other carriers in a
322 manner consistent with the basis for assessment set forth in this Code section. The carrier
323 receiving the deferment shall remain liable to the pool for the amount deferred and shall
324 be prohibited from reinsuring any individuals with the pool until such time as it pays the
325 assessments.

326 33-29A-30.

327 The board, as part of the plan of operation, shall develop standards setting forth the manner
328 and levels of compensation to be paid to agents for the sale of individual and HSA
329 compatible health benefit plans for eligible individuals and their dependents only. In
330 establishing such standards, the board shall take into consideration the need to assure broad
331 availability of coverages, the objectives of the pool, the time and effort expended in placing
332 the coverage, the need to provide ongoing service to the individual, the levels of
333 compensation currently used in the industry and the overall costs of coverage to individuals
334 selecting these plans.

335 33-29A-31.

336 (a) Any eligible individual person, who is and continues to be a resident shall be eligible
337 for coverage under an individual and HSA compatible health benefit plan if evidence is
338 provided that:

339 (1) Such person has been rejected by two individual carriers on the basis of health status
340 or claims experience or an individual carrier reports to the pool that such person as an
341 applicant for coverage would be declined were it not for availability of reinsurance. In
342 such cases, each decline or prospective decline will be reviewed to determine if, with

343 reasonable confidence, such person would likely be declined by any other individual
 344 insurer participating in the pool;

345 (2) An individual carrier refuses to issue a health benefit plan providing coverage
 346 substantially similar to coverage offered under an equivalent pool plan except at a rate
 347 exceeding the rate for the pool plan, and such offer of coverage includes waivers of
 348 preexisting conditions. The pool shall have authority to review cases where an eligible
 349 individual wishes to refuse rated offers to provide for exceptions regarding eligibility;

350 (3) Such person is a federally eligible individual; or

351 (4) Such person is legally domiciled in Georgia on the date of application to the pool and
 352 is eligible for the credit for health insurance costs under Section 35 of the Internal
 353 Revenue Code of 1986. In addition, if such person maintained creditable health
 354 insurance coverage for an aggregate period of three months as of the date on which the
 355 individual seeks to enroll in pool coverage, not counting any period prior to a 63 day
 356 break in coverage:

357 (A) The preexisting condition limitations set forth in Section 35 of the Internal
 358 Revenue Code of 1986, shall apply; and

359 (B) The requirement for exhaustion of any available coverage under Title X of the
 360 Consolidated Omnibus Budget Reconciliation Act of 1986, Public Law 99-272
 361 (COBRA) or state continuation benefits is waived.

362 (b) A rejection or refusal by a carrier offering only stop loss, excess of loss or reinsurance
 363 coverage with respect to an applicant under subsection (a) of this Code section shall not
 364 constitute sufficient evidence for purposes of subsection (a) of this Code section.

365 (c) Each resident dependent of a person who is eligible for coverage under the pool shall
 366 also be eligible for coverage under the pool if such person is eligible for coverage under
 367 this chapter by virtue of a referring program that requires dependent eligibility.

368 (d) Any eligible individual person meeting the eligibility requirements of subsection (a),
 369 (b), or (c) of this Code section shall be eligible for coverage under a pool plan even though
 370 the person has existing coverage under other health insurance or under a group health plan
 371 provided: (1) there is a reasonable probability that the lifetime benefit maximum of the
 372 existing coverage will be exceeded within 90 days; and (2) the lifetime benefit maximum
 373 under the existing coverage is at least \$500,000.00. In all cases, coverage under a pool
 374 plan is secondary to the existing coverage and all other insurance.

375 (e) A person shall not be eligible for coverage under a pool plan if:

376 (1) The person is not a federally eligible individual and, except as provided otherwise in
 377 subsection (d) of this Code section, has or obtains health insurance coverage substantially
 378 similar to or more comprehensive than a pool plan, or would be eligible to have such

379 coverage at a rate not exceeding the rate for the pool plan if the person elected to obtain
 380 it;

381 (2) The person is determined to be eligible for health care benefits under Medicaid;

382 (3) The person has previously terminated pool plan coverage unless 12 months have
 383 lapsed since such termination; provided however, that this provision shall not apply with
 384 respect to an applicant who is a federally eligible individual; or

385 (4) The person is an inmate or resident of a state or other public institution, or a state,
 386 local or private correctional facility; provided however, that this provision shall not apply
 387 with respect to an applicant who is a federally eligible individual.

388 (f) Notwithstanding any other provision of this article, eligibility for continuation of
 389 coverage under COBRA shall not render a person ineligible for coverage under a pool plan,
 390 except that the pool may establish procedures for such eligible persons to be subject to
 391 limits on certain preexisting conditions not to exceed 12 months or the length of time
 392 remaining in COBRA eligibility, whichever is less.

393 (g) Coverage shall cease:

394 (1) On the first day of the month following the date a person is no longer a resident of
 395 this state;

396 (2) On the first day of the month following the date a person requests coverage to end;

397 (3) Upon the death of the covered person; or

398 (4) At the option of the board, 30 days after the plan makes any inquiry concerning the
 399 person's eligibility or place of residence to which the person does not reply.

400 (h) A person who ceases to meet the eligibility requirements of this Code section may be
 401 terminated on the first day of the month following the date when the individual becomes
 402 ineligible.

403 33-29A-32.

404 (a) The board shall review and approve or disapprove individual and HSA compatible
 405 health benefit plans submitted by individual health insurance carriers, with an emphasis on
 406 making coverage available for preventive care and wellness programs as provided under
 407 Georgia law.

408 (b) The board shall also review and approve or disapprove individual and HSA
 409 compatible health benefit plans which each contain benefit and cost-sharing arrangements
 410 that are consistent with the basic method of operation and the benefit plans of managed
 411 care organizations, including any restrictions imposed by federal law, which may include
 412 cost containment features such as the following:

413 (1) Utilization review of health care services, including review of medical necessity of
 414 hospital and physician services;

- 415 (2) Case management;
 416 (3) Selective contracting with hospitals, physicians and other health care providers;
 417 (4) Reasonable benefit differentials applicable to providers that participate or do not
 418 participate in arrangements using restricted network provisions; and
 419 (5) Other managed care provisions.
- 420 (c) Individual and HSA compatible health benefit plans submitted by individual health
 421 insurance carriers and approved for use in the pool shall meet minimum specifications
 422 required by Section 2741 of the federal Public Health Service Act, 42 U.S.C.A. Section
 423 300gg-41.
- 424 (d) The board may appoint an advisory committee to assist in reviewing and approving or
 425 disapproving the health benefit plans prescribed by this Code section.
- 426 (e) The board shall develop appeals procedures for individuals who have a grievance with
 427 the pool with regard to eligibility or termination of health plans issued pursuant to this
 428 chapter."

429 **SECTION 4.**

430 This Act shall become effective on January 1, 2011, only if an amendment to the
 431 Constitution authorizing the General Assembly to provide for allocation of 1/4 of 1 percent
 432 of premium taxes collected to offset the losses of the Georgia High Risk Individual
 433 Reinsurance Pool is ratified by the voters of the November, 2010, general election. If such
 434 an amendment is not so ratified, this Act shall not become effective and shall stand repealed
 435 on January 1, 2011.

436 **SECTION 5.**

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