

The House Committee on Insurance offers the following substitute to SB 310:

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 provide for regulation and licensure of pharmacy benefits managers by the Commissioner
3 of Insurance; to provide for definitions; to provide for license requirements and filing fees;
4 to provide for requirements and procedures affecting pharmacy benefits managers; to require
5 a surety bond; to provide that a pharmacy benefits manager shall not engage in the practice
6 of medicine; to make certain audit requirements applicable to pharmacy benefits managers;
7 to provide that a pharmacy benefits manager shall not have to be licensed as an
8 administrator; to provide for regulation and licensure of multiple employer self-insured
9 health plans by the Commissioner of Insurance; to change certain license requirements; to
10 remove certain aggregate excess stop-loss and individual excess stop-loss coverage
11 requirements; to change certain reporting requirements; to provide for a minimum loss ratio
12 percentage and standards; to provide for application requirements; to provide for
13 applicability of insurance laws; to provide for related matters; to provide for an effective
14 date; to repeal conflicting laws; and for other purposes.

15 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

16 SECTION 1.

17 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
18 adding a new chapter to read as follows:

19 "CHAPTER 64

20 33-64-1.

21 As used in this chapter, the term:

22 (1) 'Business entity' means a corporation, association, partnership, sole proprietorship,
23 limited liability company, limited liability partnership, or other legal entity.

24 (2) 'Commissioner' means the Commissioner of Insurance.

25 (3) 'Covered entity' means an employer, labor union, or other group of persons organized
 26 in this state that provides health coverage to covered individuals who are employed or
 27 reside in this state.

28 (4) 'Covered individual' means a member, participant, enrollee, contract holder, policy
 29 holder, or beneficiary of a covered entity who is provided health coverage by a covered
 30 entity.

31 (5) 'Health system' means a hospital or any other facility or entity owned, operated, or
 32 leased by a hospital and a long-term care home.

33 (6) 'Pharmacy benefits management' means the service provided to a health plan or
 34 covered entity, directly or through another entity, including the procurement of
 35 prescription drugs to be dispensed to patients, or the administration or management of
 36 prescription drug benefits, including, but not limited to, any of the following:

37 (A) Mail service pharmacy;

38 (B) Claims processing, retail network management, or payment of claims to
 39 pharmacies for dispensing prescription drugs;

40 (C) Clinical or other formulary or preferred drug list development or management;

41 (D) Negotiation or administration of rebates, discounts, payment differentials, or other
 42 incentives for the inclusion of particular prescription drugs in a particular category or
 43 to promote the purchase of particular prescription drugs;

44 (E) Patient compliance, therapeutic intervention, or generic substitution programs; and

45 (F) Disease management.

46 (7) 'Pharmacy benefits manager' means a person, business entity, or other entity that
 47 performs pharmacy benefits management. The term includes a person or entity acting for
 48 a pharmacy benefits manager in a contractual or employment relationship in the
 49 performance of pharmacy benefits management for a covered entity. The term does not
 50 include services provided by pharmacies operating under a hospital pharmacy license.
 51 The term also does not include health systems while providing pharmacy services for
 52 their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs
 53 for outpatient procedures.

54 33-64-2.

55 (a) No person, business entity, or other entity shall act as or hold itself out to be a
 56 pharmacy benefits manager in this state, other than an applicant licensed in this state for
 57 the kinds of business for which it is acting as a pharmacy benefits manager, unless such
 58 person, business entity, or other entity holds a license as a pharmacy benefits manager
 59 issued by the Commissioner pursuant to this chapter. The license shall be renewable on
 60 an annual basis. Failure to hold such license shall subject such person, business entity, or

61 other entity to the fines and other appropriate penalties as provided in Chapter 2 of this
62 title.

63 (b) An application for a pharmacy benefits manager's license or an application for renewal
64 of such license shall be accompanied by a filing fee of \$500.00 for an initial license and
65 \$400.00 for renewal.

66 (c) A license shall be issued or renewed and shall not be suspended or revoked by the
67 Commissioner unless the Commissioner finds that the applicant for or holder of the license:

68 (1) Has intentionally misrepresented or concealed any material fact in the application for
69 the license;

70 (2) Has obtained or attempted to obtain the license by misrepresentation, concealment,
71 or other fraud;

72 (3) Has committed fraud; or

73 (4) Has failed to obtain for initial licensure or retain for annual licensure renewal a net
74 worth of at least \$200,000.00.

75 (d) If the Commissioner moves to suspend, revoke, or nonrenew a license for a pharmacy
76 benefits manager, the Commissioner shall provide notice of that action to the pharmacy
77 benefits manager, and the pharmacy benefits manager may invoke the right to an
78 administrative hearing in accordance with Chapter 2 of this title.

79 (e) No licensee whose license has been revoked as prescribed under this Code section shall
80 be entitled to file another application for a license within five years from the effective date
81 of the revocation or, if judicial review of such revocation is sought, within five years from
82 the date of final court order or decree affirming the revocation. The application when filed
83 may be refused by the Commissioner unless the applicant shows good cause why the
84 revocation of its license shall not be deemed a bar to the issuance of a new license.

85 (f) Appeal from any order or decision of the Commissioner made pursuant to this chapter
86 shall be taken as provided in Chapter 2 of this title.

87 (g)(1) The Commissioner shall have the authority to issue a probationary license to any
88 applicant under this title.

89 (2) A probationary license may be issued for a period of not less than three months and
90 not longer than 12 months and shall be subject to immediate revocation for cause at any
91 time without a hearing.

92 (3) The Commissioner shall prescribe the terms of probation, may extend the
93 probationary period, or refuse to grant a license at the end of any probationary period in
94 accordance with rules and regulations.

95 (h) A pharmacy benefits manager's license may not be sold or transferred to a nonaffiliated
96 or otherwise unrelated party. A pharmacy benefits manager may not contract or
97 subcontract any of its negotiated formulary services to any unlicensed nonaffiliated

98 business entity unless a special authorization is approved by the Commissioner prior to
99 entering into a contracted or subcontracted arrangement.

100 (i) In addition to all other penalties provided for under this title, the Commissioner shall
101 have the authority to assess a monetary penalty against any person, business entity, or other
102 entity acting as a pharmacy benefits manager without a license of up to \$1,000.00 for each
103 transaction in violation of this chapter, unless such person, business entity, or other entity
104 knew or reasonably should have known it was in violation of this chapter, in which case
105 the monetary penalty provided for in this subsection may be increased to an amount of up
106 to \$5,000.00 for each and every act in violation.

107 (j) A licensed pharmacy benefits manager shall not market or administer any insurance
108 product not approved in Georgia or that is issued by a nonadmitted insurer or unauthorized
109 multiple employer self-insured health plan.

110 (k) In addition to all other penalties provided for under this title, the Commissioner shall
111 have the authority to place any pharmacy benefits manager on probation for a period of
112 time not to exceed one year for each and every act in violation of this chapter and may
113 subject such pharmacy benefits manager to a monetary penalty of up to \$1,000.00 for each
114 and every act in violation of this chapter, unless the pharmacy benefits manager knew or
115 reasonably should have known he or she was in violation of this chapter, in which case the
116 monetary penalty provided for in this subsection may be increased to an amount of up to
117 \$5,000.00 for each and every act in violation.

118 (l) A pharmacy benefits manager operating as a line of business or affiliate of a health
119 insurer, health care center, hospital service corporation, medical service corporation, or
120 fraternal benefit society licensed in this state or of any affiliate of such health insurer,
121 health care center, hospital service corporation, medical service corporation, or fraternal
122 benefit society shall not be required to obtain a license pursuant to this chapter. Such
123 health insurer, health care center, hospital service corporation, medical service corporation,
124 or fraternal benefit society shall notify the Commissioner annually, in writing, on a form
125 provided by the Commissioner, that it is affiliated with or operating as a line of business
126 as a pharmacy benefits manager.

127 33-64-3.

128 (a) Every applicant for a pharmacy benefits manager's license shall file with the
129 application and shall thereafter maintain in force a bond in the amount of \$100,000.00 in
130 favor of the Commissioner executed by a corporate surety insurer authorized to transact
131 insurance in this state. The terms and type of the bond shall be established by rules and
132 regulations.

133 (b) The bond shall remain in force until the surety is released from liability by the
134 Commissioner or until the bond is canceled by the surety. Without prejudice to any
135 liability accrued prior to cancellation, the surety may cancel the bond upon 30 days'
136 advance notice, in writing, filed with the Commissioner.

137 (c) Every applicant for a pharmacy benefits manager's license shall obtain and shall
138 thereafter maintain in force errors and omissions coverage or other appropriate liability
139 insurance, written by an insurer authorized to transact insurance in this state, in an amount
140 of at least \$250,000.00.

141 (d) The coverage required in subsection (c) of this Code section shall remain in force for
142 a term of at least one year and shall contain language that includes that the insurer may
143 cancel the insurance upon 60 days' advance notice filed with the Commissioner. Other
144 terms and conditions relating to the errors and omissions policy may be imposed on the
145 applicant in accordance with rules and regulations.

146 (e) In the event a licensed pharmacy benefits manager fails to renew, surrenders, or
147 otherwise terminates its license, it must retain both the bond and the errors and omissions
148 coverage for a period of not less than one year after the licensee has failed to renew,
149 surrendered, or otherwise terminated the license.

150 33-64-4.

151 No pharmacy benefits manager shall engage in the practice of medicine.

152 33-64-5.

153 Pharmacy benefits managers, whether licensed pursuant to this chapter or exempt from
154 licensure pursuant to subsection (l) of Code Section 33-64-2, shall be subject to Code
155 Section 26-4-118, 'The Pharmacy Audit Bill of Rights,' to the same extent and in the same
156 manner as pharmacies.

157 33-64-6.

158 A pharmacy benefits manager licensed pursuant to this chapter shall not be required to
159 obtain a license as an administrator pursuant to Article 2 of Chapter 23 of Title 33 to
160 perform any function as a pharmacy benefits manager pursuant to this chapter.

161 33-64-7.

162 The Commissioner may not enlarge upon or extend the provisions of this chapter through
163 any act, rule, or regulation.

164 **SECTION 2.**

165 Said title is further amended by revising Code Section 33-50-3, relating to the application for
 166 license for any multiple employer self-insured health plan, as follows:

167 "33-50-3.

168 (a) Application for a license ~~must~~ shall be made on forms prescribed by the Commissioner.
 169 ~~No multiple employer self-insured health plan may be licensed unless it has and maintains~~
 170 ~~a minimum of 250 covered employees.~~

171 (b) Every multiple employer self-insured health plan shall pay to the Commissioner annual
 172 license fees, as established by rule or regulation of the Commissioner.

173 (c) Every multiple employer self-insured health plan shall pay to the Commissioner the
 174 premium taxes ~~required for insurance companies as set forth in Chapter 8 of this title on~~
 175 the plan's net retained premium after deducting premium paid by the plan to its excess
 176 insurer and any other applicable deductions provided for in Chapter 8 of Title 33. The
 177 applicable premium tax rate shall be the applicable rates for insurance companies provided
 178 for in Chapter 8 of Title 33.

179 ~~(d) The Commissioner shall establish, by rule or regulation, security deposits for multiple~~
 180 ~~employer self-insured health plans."~~

181 **SECTION 3.**

182 Said title is further amended by revising Code Section 33-50-5, relating to aggregate excess
 183 stop-loss coverage and individual excess stop-loss coverage, as follows:

184 "33-50-5.

185 ~~A multiple employer self-insured health plan shall include aggregate excess stop-loss~~
 186 ~~coverage and individual excess stop-loss coverage provided by an insurer licensed by the~~
 187 ~~state. Aggregate excess stop-loss coverage shall include provisions to cover incurred,~~
 188 ~~unpaid claim liability in the event of plan termination. The excess or stop-loss insurer shall~~
 189 ~~bear the risk of coverage for any member of the pool that becomes insolvent with~~
 190 ~~outstanding contributions due. In addition, the plan shall have a participating employer's~~
 191 ~~fund in an amount at least equal to the point at which the excess or stop-loss insurer shall~~
 192 ~~assume 100 percent of additional liability. A plan shall submit its proposed excess or~~
 193 ~~stop-loss insurance contract to the Commissioner at least 30 days prior to the proposed~~
 194 ~~plan's effective date and at least 30 days subsequent to any renewal date. The~~
 195 ~~Commissioner shall review the contract to determine whether it meets the standards~~
 196 ~~established by this chapter and respond within a 30 day period. Any excess or stop-loss~~
 197 ~~insurance plan cannot be canceled without 90 days' notice to the insured and the~~
 198 ~~Commissioner.~~

- 199 (a) No multiple employer self-insured health plan shall be licensed unless it shall possess
200 and thereafter maintain a minimum surplus of at least \$200,000.00.
- 201 (b) A multiple employer self-insured health plan shall be subject to and comply with the
202 applicable regulatory action level risk-based capital requirements prescribed by Chapter
203 56 of this title.
- 204 (c) Every multiple employer self-insured health plan shall maintain a security deposit with
205 the Commissioner. The amount of the deposit shall be \$100,000.00 and shall be in the
206 form of securities eligible for the investment of capital funds of domestic insurers. The
207 deposit shall be administered in accordance with the provisions of Chapter 12 of this title.
- 208 (d) Every multiple employer self-insured health plan shall annually obtain an opinion from
209 a qualified actuary as to the adequacy of its loss reserves. Such opinion shall be prepared
210 and issued based on standards adopted from time to time by the Actuarial Standards Board
211 and in accordance with instruction prescribed by the National Association of Insurance
212 Commissioners.
- 213 (e) Every multiple employer self-insured health plan licensed pursuant to this chapter shall
214 have an annual audit by an independent certified public accountant in accordance with
215 Georgia Insurance Department Regulation 120-2-60 and instructions prescribed by the
216 National Association of Insurance Commissioners.
- 217 (f) Every multiple employer self-insured health plan shall file financial statements with the
218 Commissioner in accordance with the provisions of Georgia Insurance Department
219 Regulation 120-2-18-.06.
- 220 (g) Every multiple employer self-insured health plan shall obtain and thereafter maintain
221 aggregate excess stop-loss coverage and individual excess stop-loss coverage.
- 222 (1) Excess stop-loss coverage required by this Code section shall be issued by an insurer
223 licensed by the state.
- 224 (2) The retention limits for both the aggregate excess stop-loss coverage and individual
225 excess stop-loss coverage shall be determined annually by a qualified actuary based on
226 sound actuarial principles.
- 227 (3) Any stop-loss contract maintained pursuant to this Code section shall contain a
228 provision that the stop-loss insurer shall give the multiple employer self-insured health
229 plan and the Commissioner a minimum of 180 days' notice of cancellation or nonrenewal.
- 230 (4) If the multiple employer self-insured health plan fails to obtain replacement coverage
231 within 90 days after receipt of the notice of cancellation or nonrenewal, the trustees of the
232 plan shall provide for the orderly liquidation of the multiple employer self-insured health
233 plan.
- 234 (h) Each participating employer shall be jointly and severally liable for all legal
235 obligations of the multiple employer self-insured health plan.

236 (1) If the assets of the multiple employer self-insured health plan are at any time
 237 insufficient to enable the plan to discharge its legal liabilities and other obligations and
 238 to maintain the surplus required under this Code section, it shall forthwith make up the
 239 deficiency or levy an assessment upon its participating employers for the amount needed
 240 to make up the deficiency.

241 (2) If the multiple employer self-insured health plan fails to make up the deficiency or
 242 make the required assessment within 30 days after the Commissioner orders it to do so
 243 or if the deficiency is not fully made up within 60 days after the date on which any such
 244 assessment is made or within such longer period as may be specified by the
 245 Commissioner, the plan shall be deemed to be insolvent.

246 (3) If the liquidation of a multiple employer self-insured health plan is ordered, an
 247 assessment shall be levied upon its participating employers for such an amount as the
 248 Commissioner determines to be necessary to discharge all liabilities of the plan, including
 249 the reasonable costs of liquidation.

250 (i) A multiple employer self-insured health plan licensed before January 1, 2010, shall
 251 have until December 31, 2011, to comply with the provisions of this Code section."

252 **SECTION 4.**

253 Said title is further amended by revising Code Section 33-50-6, relating to requirements for
 254 holding of funds collected, as follows:

255 "33-50-6.

256 Funds collected from the participating employers under multiple employer self-insured
 257 health plans ~~must~~ shall be held in trust subject to the following requirements:

258 (1) A board of trustees elected by participating employers ~~must~~ shall serve as fund
 259 managers on behalf of participants. Trustees ~~must~~ shall be plan participants or be an
 260 employee or owner of a participating employer or an employee of a sponsoring
 261 association. No participating employer ~~may~~ shall be represented by more than one
 262 trustee. A minimum of three and a maximum of seven trustees may be elected. Trustees
 263 ~~may~~ shall not receive remuneration but they may be reimbursed for actual and reasonable
 264 expenses incurred in connection with duties as trustee;

265 (2) Trustees ~~must~~ shall be bonded in an amount not less than \$150,000.00 from a
 266 licensed surety company or covered under a directors and officers liability policy issued
 267 to the multiple employer self-insured health plan;

268 (3) Investment of plan funds is shall be subject to the same restrictions which are
 269 applicable to insurers as provided in Chapter 11 of this title; and

270 ~~(4) Trustees, on behalf of the plan, shall file an annual report with the Commissioner by~~
 271 ~~March 1 showing the condition and affairs of the plan as of the preceding December 31.~~

272 ~~The report must be made on forms prescribed by the Commissioner. The report shall~~
 273 ~~summarize the financial condition of the fund, itemize collections from participating~~
 274 ~~employers, detail all fund expenditures, and provide any additional information which the~~
 275 ~~Commissioner requires. A multiple employer self-insured health plan shall maintain a~~
 276 ~~minimum loss ratio of at least 70 percent. Compliance with such minimum loss ratio~~
 277 ~~standard shall be evaluated annually by a multiple employer self-insured health plan.~~
 278 ~~Failure to comply with minimum loss ratio standards shall result in a premium refund to~~
 279 ~~participating employers."~~

280 SECTION 5.

281 Said title is further amended by revising Code Section 33-50-7, relating to loss reserves for
 282 incurred losses and surplus account, as follows:

283 "33-50-7.

284 ~~(a) A plan shall establish loss reserves for all incurred losses, both reported and~~
 285 ~~unreported, for expenses and for unearned premiums in a manner and amount established~~
 286 ~~by the Commissioner by rule or regulation.~~

287 ~~(b) A plan also shall establish a surplus account equal to the greater of:~~

288 ~~(1) Three times the average paid monthly premium during the plan's most recent fund~~
 289 ~~year;~~

290 ~~(2) For plans which do not yet have one fund year's experience, three times the estimated~~
 291 ~~monthly premium; or~~

292 ~~(3) One hundred thousand dollars.~~

293 Every application for benefits and every benefit plan issued by a multiple employer
 294 self-insured health plan shall contain in contrasting color, in not less than ten-point type,
 295 the following statements:

296 (1) The plan is a self-insured plan, and benefits are not guaranteed by a licensed insurer;

297 (2) The plan is not covered by the Georgia Life and Health Guaranty Association;

298 (3) This is a fully assessable benefit plan. In the event that the multiple employer
 299 self-insured health plan is unable to pay its obligations, participating employers shall be
 300 required to contribute on a joint and several basis the funds necessary to meet any unpaid
 301 obligations; and

302 (4) Certain other major protections offered to Georgia residents under the Georgia
 303 Insurance Code and Rules and Regulations, such as conversion rights and certain
 304 mandated or required benefits, may not be available through the multiple employer
 305 self-insured plan."

306 **SECTION 6.**

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

308 "33-50-14.

309 A multiple employer self-insured health plan, which covers lives in other states, may cover

310 lives in this state only if the Commissioner deems the plan to be in compliance with the

311 requirements of this chapter."

312 **SECTION 7.**

313 Section 1 of this Act shall become effective on January 15, 2011. All other sections of this

314 Act shall become effective on July 1, 2010.

315 **SECTION 8.**

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