Senate Bill 182

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 revise the time periods and eligibility for continuation coverage under certain group accident and sickness insurance plans; to provide for additional continuation plan options; to change the age for continuation coverage under certain group accident and sickness insurance plans from 60 to 55; to provide for the coverage of dependents under group and individual accident and sickness policies up to and including 25 years of age if such dependent is a dependent for state income tax purposes for such policyholder or group member; to authorize early conversion rights under certain circumstances; to provide for certain premium calculations and experience ratings; to require the Commissioner of Insurance to promulgate rules and regulations to provide for reporting and notification of eligibility requirements for participation in the Georgia Health Insurance Assignment System and the Georgia Health Benefits Assignment System; to provide for related matters; 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 Code Section 33-24-21.1, relating to conversion privilege and continuation right provisions in group accident and sickness contracts, 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.

(7) 'Qualifying event' means, with respect to a group member, any of the following events, which, but for the continuation coverage provided under this Code section, would result in the loss of coverage for the group member or his or her spouse or eligible dependent beneficiary under the group plan:

(A) The death of the group member;

(B) The termination, other than a termination for cause, or reduction in hours of the group member's employment;

(C) The divorce or legal separation of the group member from his or her spouse;

(D) The group member becoming entitled to benefits under Title XVIII of the federal Social Security Act, 42 U.S.C. Section 1395, et seq.; or

(E) A dependent child ceasing to be a dependent child under the generally applicable requirements of the group plan.

(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)(1) 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.

(2) For a group of more than 50 persons, such coverage must continue for the fractional policy month remaining, if any, at termination plus three additional policy months.

(3) For a group of not less than two and not more than 50 persons, such ~~Such~~ coverage must continue for the fractional policy month remaining, if any, at termination plus ~~three additional policy months~~:

(A) In the event of loss of coverage due to an event described in subparagraph (a)(7)(B) of this Code section, 18 additional policy months;

(B) In the event that a second qualifying event, as described in subparagraph (a)(7)(B) of this Code section, occurs during the 18 month period of coverage under subparagraph (A) of this paragraph, 36 additional policy months;

(C) In the event of loss of coverage due to an event described in paragraph (7) of subsection (a) of this Code section other than an event described in subparagraph (a)(7)(B) of this Code section, 36 additional policy months; and

(D) In the event of loss of coverage due to an event described in paragraph (7) of subsection (a) of this Code section that occurs less than 18 months after the date that the group member became eligible for benefits under Title XVIII of the federal Social Security Act, 42 U.S.C. Section 1395, et seq., 36 additional months for any qualifying eligible individuals other than the group member.

(4) In the event that a qualifying eligible individual is determined under Title II or Title XVI of the federal Social Security Act (42 U.S.C. Section 401, et seq. or Section 1381, et seq.) to have been disabled at any time during the first 60 days of continuation coverage under this Code section, any reference to 18 months in subparagraph (A) or (B) of paragraph (3) of this subsection shall be deemed to be a reference to 29 months with regard to such qualifying eligible individuals, but only if the qualifying eligible individual has provided notice of such determination to the insurer before the end of such 18 months.

(5) For a qualifying eligible individual as described in paragraph (3) of this subsection, continuation coverage shall be available notwithstanding eligibility for extended coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

(6) Such coverage shall continue 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.

(7) In addition to the group policy under which the group member was insured, the group member and any qualifying eligible individual shall also be offered the option of continuation coverage through a high deductible health plan, or its actuarial equivalent, that is eligible for use with a health savings account under the applicable provisions of Section 223 of the Internal Revenue Code. Such high deductible health plans shall have premiums consistent with the underlying group plan of coverage rated relative to the standard or manual rates for the benefits provided.

(8) At the end of such period and at any time during 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.

(9) For a group of not less than two and not more than 50 persons, claims for a covered individual under continuation of coverage shall not be considered in rating or rerating the group premiums for the group from which the continuation of coverage is provided, except that the pooled experience for all of the insurer's continuation of coverage claims for fully insured claims in the two to 50 life policies may impact all such groups on an equal percentage basis.

(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. 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 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 the individual terminated 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) 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~~ For a group of more than 50 persons, 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

(4) 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~~ 2009, and to group plans and group contracts then in effect on the first anniversary date occurring on or after July 1, ~~1998~~ 2009.″

SECTION 2.

Said title is further amended by revising Code Section 33-24-21.2, relating to continuation of coverage under group accident and sickness plans for persons 60 years of age or older, as follows:

″33-24-21.2.

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

(1) '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.

(2) 'Group member' means a person who has been a member of the group for at least six months; 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.

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

(4) 'Internal Revenue Code' means the federal Internal Revenue Code as defined in Code Section 48-1-2.

(5) 'Plan administrator' means:

(A) The person designated as the plan administrator by the instrument under which the group contract or plan is operated; or

(B) If no plan administrator is designated, the plan sponsor.

(b)(1) A group contract or plan providing coverage for hospital or medical expenses for a group of not less than two and not more than 50 persons, other than coverage limited

to expenses from accidents or specific diseases, which is issued, delivered, issued for delivery, or renewed in this state to provide coverage for the employees of an employer subject to the provisions of Section 4980B of the Internal Revenue Code, shall contain a provision that a group member whose insurance under the contract or plan otherwise terminates after the expiration of the period of continuation of coverage for which the individual is eligible under Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code shall be entitled to continue coverage under that group contract or plan for himself or herself and his or her eligible dependents if the group member was ~~60~~ 55 years of age or older as of the date on which the continuation of coverage afforded under Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code commences.

(2) A group contract or plan providing coverage for hospital or medical expenses for a group of more than 50 persons, other than coverage limited to expenses from accidents or specified diseases, which is issued, delivered, issued for delivery, or renewed in this state to provide coverage for the employees of an employer subject to the provisions of Section 4980B of the Internal Revenue Code, shall contain a provision that a group member whose insurance under the contract or plan otherwise terminates after the expiration of the period of continuation of coverage for which the individual is eligible under Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code shall be entitled to continue coverage under that group contract or plan for himself or herself and his or her eligible dependents if the group member was 60 years of age or older as of the date on which the continuation of coverage afforded under Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code commences.

~~(2)~~(3) A group member shall not be entitled to have coverage continued under paragraph (1) or (2) of this subsection if:

(A) Termination of employment is voluntary for other than health reasons;

(B) Termination of coverage occurred because the employment of a group member was terminated for reasons which would cause a forfeiture of unemployment compensation under Chapter 8 of Title 34, the 'Employment Security Law';

(C) Termination of coverage occurred because the group member failed to pay any required contribution;

(D) Any discontinued coverage is immediately replaced by similar group coverage; or

(E) 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 paragraph shall not affect conversion rights available to a group member under any contract or plan.

(c) A group contract or plan providing coverage for hospital or medical expenses for a group of not less than two and not more than 50 persons, other than coverage limited to

expenses from accidents or specific diseases, which is issued, delivered, issued for delivery, or renewed in this state to provide coverage for the employees of an employer subject to the provisions of Section 4980B of the federal Internal Revenue Code, shall contain a provision that:

(1) The surviving spouse of a group member may continue coverage under the plan, at the death of the group member, with respect to the spouse and any dependent children whose coverage under the plan otherwise would terminate because of the death of the group member if the surviving spouse is ~~60~~ 55 years of age or older at the time of the death; and

(2) The divorced spouse of a group member may continue coverage under the plan, upon dissolution of marriage with the group member, with respect to the divorced spouse and any dependent children whose coverage under the plan otherwise would terminate because of the dissolution of marriage, if the divorced spouse is ~~60~~ 55 years of age or older at the time of the dissolution or legal separation.

(d) A group contract or plan providing coverage for hospital or medical expenses for a group of more than 50 persons, other than coverage limited to expenses from accidents or specified diseases, which is issued, delivered, issued for delivery, or renewed in this state to provide coverage for the employees of an employer subject to the provisions of Section 4980B of the federal Internal Revenue Code, shall contain a provision that:

(1) The surviving spouse of a group member may continue coverage under the plan, at the death of the group member, with respect to the spouse and any dependent children whose coverage under the plan otherwise would terminate because of the death of the group member if the surviving spouse is 60 years of age or older at the time of the death; and

(2) The divorced spouse of a group member may continue coverage under the plan, upon dissolution of marriage with the group member, with respect to the divorced spouse and any dependent children whose coverage under the plan otherwise would terminate because of the dissolution of marriage, if the divorced spouse is 60 years of age or older at the time of the dissolution or legal separation.

~~(d)~~(e) Each group certificate issued to each group member shall set forth the continuation right provided in subsections (b), (c), and ~~(c)~~(d) of this Code section in a separate provision bearing its own caption. The provision shall clearly set forth a full description or the continuation right available, including all requirements, limitations, exceptions, the premium required or a brief statement concerning the method of calculation thereof, and the time of payment of all premiums due during the period of continuation.

~~(e)~~(f) In the event and to the extent that this Code section is applicable, the election by the group member or divorced or surviving spouse to obtain continuation of coverage as

provided under the provisions of Section 4980B of the Internal Revenue Code or under the provisions of Code Section 33-24-21.1 shall constitute election of continuation of coverage under this Code section without further action by the group member or surviving or divorced spouse. The provisions of Section 4980B of the Internal Revenue Code or of Code Section 33-24-21.1, whichever is applicable, regarding notice to a group member or a divorced or surviving spouse of the right to continue coverage shall apply to the continuation of coverage provided under this Code section.

~~(f)~~(g) If an eligible group member or the divorced or surviving spouse elects continuation of coverage under subsection (b)~~,~~ (c)~~,~~ or ~~(c)~~(d) of this Code section:

(1) The monthly premium for the continuation shall not be greater than ~~120~~ 102 percent of the total of the amount that would be charged if the eligible group member or the divorced or surviving spouse were a current group member and the amount that the group policyholder would contribute toward the premium if the eligible group member or the divorced or surviving spouse were a current group member;

(2) The first premium for the continuation of coverage under this Code section shall be paid by the eligible group member or the divorced or surviving spouse on the first regular due date following the expiration of the eligible person's benefits under the provisions of Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code; and

(3) The right to continuation of coverage shall terminate upon the earliest of any of the following:

(A) The failure to pay premiums or required premium contributions, if applicable, when due, including any grace period allowed by the policy;

(B) The date that the group plan is terminated as to all group members, except that if a different group plan is made available to group members, the eligible group member or the divorced or surviving spouse shall be eligible for continuation of the same coverage under the new plan;

(C) The date on which the eligible group member or divorced or surviving spouse becomes insured under any other group health plan; or

(D) The date on which the eligible group member or the divorced or surviving spouse becomes eligible for federal medicare coverage.

~~(g)~~(h) This Code section shall apply to any group contract or group plan ~~which covers 20 or more employees and~~ which is issued, delivered, issued for delivery, or renewed in this state on or after July 1, ~~1992~~ 2009, and to any group contract or group plan ~~covering 20 or more employees~~ then in effect on the first anniversary date occurring on or after July 1, ~~1992~~ 2009.″

SECTION 3.

Said title is further amended by revising Code Section 33-29-2, relating to requirements as to individual accident and sickness policies generally, as follows:

"33-29-2.

(a) No policy of accident and sickness insurance shall be delivered or issued for delivery in this state unless it meets the following requirements:

(1) The entire money and other considerations for the policy are expressed in such policy;

(2) The time at which the insurance takes effect and terminates is expressed in such policy;

(3) It purports to insure only one person, provided that a policy may insure, originally or by subsequent amendment upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children, or any children, under a specified age which shall not exceed 19 years, and any other person dependent upon the policyholder; provided, further, that, if a policy purports to insure a dependent child of the policyholder, the child shall continue to be insured up to and including age 25 so long as the policy continues in effect, the child remains a dependent of the policyholder~~, and~~ for Georgia income tax purposes ~~the child, in each calendar year since reaching the age specified in the policy for termination of benefits as a dependent of the policyholder, has been enrolled for five calendar months or more as a full-time student in a postsecondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury~~;

(4) The style, arrangement, and overall appearance of the policy gives no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower case unspaced alphabet length not less than 120 point. The text shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions. When a policy is renewable only at the option of the insurer, such fact shall be made known in prominent lettering on the face of the policy;

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Code Sections 33-29-3 and 33-29-4, are printed, at the insurer's option, either with the benefit provisions to which they apply or under an appropriate caption such as 'exceptions,' or 'exceptions and reductions,' provided that, if an exception or reduction specifically applies only to a particular benefit of the policy,

a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(6) Each form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof;

(7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks or short-rate table filed with the Commissioner;

(8) It contains no provision purporting to exclude or reduce coverage provided an otherwise insurable person solely for the reason that the person is eligible for or receiving medical assistance, as defined in Code Section 49-4-141. Any such provision appearing in an individual accident and sickness insurance policy, subsequent to July 1, 1978, shall be null and void; and

(9) It contains no provision relating to insurance with other insurers, provided that group conversion policies and major medical policies may contain provisions relating to other insurance benefits payable under group or blanket accident and sickness insurance policies.

(b) Individual major medical policies, including franchise and conversion policies, shall make available to each applicant for such coverage optional cash deductible amounts up to at least $5,000.00. No such policy shall contain any provision in which the length of the cash deductible accumulation period is not reasonable in relation to the amount of the cash deductibles. An insurer may offer higher optional deductibles to existing policyholders as a means of reducing the cost of such policies or to offset premium increases.

(c) This Code section shall also apply to policies issued by a hospital service nonprofit corporation or a nonprofit medical service corporation.

(d) This Code section shall not be construed so as to impair the obligation of any contract in existence prior to January 1, 1979."

SECTION 4.

Said title is further amended by adding a new subsection to Code Section 33-29A-8, relating to rules and regulations of the availability and assignment system, to read as follows:

"(c) The Commissioner shall also adopt rules and regulations to provide for reporting and notification of the eligibility requirements for participating in the Georgia Health Insurance Assignment System and the Georgia Health Benefits Assignment System in order to ensure that all citizens of this state as well as the insurance agents of this state are aware of such eligibility requirements."

SECTION 5.

Said title is further amended by revising Code Section 33-30-4, relating to required provisions in group or blanket accident and sickness policies generally, as follows:

"33-30-4.

Each group accident and sickness policy shall contain in substance the following provisions:

(1) A provision that, in the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of the group policy or contract, all statements made by the policyholder shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder, a copy of which has been furnished to the policyholder;

(2) A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of the employee or member and to whom benefits are payable. If dependents or family members are included in the coverage, additional certificates need not be issued for delivery to the dependents or family members;

(3) A provision that from time to time eligible new employees or members or dependents, in accordance with the terms of the policy, may be added to the group originally insured;

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

(5) A provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first, during which grace period the policy shall continue in force unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to

the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.″

SECTION 6.

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