

The Senate Insurance and Labor Committee offered the following substitute to SB 182:

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 revise the time periods and eligibility for continuation coverage under certain group accident
3 and sickness insurance plans; to provide for additional continuation plan options; to change
4 the age for continuation coverage under certain group accident and sickness insurance plans
5 from 60 to 55; to provide for the coverage of dependents under group and individual accident
6 and sickness policies up to and including 25 years of age if such dependent is a dependent
7 for state income tax purposes for such policyholder or group member; to authorize early
8 conversion rights under certain circumstances; to provide for certain premium calculations
9 and experience ratings; to require the Commissioner of Insurance to promulgate rules and
10 regulations to provide for reporting and notification of eligibility requirements for
11 participation in the Georgia Health Insurance Assignment System and the Georgia Health
12 Benefits Assignment System; to provide for related matters; to repeal conflicting laws; and
13 for other purposes.

14 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

15 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
16 revising Code Section 33-24-21.1, relating to conversion privilege and continuation right
17 provisions in group accident and sickness contracts, as follows:
18

19 "33-24-21.1.

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

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

23 (A) Medicare or Medicaid;

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

- 25 (C) An individual accident and sickness insurance policy, including coverage issued
 26 by a health maintenance organization, nonprofit hospital or nonprofit medical service
 27 corporation, health care corporation, or fraternal benefit society;
- 28 (D) A spouse's benefits or coverage under medicare or Medicaid or an employer based
 29 health insurance or health benefit arrangement;
- 30 (E) A conversion policy;
- 31 (F) A franchise policy issued on an individual basis to a member of a true association
 32 as defined in subsection (b) of Code Section 33-30-1;
- 33 (G) A health plan formed pursuant to 10 U.S.C. Chapter 55;
- 34 (H) A health plan provided through the Indian Health Service or a tribal organization
 35 program or both;
- 36 (I) A state health benefits risk pool;
- 37 (J) A health plan formed pursuant to 5 U.S.C. Chapter 89;
- 38 (K) A public health plan; or
- 39 (L) A Peace Corps Act health benefit plan.
- 40 (2) 'Eligible dependent' means a person who is entitled to medical benefits coverage
 41 under a group contract or group plan by reason of such person's dependency on or
 42 relationship to a group member.
- 43 (3) 'Group contract or group plan' is synonymous with the term 'contract or plan' and
 44 means:
- 45 (A) A group contract of the type issued by a nonprofit medical service corporation
 46 established under Chapter 18 of this title;
- 47 (B) A group contract of the type issued by a nonprofit hospital service corporation
 48 established under Chapter 19 of this title;
- 49 (C) A group contract of the type issued by a health care plan established under
 50 Chapter 20 of this title;
- 51 (D) A group contract of the type issued by a health maintenance organization
 52 established under Chapter 21 of this title; or
- 53 (E) A group accident and sickness insurance policy or contract, as defined in
 54 Chapter 30 of this title.
- 55 (4) 'Group member' means a person who has been a member of the group for at least six
 56 months and who is entitled to medical benefits coverage under a group contract or group
 57 plan and who is an insured, certificate holder, or subscriber under the contract or plan.
- 58 (5) 'Insurer' means an insurance company, health care corporation, nonprofit hospital
 59 service corporation, medical service nonprofit corporation, health care plan, or health
 60 maintenance organization.
- 61 (6) 'Qualifying eligible individual' means:

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

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

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

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

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

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

75 (A) The death of the group member;

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

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

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

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

90 (c)(1) Any group member or qualifying eligible individual whose coverage has been
 91 terminated and who has been continuously covered under the group contract or group
 92 plan, and under any contract or plan providing similar benefits which it replaces, for at
 93 least six months immediately prior to such termination, shall be entitled to have his or her
 94 coverage and the coverage of his or her eligible dependents continued under the contract
 95 or plan.

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

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

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

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

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

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

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

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

125 (6) Such coverage shall continue upon payment of the premium by cash, certified check,
126 or money order, at the option of the employer, to the policyholder or employer, at the
127 same rate for active group members set forth in the contract or plan, on a monthly basis
128 in advance as such premium becomes due during this coverage period. Such premium
129 payment must include any portion of the premium paid by a former employer or other
130 person if such employer or other person no longer contributes premium payments for this
131 coverage.

132 (7) In addition to the group policy under which the group member was insured, the group
133 member and any qualifying eligible individual shall also be offered the option of
134 continuation coverage through a high deductible health plan, or its actuarial equivalent,

135 that is eligible for use with a health savings account under the applicable provisions of
136 Section 223 of the Internal Revenue Code. Such high deductible health plans shall have
137 premiums consistent with the underlying group plan of coverage rated relative to the
138 standard or manual rates for the benefits provided.

139 (8) At the end of such period and at any time during such period, the group member shall
140 have the same conversion rights that were available on the date of termination of
141 coverage in accordance with the conversion privileges contained in the group contract or
142 group plan.

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

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

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

171 (e) If the group contract or group plan terminates while any group member or qualifying
172 eligible individual is covered or whose coverage is being continued, the group
173 administrator, as prescribed by the insurer, must notify each such group member or
174 qualifying eligible individual that he or she must exercise his or her conversion rights
175 within:

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

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

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

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

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

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

209 (A) Solely for purposes of this subsection, the claims experience produced by all
210 groups covered under comprehensive major medical or hospitalization accident and
211 sickness insurance for each insurer shall be fully pooled to determine the group pool
212 rate. Except to the extent that the claims experience of an individual group affects the
213 overall experience of the group pool, the claims experience produced by any individual
214 group of each insurer shall not be used in any manner for enhanced conversion policy
215 rating purposes;

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

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

238 (3) Any group member who is not a qualifying eligible individual and whose insurance
239 under the group policy has been terminated for any reason, including failure of the
240 employer to pay premiums to the insurer, other than eligibility for medicare (reaching a
241 limiting age for coverage under the group policy) or failure of the group member to pay
242 a required premium contribution, and who has been continuously covered under the
243 group contract or group plan, and under any contract or plan providing similar benefits

244 which it replaces, for at least six months immediately prior to termination shall be
 245 entitled, without evidence of insurability, to convert to individual or group coverage
 246 covering such group member and any eligible dependents who were covered under the
 247 group member's coverage under the group contract or group plan. ~~Such~~ For a group of
 248 more than 50 persons, such conversion coverage must be, at the option of the individual,
 249 retroactive to the date of termination of the group coverage or the date on which
 250 continuation or COBRA coverage ended, whichever is later. The premium of the basic
 251 converted policy shall be determined in accordance with the insurer's table of premium
 252 rates applicable to the age and classification of risks of each person to be covered under
 253 that policy and to the type and amount of coverage provided. This form of conversion
 254 coverage shall be known as the 'Basic Conversion Option'; and

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

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

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

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

278 (k) This Code section shall apply to all group plans and group contracts delivered or issued
 279 for delivery in this state on or after July 1, ~~1998~~ 2009, and to group plans and group

280 contracts then in effect on the first anniversary date occurring on or after July 1, ~~1998~~ 2009."

281 **SECTION 2.**

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

285 "33-24-21.2.

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

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

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

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

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

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

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

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

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

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

307 (5) 'Plan administrator' means:

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

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

311 (b)(1) A group contract or plan providing coverage for hospital or medical expenses for
 312 a group of not less than two and not more than 50 persons, other than coverage limited
 313 to expenses from accidents or specific diseases, which is issued, delivered, issued for
 314 delivery, or renewed in this state to provide coverage for the employees of an employer
 315 subject to the provisions of Section 4980B of the Internal Revenue Code, shall contain

316 a provision that a group member whose insurance under the contract or plan otherwise
 317 terminates after the expiration of the period of continuation of coverage for which the
 318 individual is eligible under Code Section 33-24-21.1 or Section 4980B of the Internal
 319 Revenue Code shall be entitled to continue coverage under that group contract or plan for
 320 himself or herself and his or her eligible dependents if the group member was ~~60~~ 55 years
 321 of age or older as of the date on which the continuation of coverage afforded under Code
 322 Section 33-24-21.1 or Section 4980B of the Internal Revenue Code commences.

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

335 ~~(2)~~(3) A group member shall not be entitled to have coverage continued under
 336 paragraph (1) or (2) of this subsection if:

- 337 (A) Termination of employment is voluntary for other than health reasons;
- 338 (B) Termination of coverage occurred because the employment of a group member was
- 339 terminated for reasons which would cause a forfeiture of unemployment compensation
- 340 under Chapter 8 of Title 34, the 'Employment Security Law';
- 341 (C) Termination of coverage occurred because the group member failed to pay any
- 342 required contribution;
- 343 (D) Any discontinued coverage is immediately replaced by similar group coverage; or
- 344 (E) The group contract or group plan was terminated in its entirety or was terminated
- 345 with respect to a class to which the group member belonged.

346 This paragraph shall not affect conversion rights available to a group member under any
 347 contract or plan.

348 (c) A group contract or plan providing coverage for hospital or medical expenses for a
 349 group of not less than two and not more than 50 persons, other than coverage limited to
 350 expenses from accidents or specific diseases, which is issued, delivered, issued for
 351 delivery, or renewed in this state to provide coverage for the employees of an employer

352 subject to the provisions of Section 4980B of the federal Internal Revenue Code, shall
 353 contain a provision that:

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

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

364 (d) A group contract or plan providing coverage for hospital or medical expenses for a
 365 group of more than 50 persons, other than coverage limited to expenses from accidents or
 366 specified diseases, which is issued, delivered, issued for delivery, or renewed in this state
 367 to provide coverage for the employees of an employer subject to the provisions of Section
 368 4980B of the federal Internal Revenue Code, shall contain a provision that:

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

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

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

385 ~~(e)~~(f) In the event and to the extent that this Code section is applicable, the election by the
 386 group member or divorced or surviving spouse to obtain continuation of coverage as
 387 provided under the provisions of Section 4980B of the Internal Revenue Code or under the
 388 provisions of Code Section 33-24-21.1 shall constitute election of continuation of coverage

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

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

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

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

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

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

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

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

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

417 ~~(g)~~(h) This Code section shall apply to any group contract or group plan ~~which covers 20~~
 418 ~~or more employees and~~ which is issued, delivered, issued for delivery, or renewed in this
 419 state on or after July 1, ~~1992~~ 2009, and to any group contract or group plan ~~covering 20 or~~
 420 ~~more employees~~ then in effect on the first anniversary date occurring on or after July 1,
 421 ~~1992~~ 2009."

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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,

- 459 a statement of such exception or reduction shall be included with the benefit provision
 460 to which it applies;
- 461 (6) Each form, including riders and endorsements, shall be identified by a form number
 462 in the lower left-hand corner of the first page thereof;
- 463 (7) It contains no provision purporting to make any portion of the charter, rules,
 464 constitution, or bylaws of the insurer a part of the policy unless such portion is set forth
 465 in full in the policy, except in the case of the incorporation of, or reference to, a statement
 466 of rates or classification of risks or short-rate table filed with the Commissioner;
- 467 (8) It contains no provision purporting to exclude or reduce coverage provided an
 468 otherwise insurable person solely for the reason that the person is eligible for or receiving
 469 medical assistance, as defined in Code Section 49-4-141. Any such provision appearing
 470 in an individual accident and sickness insurance policy, subsequent to July 1, 1978, shall
 471 be null and void; and
- 472 (9) It contains no provision relating to insurance with other insurers, provided that group
 473 conversion policies and major medical policies may contain provisions relating to other
 474 insurance benefits payable under group or blanket accident and sickness insurance
 475 policies.
- 476 (b) Individual major medical policies, including franchise and conversion policies, shall
 477 make available to each applicant for such coverage optional cash deductible amounts up
 478 to at least \$5,000.00. No such policy shall contain any provision in which the length of the
 479 cash deductible accumulation period is not reasonable in relation to the amount of the cash
 480 deductibles. An insurer may offer higher optional deductibles to existing policyholders as
 481 a means of reducing the cost of such policies or to offset premium increases.
- 482 (c) This Code section shall also apply to policies issued by a hospital service nonprofit
 483 corporation or a nonprofit medical service corporation.
- 484 (d) This Code section shall not be construed so as to impair the obligation of any contract
 485 in existence prior to January 1, 1979."

486 SECTION 4.

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

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

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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

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

533 **SECTION 6.**

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