Senate Bill 94

By: Senator Hill of the 32nd

AS PASSED

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 require
4 the Commissioner of Insurance to promulgate rules and regulations to provide for reporting
5 and notification of eligibility requirements for participation in the Georgia Health Insurance
6 Assignment System and the Georgia Health Benefits Assignment System; to provide that the
7 Commissioner of Insurance shall be authorized to allow certain health reimbursement
8 arrangement only plans that encourage employer financial support of health insurance or
9 health related expenses to be approved for sale in connection with or packaged with
10 otherwise approved individual health insurance policies; to provide for related matters; to
11 repeal conflicting laws; and for other purposes.

12 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

13 **SECTION 1.**

14 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
15 revising Code Section 33-24-21.1, relating to conversion privilege and continuation right
16 provisions in group accident and sickness contracts, as follows:
17 "33-24-21.1.
18 (a) As used in this Code section, the term:
19 (1) 'Assistance eligible individual' shall have the same meaning as provided by
20 Section 3001 of Title III of the federal American Recovery and Reinvestment Act of
21 2009.
22 ~~(1)~~(2) 'Creditable coverage' under another health benefit plan means medical expense
23 coverage with no greater than a 90 day gap in coverage under any of the following:
24 (A) Medicare or Medicaid;
25 (B) An employer based accident and sickness insurance or health benefit arrangement;

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

63 ~~(6)~~(7) 'Qualifying eligible individual' means:
64 (A) A Georgia domiciliary, for whom, as of the date on which the individual seeks
65 coverage under this Code section, the aggregate of the periods of creditable coverage
66 is 18 months or more; and
67 (B) Who is not eligible for coverage under any of the following:
68 (i) A group health plan, including continuation rights under this Code section or the
69 federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA);
70 (ii) Part A or Part B of Title XVIII of the federal Social Security Act; or
71 (iii) The state plan under Title XIX of the federal Social Security Act or any
72 successor program.
73 (a.1) Any group member or qualifying eligible individual who is an assistance eligible
74 individual as provided by Section 3001 of Title III of the federal American Recovery and
75 Reinvestment Act (P.L. 111-5), during the period permitted under such act whose coverage
76 has been terminated and who has been continuously covered under the group contract or
77 group plan, and under any contract or plan providing similar benefits that it replaces, for
78 at least six months immediately prior to such termination, shall be entitled to have his or
79 her coverage and the coverage of his or her eligible dependents continued under the
80 contract or plan. Such coverage shall continue for the fractional policy month remaining,
81 if any, at termination plus nine additional policy months upon payment of the premium to
82 the insurer by cash, certified check, or money order, at the same rate for active group
83 members set forth in the contract or plan, on a monthly basis in advance as such premium
84 becomes due during this coverage period. For the period that the assistance eligible
85 individual is eligible for the premium assistance subsidy as provided in Section 3001 of
86 Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), such
87 premium payment shall be calculated as 35 percent of the rate for active group members
88 including any portion of the premium paid by a former employer or other person if such
89 employer or other person no longer contributes premium payments for this coverage.
90 (a.2) The rights and benefits under this Code section attributable to Section 3001 of Title
91 III of the federal American Recovery and Reinvestment Act (P.L. 111-5) shall expire when
92 that act expires. Any extension of such benefits shall require an Act of the Georgia General
93 Assembly. Under no circumstances shall the extended benefits for assistance eligible
94 individuals become the responsibility of the State of Georgia or any insurer after September
95 30, 2010.
96 (b) Each group contract or group plan delivered or issued for delivery in this state, other
97 than a group accident and sickness insurance policy, contract, or plan issued in connection
98 with an extension of credit, which provides hospital, surgical, or major medical coverage,
99 or any combination of these coverages, on an expense incurred or service basis, excluding

100 contracts and plans which provide benefits for specific diseases or accidental injuries only,
101 shall provide that members and qualifying eligible individuals whose insurance under the
102 group contract or plan would otherwise terminate shall be entitled to continue their
103 hospital, surgical, and major medical insurance coverage under that group contract or plan
104 for themselves and their eligible dependents.

105 (c)(1) Any group member or qualifying eligible individual whose coverage has been
106 terminated and who has been continuously covered under the group contract or group
107 plan, and under any contract or plan providing similar benefits which it replaces, for at
108 least six months immediately prior to such termination, shall be entitled to have his or her
109 coverage and the coverage of his or her eligible dependents continued under the contract
110 or plan. Such coverage must continue for the fractional policy month remaining, if any,
111 at termination plus three additional policy months, except the period of continuation
112 coverage for assistance eligible individual in subsection (a.1) of this Code section, shall
113 be nine months, upon payment of the premium by cash, certified check, or money order,
114 at the option of the employer, to the policyholder or employer, at the same rate for active
115 group members set forth in the contract or plan, on a monthly basis in advance as such
116 premium becomes due during this coverage period. Such premium payment must include
117 any portion of the premium paid by a former employer or other person if such employer
118 or other person no longer contributes premium payments for this coverage. At the end
119 of such period, the group member shall have the same conversion rights that were
120 available on the date of termination of coverage in accordance with the conversion
121 privileges contained in the group contract or group plan.

122 (2) A covered individual who is an assistance eligible individual has a right to elect
123 continuation of his or her coverage and the coverage of his or her dependents at any time
124 between the effective date of this paragraph and 60 days after receiving notice from the
125 employer's insurer of the right to participate in a second election period for state
126 continuation benefits under this Code section in accordance with Section 3001 of Title III
127 of the federal American Recovery and Reinvestment Act (P.L. 111-5) if:

128 (A) The individual was involuntarily terminated from employment between
129 September 1, 2008, and February 17, 2009, as defined in Section 3001 of Title III of the
130 federal American Recovery and Reinvestment Act (P.L. 111-5);

131 (B) The individual was eligible for state continuation under this chapter at the time of
132 termination;

133 (C) The individual continues to be eligible for state continuation benefits under this
134 chapter, provided that the total period of continuous eligibility shall not exceed nine
135 policy months from the month of the qualifying event making the individual an

136 assistance eligible individual or the date of the election as provided in this paragraph,
137 whichever is later; and
138 (D) The individual or the employer of the individual contacts the insurer and informs
139 the insurer that the individual wants to take advantage of the second election period for
140 state continuation coverage under the provisions of Section 3001 of Title III of the
141 federal American Recovery and Reinvestment Act (P.L. 111-5).
142 (3) In addition to the group policy under which the group member was insured, the group
143 member and any qualifying eligible individual shall, to the extent that such plan is
144 currently offered under the group plans offered by the company, also be offered the
145 option of continuation coverage through a high deductible health plan, or its actuarial
146 equivalent, that is eligible for use with a health savings account under the applicable
147 provisions of Section 223 of the Internal Revenue Code. Such high deductible health
148 plans shall have premiums consistent with the underlying group plan of coverage rated
149 relative to the standard or manual rates for the benefits provided.
150 (4) Claims for a covered individual under continuation of coverage shall not be
151 considered in rating or rerating the group premiums for the group from which the
152 continuation of coverage is provided, except that the pooled experience for all of the
153 insurer's continuation of coverage claims for fully insured claims may impact all such
154 groups on an equal percentage basis.
155 (d)(1) A group member shall not be entitled to have coverage continued if:
156 (A) termination of coverage occurred because the employment of the group member was
157 terminated for cause; (B) termination of coverage occurred because the group member
158 failed to pay any required contribution; or (C) any discontinued group coverage is
159 immediately replaced by similar group coverage including coverage under a health
160 benefits plan as defined in the federal Employee Retirement Income Security Act
161 of 1974, 29 U.S.C. Section 1001, et seq. Further, a group member shall not be entitled
162 to have coverage continued if the group contract or group plan was terminated in its
163 entirety or was terminated with respect to a class to which the group member belonged.
164 This subsection shall not affect conversion rights available to a qualifying eligible
165 individual under any contract or plan.
166 (2) A qualifying eligible individual shall not be entitled to have coverage continued if
167 the most recent creditable coverage within the coverage period was terminated based on
168 one of the following factors: (A) failure of the qualifying eligible individual to pay
169 premiums or contributions in accordance with the terms of the health insurance coverage
170 or failure of the issuer to receive timely premium payments; (B) the qualifying eligible
171 individual has performed an act or practice that constitutes fraud or made an intentional
172 misrepresentation of material fact under the terms of coverage; or (C) any discontinued

173 group coverage is immediately replaced by similar group coverage including coverage
174 under a health benefits plan as defined in the federal Employee Retirement Income
175 Security Act of 1974, 29 U.S.C. Section 1001, et seq. This subsection shall not affect
176 conversion rights available to a group member under any contract or plan.
177 (e) If the group contract or group plan terminates while any group member or qualifying
178 eligible individual is covered or whose coverage is being continued, the group
179 administrator, as prescribed by the insurer, must notify each such group member or
180 qualifying eligible individual that he or she must exercise his or her conversion rights
181 within:
182 (1) Thirty days of such notice for group members who are not qualifying eligible
183 individuals; or
184 (2) Sixty-three days of such notice for qualifying eligible individuals.
185 (f) Every group contract or group plan, other than a group accident and sickness insurance
186 policy, contract, or plan issued in connection with an extension of credit, which provides
187 hospital, surgical, or major medical expense insurance, or any combination of these
188 coverages, on an expense incurred or service basis, excluding policies which provide
189 benefits for specific diseases or for accidental injuries only, shall contain a conversion
190 privilege provision.
191 (g) Eligibility for the converted policies or contracts shall be as follows:
192 (1) Any qualifying eligible individual whose insurance and its corresponding eligibility
193 under the group policy, including any continuation available, elected, and exhausted
194 under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act
195 of 1986 (COBRA), has been terminated for any reason, including failure of the employer
196 to pay premiums to the insurer, other than fraud or failure of the qualifying eligible
197 individual to pay a required premium contribution to the employer or, if so required, to
198 the insurer directly and who has at least 18 months of creditable coverage immediately
199 prior to termination shall be entitled, without evidence of insurability, to convert to
200 individual or group based coverage covering such qualifying eligible individual and any
201 eligible dependents who were covered under the qualifying eligible individual's coverage
202 under the group contract or group plan. Such conversion coverage must be, at the option
203 of the individual, retroactive to the date of termination of the group coverage or the date
204 on which continuation or COBRA coverage ended, whichever is later. The insurer must
205 offer qualifying eligible individuals at least two distinct conversion options from which
206 to choose. One such choice of coverage shall be comparable to comprehensive health
207 insurance coverage offered in the individual market in this state or comparable to a
208 standard option of coverage available under the group or individual health insurance laws
209 of this state. The other choice may be more limited in nature but must also qualify as

210 creditable coverage. Each coverage shall be filed, together with applicable rates, for
211 approval by the Commissioner. Such choices shall be known as the 'Enhanced
212 Conversion Options';
213 (2) Premiums for the enhanced conversion options for all qualifying eligible individuals
214 shall be determined in accordance with the following provisions:
215 (A) Solely for purposes of this subsection, the claims experience produced by all
216 groups covered under comprehensive major medical or hospitalization accident and
217 sickness insurance for each insurer shall be fully pooled to determine the group pool
218 rate. Except to the extent that the claims experience of an individual group affects the
219 overall experience of the group pool, the claims experience produced by any individual
220 group of each insurer shall not be used in any manner for enhanced conversion policy
221 rating purposes;
222 (B) Each insurer's group pool shall consist of each insurer's total claims experience
223 produced by all groups in this state, regardless of the marketing mechanism or
224 distribution system utilized in the sale of the group insurance from which the qualifying
225 eligible individual is converting. The pool shall include the experience generated under
226 any medical expense insurance coverage offered under separate group contracts and
227 contracts issued to trusts, multiple employer trusts, or association groups or trusts,
228 including trusts or arrangements providing group or group-type coverage issued to a
229 trust or association or to any other group policyholder where such group or group-type
230 contract provides coverage, primarily or incidentally, through contracts issued or issued
231 for delivery in this state or provided by solicitation and sale to Georgia residents
232 through an out-of-state multiple employer trust or arrangement; and any other
233 group-type coverage which is determined to be a group shall also be included in the
234 pool for enhanced conversion policy rating purposes; and
235 (C) Any other factors deemed relevant by the Commissioner may be considered in
236 determination of each enhanced conversion policy pool rate so long as it does not have
237 the effect of lessening the risk-spreading characteristic of the pooling requirement.
238 Duration since issue and tier factors may not be considered in conversion policy rating.
239 Notwithstanding subparagraph (A) of this paragraph, the total premium calculated for
240 all enhanced conversion policies may deviate from the group pool rate by not more than
241 plus or minus 50 percent based upon the experience generated under the pool of
242 enhanced conversion policies so long as rates do not deviate for similarly situated
243 individuals covered through the pool of enhanced conversion policies;
244 (3) Any group member who is not a qualifying eligible individual and whose insurance
245 under the group policy has been terminated for any reason, including failure of the
246 employer to pay premiums to the insurer, other than eligibility for medicare (reaching a

247 limiting age for coverage under the group policy) or failure of the group member to pay
248 a required premium contribution, and who has been continuously covered under the
249 group contract or group plan, and under any contract or plan providing similar benefits
250 which it replaces, for at least six months immediately prior to termination shall be
251 entitled, without evidence of insurability, to convert to individual or group coverage
252 covering such group member and any eligible dependents who were covered under the
253 group member's coverage under the group contract or group plan. Such conversion
254 coverage must be, at the option of the individual, retroactive to the date of termination
255 of the group coverage or the date on which continuation or COBRA coverage ended,
256 whichever is later. The premium of the basic converted policy shall be determined in
257 accordance with the insurer's table of premium rates applicable to the age and
258 classification of risks of each person to be covered under that policy and to the type and
259 amount of coverage provided. This form of conversion coverage shall be known as the
260 'Basic Conversion Option'; and
261 (4) Nothing in this Code section shall be construed to prevent an insurer from offering
262 additional options to qualifying eligible individuals or group members.
263 (h) Each group certificate issued to each group member or qualifying eligible individual,
264 in addition to setting forth any conversion rights, shall set forth the continuation right in a
265 separate provision bearing its own caption. The provisions shall clearly set forth a full
266 description of the continuation and conversion rights available, including all requirements,
267 limitations, and exceptions, the premium required, and the time of payment of all premiums
268 due during the period of continuation or conversion.
269 (i) This Code section shall not apply to limited benefit insurance policies. For the
270 purposes of this Code section, the term 'limited benefit insurance' means accident and
271 sickness insurance designed, advertised, and marketed to supplement major medical
272 insurance. The term limited benefit insurance includes accident only, CHAMPUS
273 supplement, dental, disability income, fixed indemnity, long-term care, medicare
274 supplement, specified disease, vision, and any other accident and sickness insurance other
275 than basic hospital expense, basic medical-surgical expense, and comprehensive major
276 medical insurance coverage.
277 (j) The Commissioner shall adopt such rules and regulations as he or she deems necessary
278 for the administration of this Code section. Such rules and regulations may prescribe
279 various conversion plans, including minimum conversion standards and minimum benefits,
280 but not requiring benefits in excess of those provided under the group contract or group
281 plan from which conversion is made, scope of coverage, preexisting limitations, optional
282 coverages, reductions, notices to covered persons, and such other requirements as the
283 Commissioner deems necessary for the protection of the citizens of this state.

284 (k)(1) ~~This~~ Except as provided in paragraph (2) of this subsection, this Code section shall
285 apply to all group plans and group contracts delivered or issued for delivery in this state
286 on or after July 1, ~~1998~~ 2009, and to group plans and group contracts then in effect on the
287 first anniversary date occurring on or after July 1, ~~1998~~ 2009.
288 (2) The provisions of paragraphs (2) and (3) of subsection (c) of this Code section shall
289 apply to all group plans and group contracts in effect on September 1, 2008.
290 (l) As soon as practicable, but no later than 30 days after the effective date of this
291 subsection, the Commissioner shall develop and direct insurers to issue notices for
292 assistance eligible individuals regarding availability of expanded eligibility, second
293 election, and continuation coverage assistance to be sent to the last known addresses of
294 such assistance eligible individuals.
295 (m) Nothing in this chapter shall imply that individuals entitled to continuation coverage
296 who are not assistance eligible individuals shall receive benefits beyond the period of
297 coverage provided in paragraph (1) of subsection (c) of this Code section or that assistance
298 eligible individuals are entitled to any continuation benefit period beyond what is provided
299 by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of
300 2009."

301 **SECTION 2.**

302 Said title is further amended by adding a new Code section to read as follows:
303 "33-51-7.
304 (a) The Commissioner shall be authorized to allow health reimbursement arrangement
305 only plans that encourage employer financial support of health insurance or health related
306 expenses recognized under the rules of the federal Internal Revenue Service to be approved
307 for sale in connection with or packaged with individual health insurance policies otherwise
308 approved by the Commissioner.
309 (b) Health reimbursement arrangement only plans that are not sold in connection with or
310 packaged with individual health insurance policies shall not be considered insurance under
311 this title.
312 (c) Individual insurance policies offered or funded through health reimbursement
313 arrangements shall not be considered employer sponsored or group coverage for purposes
314 of this title, and nothing in this Code section shall be interpreted to require an insurer to
315 offer an individual health insurance policy for sale in connection with or packaged with a
316 health reimbursement arrangement or to accept premiums from health reimbursement
317 arrangement plans for individual health insurance policies."

318 **SECTION 3.**

319 This Act shall become effective upon its approval by the Governor or upon its becoming law

320 without such approval.

321 **SECTION 4.**

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