Senate Bill 6

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 change certain provisions concerning use of the premium taxes; to change certain provisions of the group accident and sickness contracts, conversion privilege, and continuation of right provisions; to provide for the creation of the Georgia Individual High Risk Reinsurance Pool; to provide for definitions; to provide for operation; to provide for powers and authority; to provide for reinsurance; to provide for premium rates; to provide for assessments; to provide for standards for agents; to provide for design of products; to make certain funding provisions contingent upon passage of a constitutional amendment; to provide for an effective date and applicability; to provide for related matters; to repeal the Commission on the Georgia Health Insurance Risk Pool; 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 33-8-4, relating to amount and method of computing tax on insurance premiums generally, by adding a new subsection to read as follows:

"(a.1) One-fourth of 1 percent of premium taxes collected pursuant to this Code section shall offset losses of the Georgia High Risk Individual Reinsurance Pool."

SECTION 2.

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

"(n) Enhanced conversion option coverage for qualified eligible individuals as defined under this Code section shall no longer be issued after eligible individuals under Article 1 of Chapter 29A of Title 33 are offered coverage through the Georgia High Risk Individual Reinsurance Pool as provided in that chapter."

SECTION 3.

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

″ARTICLE 2

33-29A-20.

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

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

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

33-29A-21.

(a) As used in this article, the term:

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

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

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

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

(5) 'Creditable coverage' has the same meaning as specified in Sections 270l and 2741 of the federal Public Health Service Act, 42 U.S.C.A. Sections 300gg and 300gg-41.

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

(7) 'Eligible individual' means:

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

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

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

Coverage provided under this article shall not be available to any individual who is covered under other health insurance coverage, except as provided in Code Section 33-29A-31. For purposes of this article, to be eligible, an individual must also meet the requirements of Code Section 33-29A-31.

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

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

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

(11) 'HSA compatible health benefit plan' means a health savings account compatible health benefit plan accepted for use in the pool pursuant to Code Section 33-29A-32.

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

(13) 'Individual health benefit plan' means a health benefit plan accepted for use in the pool pursuant to Code Section 33-29A-32.

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

(15) 'Plan' or 'pool plan' means the individual or HSA compatible health benefit plan accepted for use in the pool pursuant to Code Section 33-29A-32.

(16) 'Plan of operation' means the plan of operation of the Georgia Individual High Risk Reinsurance Pool established pursuant to this article.

(17) 'Pool' means the Georgia Individual High Risk Reinsurance Pool created under Code Section 33-29A-23.

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

33-29A-22.

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

33-29A-23.

(a) There is hereby created an independent public body corporate and politic to be known as the Georgia Individual High Risk Reinsurance Pool. The pool will perform an essential governmental function in the exercise of powers conferred upon it in this article. The pool and any assessments imposed or collected pursuant to the operation of the pool shall at all times be free from taxation of every kind.

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

member shall be a member of the House of Representatives appointed by the Speaker of the House.

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

33-29A-24.

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

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

(c) The plan of operation shall:

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

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

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

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

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

33-29A-25.

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

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

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

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

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

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

(6) Assess carriers in accordance with the provisions of Code Section 33-29A-29, and make advance interim assessments of carriers as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year. In no event shall any assessments of carriers begin before the latter of the establishment of a plan of operation for the pool or January 1, 2013;

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

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

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

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

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

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

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

33-29A-26.

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

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

(2) The board annually may adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the 'Consumer Price Index for All Urban Consumers' of the United States Department of Labor, Bureau of Labor Statistics, unless the board proposes and the Commissioner approves a lower adjustment factor.

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

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

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

33-29A-27.

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

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

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

33-29A-28.

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

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

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

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

33-29A-29.

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

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

(c)(1) For the assessment of March 1, 2014, and prior to March 1 of each succeeding year, the board shall determine and file with the Commissioner an estimate of the assessments needed to fund the losses incurred by the pool in the previous calendar year.

(2) The individual assessments shall be determined by multiplying net losses, if net earnings are negative, as defined by subsection (a) of this Code section, by a fraction, the numerator of which shall be the carrier's total premiums earned in the preceding calendar year from all health benefit plans and policies or certificates of insurance for specific disease, and hospital confinement indemnity in this state as reported in the carrier's reports filed pursuant to subsections (d) and (e) of Code Section 33-29A-26, including reinsurance by way of excess or stop loss coverage, and the denominator of which shall be the total premiums earned in the preceding calendar year from all health benefit plans and policies or certificates of insurance for specific disease and hospital confinement indemnity in this state, including reinsurance by way of excess or stop loss coverage.

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

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

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

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

33-29A-30.

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

33-29A-31.

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

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

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

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

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

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

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

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

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

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

(d) Any eligible individual person meeting the eligibility requirements of subsection (a), (b), or (c) of this Code section shall be eligible for coverage under a pool plan even though the person has existing coverage under other health insurance or under a group health plan, provided:

(1) There is a reasonable probability that the lifetime benefit maximum of the existing coverage will be exceeded within 90 days; and

(2) The lifetime benefit maximum under the existing coverage is at least $500,000.00. In all cases, coverage under a pool plan is secondary to the existing coverage and all other insurance.

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

(1) The person is not a federally eligible individual and, except as provided otherwise in subsection (d) of this Code section, has or obtains health insurance coverage substantially

similar to or more comprehensive than a pool plan or would be eligible to have such coverage at a rate not exceeding the rate for the pool plan if the person elected to obtain it;

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

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

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

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

(g) Coverage shall cease:

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

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

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

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

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

33-29A-32.

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

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

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

(2) Case management;

(3) Selective contracting with hospitals, physicians, and other health care providers;

(4) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(5) Other managed care provisions.

(c) Individual and HSA compatible health benefit plans submitted by individual health insurance carriers and approved for use in the pool shall meet minimum specifications required by Section 2741 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-41.

(d) The board may appoint an advisory committee to assist in reviewing and approving or disapproving the health benefit plans prescribed by this Code section.

(e) The board shall develop appeals procedures for individuals who have a grievance with the pool with regard to eligibility or termination of health plans issued pursuant to this chapter.″

SECTION 4.

This Act shall become effective on January 1, 2013, only if an amendment to the Constitution authorizing the General Assembly to provide for allocation of one-fourth of 1 percent of premium taxes collected to offset the losses of the Georgia High Risk Individual Reinsurance Pool is ratified by the voters of the November, 2012, general election. If such an amendment is not so ratified, this Act shall not become effective and shall stand repealed on January 1, 2013.

SECTION 5.

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