Senate Bill 476

By: Senators Hill of the 32nd and Goggans of the 7th

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide a short title; to provide for legislative intent; to provide a definition; to provide for continuation of coverage and available policy options; to provide for the time period for conversion rights and available policy options; to provide for group conversion policies and rating methods; to prohibit certain rescissions of policies; to provide for certain renewal right and options; to provide for the continued coverage of certain dependents through age 26; to provide limitations on certain pre-existing condition policy provisions; to provide for the extended continuation of coverages beginning at age 55; to provide for related matters; to provide an effective date and applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

This Act shall be known and may be cited as the "Free Market Safety Net Act."

SECTION 2.

It is the intent of the General Assembly to increase alternatives and affordable options for continuation and portability of comprehensive major medical coverage, especially for Georgians who might otherwise become uninsured after loss of group health coverage. In addition, it is the intention of the General Assembly to provide for a group policy whereby conversion options may be exercised as group plans providing greater options and support in a portable group plan.

SECTION 3.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by revising Code Section 33-1-2, relating to definitions, by renumbering existing paragraph (1.1) as paragraph (1.2) and adding a new paragraph to read as follows:

″(1.1) 'Comprehensive major medical' means a plan with at least a $1 million coverage lifetime maximum; a cost sharing out-of-pocket maximum no greater than that applicable in any given year to a high deductible health plan as defined under Section 233 of the federal Internal Revenue Code, with applicable annual indexing; and provides health care services which an enrolled population might reasonably require in order to be maintained in good health, including, as a minimum but not restricted to, preventive care, emergency care, inpatient hospital and physician care, outpatient medical services, mental and behavioral health services, and prescription drug services.″

SECTION 4.

Said title is further amended by revising Code Section 33-24-7, relating to statements and descriptions in applications or in negotiations deemed representations and not warranties and effect of misrepresentations upon recovery under policies, by adding a new subsection to read as follows:

″(c) An insurer offering group or individual health insurance policies shall not rescind a policy or coverage with respect to a covered individual once the individual is covered under such policy or coverage; provided, however, that this subsection shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.″

SECTION 5.

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

″33-24-21.1.

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

(1) 'Assistance eligible individual' shall have the same meaning as provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of 2009, as amended.

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

(A) Medicare or Medicaid;

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

(C) An individual accident and sickness insurance policy, including coverage issued by a health maintenance organization, nonprofit hospital or nonprofit medical service corporation, health care corporation, or fraternal benefit society;

(D) A spouse's benefits or coverage under medicare or Medicaid or an employer based health insurance or health benefit arrangement;

(E) A conversion policy;

(F) A franchise policy issued on an individual basis to a member of a true association as defined in subsection (b) of Code Section 33-30-1;

(G) A health plan formed pursuant to 10 U.S.C. Chapter 55;

(H) A health plan provided through the Indian Health Service or a tribal organization program or both;

(I) A state health benefits risk pool;

(J) A health plan formed pursuant to 5 U.S.C. Chapter 89;

(K) A public health plan; or

(L) A Peace Corps Act health benefit plan.

(3) 'Eligible dependent' means a person who is entitled to medical benefits coverage under a group contract or group plan by reason of such person's dependency on or relationship to a group member.

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

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

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

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

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

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

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

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

(7) 'Qualifying eligible individual' means:

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

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

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

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

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

(a.1) Any group member or qualifying eligible individual who is an assistance eligible individual as provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, during the period permitted under such act whose coverage has been terminated and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits that it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage and the coverage of his or her eligible dependents continued under the contract or plan in accordance with paragraph (2) of subsection (c) of this Code section. Such coverage shall continue for the fractional policy month remaining, if any, at termination plus up to the maximum number of additional policy months specified in paragraph (2) of subsection (c) of this Code section upon payment of the premium to the insurer by cash, certified check, or money order, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. An assistance eligible individual who is in a transition period as defined in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, shall be treated for purposes of any continuation of coverage provision as having timely paid such premium if such individual was covered under the continuation of coverage to which such premium relates for the period immediately preceding such transition period, if such individual remains eligible for such continuation of coverage, and if such individual pays the amount of such premium not later than 30 days after the date of provision of notice regarding eligibility for extended continuation of coverage. For the period that the assistance eligible individual is eligible for the premium reduction assistance as provided in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, such premium payment shall be calculated as 35 percent of the rate for active group members including any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage.

(a.2) The rights and benefits under this Code section attributable to Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, shall expire when that act expires. Any extension of such benefits shall require an Act of the Georgia General Assembly. Under no circumstances shall the extended benefits for

assistance eligible individuals become the responsibility of the State of Georgia or any insurer after the expiration of the premium subsidy made available to individuals pursuant to Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended.

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

(c)(1) Any group member or qualifying eligible individual whose coverage has been terminated and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage and the coverage of his or her eligible dependents continued under the contract or plan. Such coverage must continue for the fractional policy month remaining, if any, at termination plus ~~three~~ 18 additional policy months, upon payment of the premium by cash, certified check, or money order, at the option of the employer, to the policyholder or employer, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. Such premium payment must include any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage. At the end of such period, the group member shall have the same conversion rights that were available on the date of termination of coverage in accordance with the conversion privileges contained in the group contract or group plan.

(2) Any group member or qualifying eligible individual who is an assistance eligible individual has a right to elect continuation of his or her coverage and the coverage of his or her dependents at any time between May 5, 2009, and 60 days after receiving notice from the employer's insurer of the right to participate in state continuation benefits under this Code section in accordance with Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, if:

(A) The individual was involuntarily terminated from employment or otherwise experienced a loss of coverage due to qualifying events specified in Section 3001 of

Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended;

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

(C) The individual continues to be eligible for state continuation benefits under this chapter, provided that the total period of continuous eligibility shall not exceed the number of policy months equal to the maximum premium reduction period specified in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, as measured from the month of the qualifying event making the individual an assistance eligible individual; and

(D) The individual or the employer of the individual contacts the insurer and informs the insurer that the individual wants to take advantage of state continuation coverage under the provisions of Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended.

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

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

(2) A qualifying eligible individual shall not be entitled to have coverage continued if the most recent creditable coverage within the coverage period was terminated based on one of the following factors: (A) failure of the qualifying eligible individual to pay premiums or contributions in accordance with the terms of the health insurance coverage

or failure of the issuer to receive timely premium payments; (B) the qualifying eligible individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage; or (C) any discontinued group coverage is immediately replaced by similar group coverage including coverage under a health benefits plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. This subsection shall not affect conversion rights available to a group member under any contract or plan.

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

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

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

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

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

(1)(A) Any ~~qualifying eligible individual~~ group member whose insurance and its corresponding eligibility under the group policy~~, including any continuation available, elected, and exhausted under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA),~~ has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than fraud or failure of the qualifying eligible individual to pay a required premium contribution to the employer or, if so required, to the insurer directly and who has at least ~~18~~ six months of creditable coverage immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group based coverage covering such qualifying eligible individual and any eligible dependents who were covered under the qualifying eligible individual's coverage under the group contract or group plan. Such conversion coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage ~~or the date on which continuation or COBRA coverage ended, whichever is later~~.

(B) The insurer must offer ~~qualifying eligible individuals~~ group members at least ~~two distinct~~ three conversion options ~~from which to choose~~ within a group conversion policy. ~~One such choice of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in this state or comparable to a standard option of coverage available under the group or individual health insurance laws of this state. The other choice may be more limited in nature but must also qualify as creditable coverage. Each coverage shall be filed, together with applicable rates, for approval by the Commissioner. Such choices shall be known as the 'Enhanced Conversion Options'~~ Such options shall include at least a comprehensive major medical plan, a high deductible health plan as defined under Section 233 of the federal Internal Revenue Code, and another choice that may be more limited in nature, but all plans must also qualify as credible coverage. Such choices shall be known as the 'Group Conversion Options.' With the payment of timely premiums, the group conversion policy shall be guaranteed renewable until the individual is eligible for group coverage or until medicare or Medicaid eligibility. The option of the high deductible health plan does not apply if the insurer does not offer a high deductible health plan or an actuarial equivalent;

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

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

(B) Each insurer's group pool shall consist of each insurer's total claims experience produced by all groups in this state, regardless of the marketing mechanism or distribution system utilized in the sale of the group insurance from which the qualifying eligible individual is converting. The pool shall include the experience generated under any medical expense insurance coverage offered under separate group contracts and contracts issued to trusts, multiple employer trusts, or association groups or trusts, including trusts or arrangements providing group or group-type coverage issued to a trust or association or to any other group policyholder where such group or group-type contract provides coverage, primarily or incidentally, through contracts issued or issued for delivery in this state or provided by solicitation and sale to Georgia residents through an out-of-state multiple employer trust or arrangement; and any other

group-type coverage which is determined to be a group shall also be included in the pool for ~~enhanced~~ group conversion policy rating purposes; ~~and~~

(C) Any other factors deemed relevant by the Commissioner may be considered in determination of each ~~enhanced~~ group conversion policy pool rate so long as it does not have the effect of lessening the risk-spreading characteristic of the pooling requirement. Duration since issue and tier factors may not be considered in conversion policy rating. Notwithstanding subparagraph (A) of this paragraph, the total premium calculated for all ~~enhanced~~ group conversion policies may deviate from the group pool rate by not more than plus or minus ~~50~~ 25 percent based upon the experience generated under the pool of ~~enhanced~~ group conversion policies so long as rates do not deviate for similarly situated individuals covered through the pool of ~~enhanced~~ group conversion policies; and

(D) Such group conversion options can use individual rating by age, gender, and other pricing characteristics as used by the insurer in similar group pricing. Group conversion options can rate individual member coverages up to 25 percent of premiums consistent with the underlying conversion group plan of coverage rated relative to the standard or manual rates for the group conversion policy benefits provided; and

~~(3) Any group member who is not a qualifying eligible individual and whose insurance under the group policy has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than eligibility for medicare (reaching a limiting age for coverage under the group policy) or failure of the group member to pay a required premium contribution, and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group coverage covering such group member and any eligible dependents who were covered under the group member's coverage under the group contract or group plan. Such conversion coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The premium of the basic converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and classification of risks of each person to be covered under that policy and to the type and amount of coverage provided. This form of conversion coverage shall be known as the 'Basic Conversion Option'; and~~

~~(4)~~(3) Nothing in this Code section shall be construed to prevent an insurer from offering additional options to qualifying eligible individuals or group members.

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

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

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

(k)(1) Except as provided in paragraph (2) of this subsection, this Code section shall apply to all group plans and group contracts delivered or issued for delivery in this state on or after July 1, 2009, and to group plans and group contracts then in effect on the first anniversary date occurring on or after July 1, 2009.

(2) The provisions of paragraphs (1), (2), and (3) of subsection (c) of this Code section shall apply to all group plans and group contracts in effect on September 1, 2008.

(l) As soon as practicable, but no later than June 4, 2009, the Commissioner shall develop and direct insurers to issue notices for assistance eligible individuals regarding availability of expanded eligibility and continuation coverage assistance to be sent to the last known addresses of such assistance eligible individuals.

(m) Nothing in this chapter shall imply that individuals entitled to continuation coverage who are not assistance eligible individuals shall receive benefits beyond the period of coverage provided in paragraph (1) of subsection (c) of this Code section or that assistance eligible individuals are entitled to any continuation benefit period beyond what is provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of 2009 or extensions to that Act which are enacted on and after May 5, 2009.″

SECTION 6.

Said title is further amended by revising paragraph (1) of subsection (a) of Code Section 33-24-21.2, relating to continuation of coverage under group accident and sickness plans for persons 60 years of age or older, as follows:

"(b)(1) A group contract or plan providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, which is issued, delivered, issued for delivery, or renewed in this state to provide coverage for the employees of an employer subject to the provisions of Section 4980B of the Internal Revenue Code, shall contain a provision that a group member whose insurance under the contract or plan otherwise terminates after the expiration of the period of continuation of coverage for which the individual is eligible under Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code shall be entitled to continue coverage under that group contract or plan for himself or herself and his or her eligible dependents if the group member was ~~60~~ 55 years of age or older as of the date on which the continuation of coverage afforded under Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code commences."

SECTION 7.

Said title is further amended by revising paragraph (3) of subsection (a) of Code Section 33-29-2, relating to requirements as to individual accident and sickness policies generally, as follows:

"(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 add or continue to insure a dependent child of the policyholder, the child ~~shall continue~~ can be added or continued to be insured up to and including age 25 so long as the policy continues in effect~~,~~ and the child is or remains a tax dependent of the policyholder~~, and 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~~. If the tax dependent child over age 19 has been previously covered and has had a lapse in coverage under the plan of more than 180 days, the insurer may request evidence of insurability to add that tax dependent;"

SECTION 8.

Said title is further amended by revising paragraph (2) of subsection (b) of Code Section 33-29-3, relating to required policy provisions for individual accident and sickness insurance, by adding a new subparagraph to read as follows:

"(C) No preexisting exclusion shall exceed 12 months from the date of issue of this policy."

SECTION 9.

Said title is further amended by revising subsections (b) and (c) of Code Section 33-29-9, relating to requirements as to references in policies to noncancelable nature or guaranteed renewability nature, exception for certain matters concerning renewability of individual accident and sickness policies, and rules and regulations, as follows:

"(b) An insurer operating in the major medical or comprehensive, guaranteed renewable business in the State of Georgia shall permit an insured to change his or her major medical or comprehensive coverage, upon election at any renewal or at any time within 30 days before or after renewal, to a comparable product currently offered by that insurer or a product currently offered by that insurer with more limited product benefits; to a product with higher deductibles; or to modify his or her existing coverage to elect any optional higher deductibles under that policy. If such product, benefit, or deductible change is elected by the insured during the 60 day required period after notice of renewal premium increase ~~but before renewal date~~ or at any time within 30 days before or after the renewal date regardless of any increase, such insured shall not be subject to any new preexisting conditions exclusion that did not apply to his or her original coverage.

(c) An insurer operating in the individual major medical or comprehensive, guaranteed renewable business in the State of Georgia shall provide notice to policyholders of the discontinuance of sales under that policy form within 60 days of such discontinuance or 60 days prior to the renewal date of the policy, whichever is later. For the purposes of this subsection, a policy form shall be deemed discontinued if there have been no new sales of the policy form during any continuous 180 day period. If such product, benefit, or deductible change is elected by the insured during a period of 60 days after notice or 30 days before or after the renewal date, such insured shall not be subject to any new preexisting conditions exclusion that did not apply to his or her original coverage.

(d) The Commissioner shall adopt such rules and regulations as he or she deems necessary for the administration of this Code section."

SECTION 10.

Said title is further amended by revising Code Section 33-29A-31, relating to definitions regarding individual accident and sickness insurance, as follows:

"33-29A-31.

For purposes of this article, the term 'individual accident and sickness insurance policy' means any policy insuring against loss resulting from sickness or from bodily injury or death by accident, or both, or any contract to furnish ambulance service in the future but does not include limited benefit insurance policies exempted from the definition of the term 'health benefit policy' in paragraph ~~(1.1)~~ (1.2) of Code Section 33-1-2. The term 'individual accident and sickness insurance policy' shall also include comprehensive major medical coverage for medical and surgical benefits, and also includes 'High Deductible Health Plans' sold or maintained under the applicable provisions of Section 223 of the Internal Revenue Code."

SECTION 11.

This Act shall become effective on July 1, 2012, and shall apply to all policies delivered, issued, or issued for delivery in this state on and after such date.

SECTION 12.

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