House Bill 99

By: Representative Smith of the 134th

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 for modernization and updates; to amend various provisions for purposes of conformity; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by revising Code Section 33-40-21, relating to rules, as follows:

"33-40-21.

~~The Commissioner may establish and from time to time amend such rules relating to risk retention groups as may be necessary or desirable to carry out the provisions of this chapter.~~ Reserved."

SECTION 2.

Said title is further amended by revising Code Section 33-41-20.1, relating to membership of captive insurance companies in Georgia Insurers Insolvency Pool, as follows:

"33-41-20.1.

~~(a) On and after January 1, 2008, every~~ Every association and industrial insured captive insurance company issuing workers' compensation insurance contracts shall become a member of the Georgia Insurers Insolvency Pool under Chapter 36 of this title as to workers' compensation only. Such captive insurance companies shall be liable for assessments pursuant to Code Section 33-36-7 and for all other obligations imposed pursuant to Chapter 36 of this title as to workers' compensation only.

~~(b) Except as provided for in Code Section 33-36-20, the Georgia Insurers Insolvency Pool shall not be liable for any claims incurred by any captive insurance company before January 1, 2008.~~"

SECTION 3.

Said title is further amended by revising Code Section 33-41-23, relating to rules and regulations, as follows:

"33-41-23.

~~The Commissioner may establish such rules and regulations and issue such interpretive rulings as may be necessary to carry out the provisions of this chapter.~~ Reserved."

SECTION 4.

Said title is further amended by revising Code Section 33-42-3, relating to applicability of chapter, as follows:

"33-42-3.

The requirements of this chapter shall apply to long-term care insurance policies issued, delivered, or issued for delivery in this state ~~on or after July 1, 1988~~. This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable provisions of this title insofar as they do not conflict with this chapter, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed, or offered as long-term care insurance need not meet the requirements of this chapter."

SECTION 5.

Said title is further amended by revising Code Section 33-42-4, relating to definitions, as follows:

"33-42-4.

As used in this chapter, the term:

(1) 'Applicant' means:

(A) In the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits; and

(B) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) 'Certificate' means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

~~(3) 'Commissioner' means the Commissioner of Insurance of this state.~~

~~(4)~~(3) 'Group long-term care insurance' means a long-term care insurance policy which is issued, delivered, or issued for delivery in this state and issued to:

(A) Any eligible group as defined in Code Section 33-30-1; or

(B) A group other than as described in Code Section 33-30-1, subject to a finding by the Commissioner that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

~~(5)~~(4) 'Long-term care insurance' means any accident and sickness insurance policy or rider advertised, marketed, offered, or designed primarily to provide coverage for not less than 12 consecutive benefit months or which provides coverage for recurring confinements separated by a period not to exceed six months with a minimum aggregate period of one year for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual accident and sickness policies or riders whether issued by insurers, fraternal benefit societies, health care plans, health maintenance organizations, or any other similar organizations. Long-term care insurance shall not include any accident and sickness insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may be provided through an individual or group life insurance policy by attachment of a long-term care rider or by the automatic inclusion of a long-term care provision which, notwithstanding Code Section 33-42-3, must meet the requirements of this chapter and regulations promulgated by the Commissioner. Any such long-term care riders or policy provisions shall not be exempt from filing requirements and must be filed with the department for approval before being used in this state.

~~(6)~~(5) 'Policy' means any policy, contract, or subscriber agreement or any rider or endorsement attached thereto, issued, delivered, issued for delivery, or renewed in this state by an insurer, fraternal benefit society, health care plan, health maintenance organization, or any other similar organization. Such term shall also include a Georgia Qualified Long-term Care Partnership Program approved policy, as defined in paragraph (4) of Code Section 49-4-161, meeting the requirements of the Georgia Qualified Long-term Care Partnership Program as enacted in subsection (a) of Code Section 49-4-162.″

SECTION 6.

Said title is further amended by revising Code Section 33-42-5, relating to group policy issued in another state, as follows:

"33-42-5.

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in subparagraph (B) of paragraph ~~(4)~~(3) of Code Section 33-42-4 unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met."

SECTION 7.

Said title is further amended by revising Code Section 33-42-6, relating to disclosures, provisions, definition of preexisting condition, loss ratio standards, right to return policy, outline of coverage, and certificate, as follows:

"33-42-6.

~~(a) The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies and for any applicable terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definition of terms.~~

~~(b)~~(a) No long-term care insurance policy may:

(1) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new policy or other form of policy within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide coverage for other levels of care which is unreasonably lower than the coverage provided for skilled nursing care in a facility.

~~(c)~~(b)(1) No long-term care insurance policy or certificate shall use a definition of 'preexisting condition' which is more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was

recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in paragraphs (1) and (2) of this subsection as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of 'preexisting condition' shall not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period provided in paragraph (2) of this subsection expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (2) of this subsection.

~~(d)~~(c)(1) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related condition within a period of less than 30 days after discharge from the institution.

(2) Notwithstanding paragraph (1) of this subsection, no long-term care insurance policy which conditions the eligibility of benefits on prior hospitalization may be delivered or issued for delivery in this state unless the insurer or other entity offering that policy also offers a long-term care insurance policy which does not condition eligibility of benefits on such a requirement.

~~(e)~~(d) The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies, provided that a specific reference to long-term care insurance policies is contained in the regulation.

~~(f)~~(e) Individual long-term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

Long-term care insurance policies or certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

~~(g)~~(f) An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall comply with the applicable provisions of Code Section 33-29-13.

~~(h)~~(g) A certificate issued pursuant to a group long-term care insurance policy, which policy is issued, delivered, issued for delivery, or renewed in this state, shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(3) A statement that the group master policy determines governing contractual provisions; and

(4) Such other provisions as the Commissioner may reasonably require.

~~(i)~~(h) No policy may be advertised, marketed, or offered as long-term care insurance unless it complies with the provisions of this chapter.″

SECTION 8.

Said title is further amended by revising Code Section 33-42-7, relating to regulations, as follows:

″33-42-7.

~~Regulations adopted pursuant to this chapter shall be in accordance with the provisions of Chapter 2 of this title.~~ Reserved.″

SECTION 9.

Said title is further amended in Code Section 33-43-2, relating to applicability of chapter, by revising subsection (a) as follows:

″(a) Except as otherwise specifically provided, this chapter shall apply to:

(1) All medicare supplement policies delivered or issued for delivery in this state ~~on or after July 1, 2000~~; and

(2) All certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state.″

SECTION 10.

Said title is further amended in Code Section 33-43-3, relating to duplicate benefits prohibited and establishment of standards, by revising subsection (h) as follows:

"(h) Persons may enroll in a medicare supplement policy at any time authorized or required by the federal government or within six months of:

(1) Enrolling in medicare Part B ~~or by May 1, 2011,~~ for an individual who is under 65 years of age and is eligible for medicare because of disability or end-stage renal disease, whichever is later;

(2) Receiving notice that such person has been retroactively enrolled in medicare Part B due to a retroactive eligibility decision made by the Social Security Administration; or

(3) Experiencing a qualifying event identified in regulations adopted pursuant to subsection (c) of this Code section."

SECTION 11.

Said title is further amended by repealing Chapter 44, relating to High Risk Health Insurance Plan, and designating said chapter as reserved.

SECTION 12.

Said title is further amended by revising Code Section 33-45-7.1, relating to provider authorized to offer continuing care when resident purchases owned living unit, as follows:

"33-45-7.1.

A provider which has obtained a certificate of authority pursuant to Code Section 33-45-5 and the written approval of the ~~commissioner~~ Commissioner is authorized to offer, as a part of the continuing care agreement, continuing care at home or continuing care in which the resident purchases a resident owned living unit, subject to the provisions of Chapters 6 and 7 of Title 31 and rules and regulations promulgated by the Department of Community Health pursuant to such chapters relating to certificate of need and licensure requirements."

SECTION 13.

Said title is further amended in Code Section 33-45-11, relating to maintaining financial reserves and requirements, by revising subsection (b) as follows:

"(b) A provider or facility which has opened but not yet achieved full occupancy, as defined by its lender or financing documents, if any, or 95 percent occupancy of its residential units; or a provider or facility that has received a certificate of authority and has been in conformance with the provisions of this chapter ~~prior to July 1, 2011,~~ shall be required to achieve the level of financial reserves required by subsection (a) of this Code section as follows:

(1) The provider or facility shall submit a plan to the Commissioner the terms of which assure that the provider or facility shall maintain sufficient progress to achieving the level of financial reserves required by this Code section; and

(2) The plan demonstrates that the provider or facility is substantially likely to achieve the required level of financial reserves within five years of opening ~~or for existing facilities that received a certificate of authority and have been in conformance with the provisions of this chapter prior to July 1, 2011, within five years of July 1, 2011~~. For purposes of this paragraph, the term 'substantially likely' means a provider or facility shall meet the level of financial reserves required by ~~paragraph (1) of this~~ subsection (a) of this Code section at a minimum rate of 20 percent per year as of the end of each fiscal year after ~~the later of~~ the date the facility opens ~~or July 1, 2011~~, up to a total of 100 percent as of the end of the fifth fiscal year."

SECTION 14.

Said title is further amended in Code Section 33-50-5, relating to minimum surplus, capital requirements, security deposit, annual audit, aggregate excess stop-loss coverage, and individual excess stop-loss coverage, by revising subsections (e), (f), and (i) as follows:

"(e) Every multiple employer self-insured health plan licensed pursuant to this chapter shall have an annual audit by an independent certified public accountant in accordance with Georgia ~~Insurance~~ Department of Insurance Regulation 120-2-60 and instructions prescribed by the National Association of Insurance Commissioners.

(f) Every multiple employer self-insured health plan shall file financial statements with the Commissioner in accordance with the provisions of Georgia ~~Insurance~~ Department of Insurance Regulation 120-2-18-.06."

"(i) ~~A multiple employer self-insured health plan licensed before January 1, 2010, shall have until December 31, 2011, to comply with the provisions of this Code section.~~ Reserved."

SECTION 15.

Said title is further amended by revising Code Section 33-50-13, relating to date when filings due, as follows:

"33-50-13.

All multiple employer self-insured health plans who have member employees in this state ~~as of July 1, 1991,~~ shall ~~have until October 1, 1991, to~~ make all filings necessary to comply with this chapter."

SECTION 16.

Said title is further amended in Code Section 33-51-3, relating to development of guidelines, promotion by Commissioner, and authority of Commissioner, by revising subsection (e) as follows:

"(e) ~~The Commissioner shall be authorized to promulgate such rules and regulations as he or she deems necessary and appropriate for the design, promotion, and regulation of health savings account eligible high deductible plans, including rules and regulations for the expedited review of standardized policies, advertisements and solicitations, and other matters deemed relevant by the Commissioner.~~ Reserved."

SECTION 17.

Said title is further amended by revising Code Section 33-53-1, relating to definitions, as follows:

"33-53-1.

As used in this chapter:

~~(1) 'Commissioner' means the Commissioner of Insurance of the State of Georgia.~~

~~(2)~~(1) 'Drug' means a drug or biologic that is used in an antineoplastic regimen.

~~(3)~~(2) 'Insurance policy' means an individual accident and sickness policy of insurance issued pursuant to Chapter 29 of this title or a group accident and sickness insurance policy issued pursuant to Chapter 30 of this title.

~~(4)~~(3) 'Standard reference compendium' means any of the following:

(A) The United States Pharmacopeia Drug Information;

(B) The American Medical Association Drug Evaluations;

(C) The American Hospital Formulary Service Drug Information."

SECTION 18.

Said title is further amended by revising Code Section 33-53-3, relating to enforcement, as follows:

"33-53-3.

~~The Commissioner is authorized to enforce the provisions of this chapter.~~ Reserved."

SECTION 19.

Said title is further amended in Code Section 33-54-2, relating to definitions, by revising paragraph (2) as follows:

"(2) 'Insurer' means an insurer, a fraternal benefit society, ~~a nonprofit medical service corporation,~~ a health care corporation, a health maintenance corporation, or a self-insured

health plan not subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.″

SECTION 20.

Said title is further amended in Code Section 33-55-1, relating to insurers to report acquisitions and dispositions of assets and material changes to ceded reinsurance agreements to Commissioner, by revising subsection (b) as follows:

″(b)(1) The report required in subsection (a) of this Code section is due within 15 days after the end of the calendar month in which any of the covered transactions occur.

(2) One complete copy of the report, including any exhibits or other attachments filed as part thereof, shall be filed with:

(A) The Commissioner ~~of Insurance~~; and

(B) The National Association of Insurance Commissioners.″

SECTION 21.

Said title is further amended by revising Code Section 33-56-9, relating to chapter supplemental to other laws and exemption for certain domestic property and casualty insurance, as follows:

″33-56-9.

(a) The provisions of this chapter are supplemental to any other provisions of the laws of this state and shall not preclude or limit any other powers or duties of the Commissioner under such laws, including, but not limited to, Chapters 2, 3, 13, 14, ~~18, 19,~~ 20, 21, and 37 of this title.

~~(b) The Commissioner may adopt reasonable rules necessary for the implementation of this chapter.~~

~~(c)~~(b) The Commissioner may exempt from the application of this chapter any domestic property and casualty insurer which:

(1) Meets all three of the following criteria:

(A) Writes direct business only in this state;

(B) Writes direct annual premiums of $2 million or less; and

(C) Assumes no reinsurance in excess of 5 percent of direct premium written; or

(2) Demonstrates to the satisfaction of the Commissioner by other means that preparation and submission of an RBC report would create an unusual and unnecessary hardship or would result in a report which is ambiguous or misleading based upon the unique nature of the company's product offerings or financial structure.

~~(d)~~(c) The Commissioner may exempt from the application of this chapter any health organization which:

(1) Has less than 1,000 covered lives; and

(2) Has less than $1 million in direct written premiums."

SECTION 22.

Said title is further amended by revising Code Section 33-56-11, relating to immunity of Commissioner and department, as follows:

"33-56-11.

There shall be no liability on the part of, and no cause of action shall arise against, the Commissioner or the ~~insurance~~ department or its employees or agents for any action taken by them in the performance of their powers and duties under this chapter."

SECTION 23.

Said title is further amended by revising Code Section 33-56-12, relating to severability, and designating said Code section as reserved, as follows:

"33-56-12.

~~In the event any section, subsection, sentence, clause, or phrase of this chapter shall be declared or adjudged invalid or unconstitutional, such adjudication shall in no manner affect the other sections, subsections, sentences, clauses, or phrases of this chapter, which shall remain of full force and effect as if the section, subsection, sentence, clause, or phrase so declared or adjudged invalid or unconstitutional were not originally a part of this chapter. The General Assembly declares that it would have passed the remaining parts of this chapter if it had known that such part or parts of this chapter would be declared or adjudged invalid or unconstitutional.~~ Reserved."

SECTION 24.

Said title is further amended in Code Section 33-58-4, relating to notice of annuity to Commissioner, by revising subsection (a) as follows:

"(a) A charitable organization that issues qualified charitable gift annuities shall notify the Commissioner in writing by the ~~later of October 1, 2000, or the~~ date on which it enters into the organization's first qualified charitable gift annuity agreement. The notice shall:

(1) Be signed by an officer or director of the organization;

(2) Identify the organization; and

(3) Certify that:

(A) The organization is a charitable organization; and

(B) The annuities issued by the organization are qualified charitable gift annuities."

SECTION 25.

Said title is further amended in Code Section 33-59-11, relating to required documents and information, confidentiality, seller's right to rescind, escrow proceedings, failure to tender consideration, and limitation on contracts with the insured for the purpose of determining the insured's health status, by revising subsection (f) as follows:

"(f) If a life settlement broker performs those verification of coverage activities required of the provider, the provider is deemed to have fulfilled the requirements of subsection (a) of Code Section ~~33-5-9~~ 33-59-9."

SECTION 26.

Said title is further amended by revising Code Section 33-59-12, relating to promulgation of regulations and determining governing law when multiple owners, as follows:

"33-59-12.

~~(a) The Commissioner may promulgate regulations implementing this chapter and regulating the activities and relationships of providers, life settlement brokers, insurers, and their agents subject to statutory limitations on administrative rule making.~~

~~(b)(1)~~(a) If there is more than one owner on a single policy, and the owners are residents of different states, the life settlement contract shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all of the owners. The law of the state of the insured shall govern in the event that equal owners fail to agree in writing upon a state of residence for jurisdictional purposes.

~~(2)~~(b) A provider from this state who enters into a life settlement contract with an owner who is a resident of another state that has enacted statutes or adopted regulations governing life settlement contracts shall be governed in the effectuation of that life settlement contract by the statutes and regulations of the owner's state of residence. If the state in which the owner is a resident has not enacted statutes or regulations governing life settlement contracts, the provider shall give the owner notice that neither state regulates the transaction upon which he or she is entering. For transactions in those states, however, the provider is to maintain all records required if the transactions were executed in the state of residence. The forms used in those states need not be approved by the Commissioner.

~~(3)~~(c) If there is a conflict in the laws that apply to an owner and a purchaser in any individual transaction, the laws of the state that apply to the owner shall take precedence and the provider shall comply with those laws."

SECTION 27.

Said title is further amended by revising Code Section 33-59-18, relating to transacting business permitted while the provider's license application is pending, as follows:

"33-59-18.

~~(a) A provider lawfully transacting business in this state prior to July 1, 2009, may continue to do so pending approval or disapproval of that person's application for a license so long as the application is filed with the Commissioner not later than 30 days after publication by the Commissioner of an application form and instructions for licensure of providers. If the publication of the application form and instructions is prior to July 1, 2009, then the filing of the application shall not be later than August 1, 2009. During the time that such an application is pending with the Commissioner, the applicant may use any form of life settlement contract that has been filed with the Commissioner pending approval thereof, provided that such form is otherwise in compliance with the provisions of this chapter. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this chapter.~~

~~(b) A person who has lawfully negotiated life settlement contracts between any owner residing in this state and one or more providers for at least one year immediately prior to July 1, 2009, may continue to do so pending approval or disapproval of that person's application for a license so long as the application is filed with the Commissioner not later than 30 days after publication by the Commissioner of an application form and instructions for registration of life settlement brokers. If the publication of the application form and instructions is prior to July 1, 2009, then the filing of the application shall not be later than August 1, 2009. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this chapter.~~ Reserved."

SECTION 28.

Said title is further amended by revising Code Section 33-60-2, relating to legislative intent, as follows:

"33-60-2.

The General Assembly recognizes the need for employers and individuals in this state to have the opportunity to choose among group and individual health insurance plans that are more affordable and flexible than standard market policies of accident and sickness insurance and the need to increase the availability of health insurance coverage by authorizing the transaction of this type of plan or policy by accident and sickness insurers licensed to transact business in this state. This chapter shall require insurers which provide major medical coverage to offer policies that contain all state mandated health benefits as well as policies that contain the limited selection of state mandated health benefits set forth

in Code Section 33-60-3; provided, however, that~~, on and after July 1, 2005,~~ employees in group plans or individuals may choose pursuant to this chapter among new health insurance plans offered by insurers that either include all state mandated health benefits or include the limited state mandated health benefits set forth in Code Section 33-60-3.″

SECTION 29.

Said title is further amended in Code Section 33-60-3, relating to definitions, by revising paragraph (3) as follows:

″(3) 'Insurer' means any insurer or nonprofit organization authorized to sell accident and sickness policies, subscriber contracts, certificates, or agreements of any form under Chapters 15, ~~18, 19,~~ 20, 21, 29, and 30 of this title.″

SECTION 30.

Said title is further amended in Code Section 33-60-4, relating to requirements for insurers and employers, sale by health maintenance organizations permitted, and purchase of additional coverage permitted, by revising subsections (a) and (b) as follows:

″(a) Notwithstanding any other provision of law ~~and on and after July 1, 2005~~:

(1) Any insurer authorized to transact business in this state offering group accident and sickness policies or contracts shall be required to offer, through a licensed agent or agency, a group health benefit plan that contains all state mandated health benefits and may offer a group alternative health benefit plan as defined in this chapter; and

(2) Any insurer authorized to transact business in this state offering individual accident and sickness policies or contracts shall be required to offer, through a licensed agent or agency, an individual health benefit plan that contains all state mandated health benefits and may offer an individual alternative health benefit plan as defined in this chapter.

(b) ~~On and after July 1, 2005, an~~ An employer who chooses to offer group health benefit plans to its employees shall offer to each eligible employee a group health benefit plan that contains all state mandated health benefits and may offer to each eligible employee a group alternative health benefit plan as defined in this chapter.″

SECTION 31.

Said title is further amended in Code Section 33-60-5, relating to required notice and acknowledgment, by revising subsection (b) as follows:

″(b) An acknowledgment separate from the notice and application provided for in subsection (a) of this Code section shall be provided to and completed by each individual policyholder or individual group member. Such acknowledgment shall contain a comparison of the benefits contained in each of the health benefit plan options being

offered to the individual policyholder or individual group member. ~~The Commissioner shall promulgate such rules and regulations as he or she deems necessary to implement this subsection including rules and regulations concerning the form and contents of such acknowledgment.~~ In the case of group health benefit plans being offered by an employer, a copy of the acknowledgment for each individual group member shall be maintained by the employer."

SECTION 32.

Said title is further amended by revising Code Section 33-60-6, relating to authority of the Commissioner with respect to this chapter, as follows:

"33-60-6.

~~The Commissioner of Insurance may promulgate rules and regulations as necessary to implement the provisions of this chapter and specify the information to be contained on the forms supplied by insurers of these policies and contracts to individual group members and policyholders.~~ Reserved."

SECTION 33.

Said title is further amended in Code Section 33-61-1, relating to definitions, by revising paragraph (3) as follows:

"(3) ~~'Commissioner' shall mean the Commissioner of Insurance of the State of Georgia.~~ Reserved."

SECTION 34.

Said title is further amended by revising Code Section 33-63-1, relating to legislative findings, as follows:

"33-63-1.

The General Assembly finds that guaranteed asset protection waivers are not insurance. All guaranteed asset protection waivers issued on or after the date of enactment of this chapter shall not be construed as insurance."

SECTION 35.

Said title is further amended by revising Code Section 33-63-9, relating to Commissioner of Insurance to enforce provisions and penalty for violations, as follows:

"33-63-9.

The Commissioner ~~of Insurance~~ may take action which is necessary or appropriate to enforce the provisions of this chapter and to protect guaranteed asset protection waiver

holders in this state. After proper notice and opportunity for hearing, the ~~commissioner~~ Commissioner may:

(1) Order the creditor, administrator, or any other person not in compliance with this chapter to cease and desist from further guaranteed asset protection waiver related operations which are in violation of this chapter; and

(2) Impose a penalty of not more than $500.00 per violation and not more than $10,000.00 in the aggregate for all violations of a similar nature. For purposes of this paragraph, violations must be of a similar nature if the violation consists of the same or similar course of conduct, action, or practice, irrespective of the number of times the conduct, action, or practice which is determined to be a violation of this chapter occurred."

SECTION 36.

Said title is further amended by revising Code Section 33-64-1, relating to definitions, as follows:

"33-64-1.

As used in this chapter, the term:

(1) 'Business entity' means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

~~(2) 'Commissioner' means the Commissioner of Insurance.~~

~~(3)~~(2) 'Covered entity' means an employer, labor union, or other group of persons organized in this state that provides health coverage to covered individuals who are employed or reside in this state.

~~(4)~~(3) 'Covered individual' means a member, participant, enrollee, contract holder, policy holder, or beneficiary of a covered entity who is provided health coverage by a covered entity.

~~(5)~~(4) 'Health system' means a hospital or any other facility or entity owned, operated, or leased by a hospital and a long-term care home.

~~(6)~~(5) 'Maximum allowable cost' means the per unit amount that a pharmacy benefits manager reimburses a pharmacist for a prescription drug, excluding dispensing fees and copayments, coinsurance, or other cost-sharing charges, if any.

~~(7)~~(6) 'Pharmacy' means a pharmacy or pharmacist licensed pursuant to Chapter 4 of Title 26 or another dispensing provider.

~~(8)~~(7) 'Pharmacy benefits management' means the service provided to a health plan or covered entity, directly or through another entity, including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including, but not limited to, any of the following:

(A) Mail order pharmacy;

(B) Claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs;

(C) Clinical or other formulary or preferred drug list development or management;

(D) Negotiation or administration of rebates, discounts, payment differentials, or other incentives for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular prescription drugs;

(E) Patient compliance, therapeutic intervention, or generic substitution programs; and

(F) Disease management.

~~(9)~~(8) 'Pharmacy benefits manager' means a person, business entity, or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. The term does not include services provided by pharmacies operating under a hospital pharmacy license. The term also does not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures. The term also does not include services provided by pharmacies affiliated with a facility licensed under Code Section 31-44-4 or a licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.″

SECTION 37.

Said title is further amended in Code Section 33-64-2, relating to license requirements and filing fees, by revising subsection (l) as follows:

″(l) A pharmacy benefits manager operating as a line of business or affiliate of a health insurer, health care center, ~~hospital service corporation, medical service corporation,~~ or fraternal benefit society licensed in this state or of any affiliate of such health insurer, health care center, ~~hospital service corporation, medical service corporation,~~ or fraternal benefit society shall not be required to obtain a license pursuant to this chapter. Such health insurer, health care center, ~~hospital service corporation, medical service corporation,~~ or fraternal benefit society shall notify the Commissioner annually, in writing, on a form provided by the Commissioner, that it is affiliated with or operating as a line of business as a pharmacy benefits manager.″

SECTION 38.

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