Senate Bill 476

By: Senators Thompson of the 33rd, Stokes of the 43rd, Tanksley of the 32nd and Hecht of the 34th

A BILL TO BE ENTITLED
AN ACT

To provide a short title; to amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to define certain terms; to prohibit additional discriminatory practices based on race, color, or national or ethnic origin; to provide for remedies for violations; to provide standards and procedures for verification of benefits and precertifications relating to managed health benefit plans; to provide for liability and personnel; to provide for applicability; to include among unfair insurance practices certain practices of insurers and managed care entities with regard to health benefit plans; to require that certain persons shall be notified of the cancellation, nonrenewal, or other termination of their insurance; to provide for 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 "Consumers´ Health Insurance Protection Act."

SECTION 2.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by inserting in Code Section 33-6-4, relating to unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, a new division (b)(8)(A)(iv) to read as follows:

"(iv)(I) Unfair discrimination prohibited by the provisions of this subparagraph includes discrimination based on race, color, and national or ethnic origin. In addition, in connection with any kind of insurance, it shall be an unfair and deceptive act or practice to refuse to insure or to refuse to continue to insure an individual; to limit the amount, extent, or kind of coverage available to an individual; or to charge an individual a different rate for the same coverage because of the race, color, or national or ethnic origin of that individual. The prohibitions

of this division are in addition to and supplement any and all other provisions of Georgia law prohibiting such discrimination which were previously enacted and currently exist, or which may be enacted subsequently, and shall not be a limitation on such other provisions of law.

(II) A violation of this division shall give rise to a civil cause of action for damages resulting from such violation including, but not limited to, all damages recoverable for breach of insuring agreements under Georgia law including damages for bad faith and attorney´s fees and costs of litigation. A violation of this Code section shall also give rise to the awarding of punitive or exemplary damages in an amount as may be determined by the trier of fact if such violation is found to be intentional. The remedies provided herein are in addition to and cumulative of all other remedies that may now or hereafter be provided by law.″

SECTION 3.

Said title is further amended by inserting between paragraphs (12) and (13) of Code Section 33-6-5, relating to unfair insurance practices, the following:

″(12.1) No insurer or managed care entity subject to licensing by the Commissioner shall violate any provision of Chapter 20A of Title 33;″.

SECTION 4.

Said title is further amended by striking in its entirety Code Section 33-20A-3, relating to definitions, and inserting in lieu thereof the following:

″33-20A-3.

As used in this article, the term:

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

(2) 'Emergency services' or 'emergency care' means those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient´s health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

~~(2.1)~~(3) 'Enrollee' means an individual who has elected to contract for or participate in a managed care plan for that individual or for that individual and that individual´s eligible dependents.

(4) 'Facility' means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution for examination, diagnosis, treatment, surgery, or maternity care but does not include physicians´ or dentists´ private offices and treatment rooms in which such physicians or dentists primarily see, consult with, and treat patients.

(5) 'Health benefit plan' has the same meaning as provided in Code Section 33-24-59.5.

~~(3)~~(6) 'Health care provider' or 'provider' means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advance practice nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer qualified pursuant to paragraph (1) or (2) of subsection (a) of Code Section 43-5-8, occupational therapist, speech language pathologist, audiologist, dietitian, or physician´s assistant.

(7) 'Home health care provider' means any provider or agency that provides health care services in a patient´s home including the supply of durable medical equipment for use in a patient´s home.

~~(4)~~(8) 'Limited utilization incentive plan' means any compensation arrangement between the plan and a health care provider or provider group that has the effect of reducing or limiting services to patients.

~~(5)~~(9) 'Managed care contractor' means a person who:

(A) Establishes, operates, or maintains a network of participating providers;

(B) Conducts or arranges for utilization review activities; and

(C) Contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

~~(6)~~(10) 'Managed care entity' includes an insurance company, hospital or medical service plan, hospital, health care provider network, physician hospital organization, health care provider, health maintenance organization, health care corporation, employer or employee organization, or managed care contractor that offers a managed care plan.

~~(7)~~(11) 'Managed care plan' means a major medical, hospitalization, or dental plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(A) Arrangements with selected providers to furnish health care services;

(B) Explicit standards for the selection of participating providers; and

(C) Cost savings for persons enrolled in the plan to use the participating providers and procedures provided for by the plan; provided, however, that the term 'managed care plan' does not apply to Chapter 9 of Title 34, relating to workers´ compensation.

(12) 'Non-urgent procedure' means any nonemergency or elective care that can be scheduled at least 24 hours prior to the service without posing a significant threat to the patient´s health or well-being.

~~(8)~~(13) 'Out of network' or 'point of service' refers to health care items or services provided to an enrollee by providers who do not belong to the provider network in the managed care plan.

~~(8.1)~~(14) 'Patient' means a person who seeks or receives health care services under a managed care plan.

(15) 'Precertification' or 'preauthorization' means any written or oral determination made at any time by an insurer or any agent thereof that an enrollee´s receipt of health care services is a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as prerequisites for payment for such services have been satisfied. 'Agent' as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.

~~(9)~~(16) 'Qualified managed care plan' means a managed care plan that the Commissioner certifies as meeting the requirements of this article.

(17) 'Verification of benefits' means any written or oral determination by an insurer or agent thereof of whether given health care services are a covered benefit under the enrollee´s health benefit plan without a determination of precertification or preauthorization as to such services. 'Agent' as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.″

SECTION 5.

Said title is further amended by adding a new subparagraph (C.1) to paragraph (1) of Code Section 33-20A-5, relating to standards for certification, to read as follows:

″(C.1) Any managed care plan licensed in this state shall obtain a signed acknowledgment from each enrollee at the time of enrollment and upon any subsequent product change elected by an enrollee acknowledging that the enrollee has been informed of the following:

(i) The number, mix, and distribution of participating providers. An enrollee shall be entitled to a list of individual participating providers and the list shall be updated at least every 30 days and may be published on an Internet service site made available by the managed care entity at no cost to such enrollee;

(ii) The existence of limitations and disclosure of such limitations on choices of health care providers; and

(iii) A summary of any agreements or contracts between the managed care plan and any health care provider or hospital as they pertain to the provisions of Code Sections

33-20A-6 and 33-20A-7. Such summary shall not be required to include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by the managed care plan and any health care provider or hospital; provided, however, such summary may include a disclosure of the category or type of compensation, whether capitation, fee for service, per diem, discounted charge, global reimbursement payment, or otherwise, paid by the managed care plan to each class of health care provider or hospital under contract with the managed care plan."

SECTION 6.

Said title is further amended by inserting immediately following Code Section 33-20A-7, relating to penalties, a new Code section to read as follows:

"33-20A-7.1.

(a) The provisions of this chapter shall apply to any managed care plan offered pursuant to Article 1 of Chapter 18 of Title 45 and to any managed care plan offered by any managed care entity.

(1) When an enrollee, provider, facility, or home health care provider calls during regular business hours to request verification of benefits from a managed care plan, the caller shall have the clear and immediate option to speak to an employee or agent of such managed care plan who shall advise the caller that:

(A) Such verification is only a determination of whether given health care services are a covered benefit under the health benefit plan and is not a guarantee of payment for those services; and

(B) If the health care services so verified are a covered benefit, whether precertification is required and the phone number to request precertification.

(2) If a managed care plan provides verification of benefits after regular business hours or by electronic or recorded means, the enrollee, provider, facility, or home health care provider making the request shall be provided by either electronic or recorded means or, at the option of the insurer, by a live person the information required in subparagraphs (A) and (B) of paragraph (1) of this subsection.

(b) When an enrollee, provider, facility, or home health care provider obtains precertification for any covered health care service, the managed care plan is liable for such precertified services at the reimbursement level provided under the health benefit plan for such services where rendered within the time limits set in the precertification unless the enrollee is no longer covered under the plan at the time the services are received by the enrollee, benefits under the contract or plan have been exhausted, or there exists substantiation of fraud by the enrollee, provider, facility, or home health care provider.

(c) Any managed care plan which requires precertification shall have sufficient personnel available 24 hours a day, seven days a week, to provide such precertifications for all procedures, other than non-urgent procedures; to advise of acceptance or rejection of such request for precertification; and to provide reasons for any such rejection. Such acceptance or rejection of a precertification request may be provided through a recorded or computer generated communication, provided that the individual requesting precertification has the clear and immediate option to speak to an employee or representative of the managed care plan capable of providing information about the precertification request."

SECTION 7.

Said title is further amended by striking Code Section 33-24-47.1, relating to notice prior to cancellation or nonrenewal of individual or group accident and sickness policy, and inserting in lieu thereof a new Code Section 33-24-47.1 to read as follows:

"33-24-47.1.

(a) This Code section shall apply only to policies, contracts, or certificates of insurance 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 governed by the provisions of Chapters 15, 18, 19, 20, 21, ~~and~~ 30, and 42 of this title.

(b) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the group policyholder. Such notice stating the time when nonrenewal will be effective, which shall not be less than 60 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered in person or by depositing the notice in the United States mails to be dispatched by at least first-class mail to the last address of record of the group policyholder and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(c) Notice to the group policyholder shall not be required by this Code section when a group or blanket accident and sickness policy is canceled by an insurer for nonpayment of any premium at the expiration of the ~~31 day~~ grace period as required by Code Section 33-30-4 or when the group policyholder has given any required written notice of termination to the insurer.

(d) Notice by the insurer to the group members shall be required by this Code section when a group or blanket accident and sickness policy is canceled or not renewed, within 14 days of the expiration of the grace period, by an insurer for nonpayment of any premium as required by Code Section 33-30-4. Such notice of cancellation shall be delivered to each group member affected either in person or by depositing the notice in the United States

mail to be dispatched by at least first-class mail to the last address of record of the group member and receiving the receipt provided by the United States Postal Service, or such other evidence of mailing as prescribed or accepted by the United States Postal Service. Such notice shall be accompanied by a statement of the enrollee´s continuation or conversion rights under Code Section 33-24-21.1 or 33-24-21.2 or any other applicable Code section. If such group or blanket accident or sickness policy is cancelled or not renewed due to intentional nonpayment of premium by the group policyholder, the group policyholder shall have the duty to notify the enrollees of termination of coverage no later than 14 days after the expiration of the grace period provided in Code Section 33-30-4.

~~(d)~~(e) A notice of termination of a policy to which subsection (b) of this Code section applies shall be mailed or delivered to the group policyholder and to each employer group or subgroup insured under the policy not less than 60 days prior to the effective date of the termination of the policy. A notice of termination shall be mailed or delivered in the same manner provided in subsection (b) of this Code section for a notice of nonrenewal."

SECTION 8.

Said title is further amended by striking paragraph (2) of Code Section 33-20A-5, relating to standards for certification, and inserting in lieu thereof a new paragraph (2) to read as follows:

"(2) ACCESS TO SERVICES. A managed care entity must demonstrate that its plan:

(A) Makes benefits available and accessible to each enrollee electing the managed care plan in the defined service area with reasonable promptness and in a manner ~~which~~ that promotes continuity in the provision of health care services, including continuity in the provision of health care services after termination of a physician´s contract as provided in Code Section 33-20A-61;

(B) When medically necessary provides health care services 24 hours a day and seven days a week;

(C) Provides payment or reimbursement for emergency services and out-of-area services; and

(D) Complies with the provisions of Code Section 33-20A-9.1 relating to nomination and reimbursement of out of network health care providers and hospitals; and".

SECTION 9.

Said title is further amended in Chapter 20A, relating to managed health care plans, by adding a new Article 3 to read as follows:

″ARTICLE 3

33-20A-60.

As used in this article, the term:

(1) 'Carrier' means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of health care services through a health benefit plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(2) 'Claimant' means any provider, facility, or individual making a claim under a health benefit plan on behalf of an enrollee.

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

(4) 'Enrollee' has the same meaning as provided in Code Section 33-20A-3.

(5) 'Health benefit plan' has the same meaning as provided in Code Section 33-24-59.5.

(6) 'Physician contract' means any contract between a physician and a carrier or a carrier´s network, physician panel, intermediary, or representative providing the terms under which the physician agrees to provide health care services to an enrollee pursuant to a health benefit plan.

(7) 'Post-payment audit' means an investigation by a health benefit plan, carrier, insurer, or panel, or agent thereof, of whether a claim was properly paid to a claimant.

(8) 'Retroactive denial of a previously paid claim' or 'retroactive denial of payment' means any attempt by a carrier retroactively to collect payments already made to a claimant with respect to a claim, or any portion thereof, by requiring repayment of such payments, by reducing other payments currently owed to the claimant, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the claimant.

33-20A-61.

(a) Every physician contract entered into, amended, extended, or renewed after July 1, 2002, by a carrier shall contain a specific provision which shall provide that, in the event that an insurance carrier, plan, network, panel, or any agent thereof should terminate a physician´s contract and thereby affect any enrollee´s opportunity to continue receiving health care services from that physician under the plan, any such enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an

inpatient shall have the right to continue to receive health care services from that physician for a period of up to 60 days from the date of the termination of the physician´s contract. Any enrollee who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that enrollee´s physician´s contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six-weeks postdelivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination, and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician´s contract. The enrollee shall not have the right to the continuation provisions provided in this Code section if the physician´s contract is terminated because of the suspension or revocation of the physician´s license or if the carrier, plan, network, panel, or any agent thereof determines that the physician poses a threat to the health, safety, or welfare of enrollees.

(b) Every physician contract entered into, amended, extended, or renewed after July 1, 2002, by a carrier shall contain a specific provision which shall provide that, in the event that a physician should terminate his or her contract with an insurance carrier, plan, network, panel, or any agent thereof and thereby affect any enrollee´s opportunity to continue receiving health care services from that physician under the plan, any such enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to receive health care services from that physician for a period of up to 60 days from the date of the termination of the physician´s contract. Any enrollee who is pregnant and receiving health care services in connection with that pregnancy at the time of the termination of that enrollee´s physician´s contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six-weeks postdelivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination, and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician´s contract. The enrollee shall not have the right to the continuation provisions provided in this Code section if the physician terminates his or her contract because of the suspension or revocation of the physician´s license or for reasons related to the quality of health care services rendered or issues related to the health, safety, or welfare of enrollees.

33-20A-62.

(a) No carrier, plan, network, panel, or any agent thereof may conduct a post-payment audit or impose a retroactive denial of payment on any claim by any claimant relating to the provision of health care services that was submitted within 90 days of the last date of service or discharge covered by such claim unless:

(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

(2) Not more than 12 months have elapsed since the last date of service or discharge covered by the claim prior to the delivery to the claimant of such written notice; and

(3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or refund due within 18 months of the last date of service or discharge covered by such claim.

(b) No carrier, plan, network, panel, or any agent thereof may conduct a post-payment audit or impose a retroactive denial of payment on any claim by any claimant relating to the provision of health care services that was submitted more than 90 days after the last date of service or discharge covered by such claim unless:

(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

(2) Not more than 12 months have elapsed since such claim was initially submitted by the claimant prior to the delivery to the claimant of such written notice; and

(3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or refund due within the sooner of 18 months after the claimant´s initial submission of such a claim or 24 months after the date of service.

(c) No carrier, plan, network, panel, or any agent thereof shall be required to respond to a provider or facility´s request for additional payment or to adjust any previously paid provider or facility´s claim or any part thereof following a final payment unless:

(1) The provider or facility makes a request in writing to the carrier, plan, network, panel, or any agent thereof specifically identifying the previously paid claim or any part thereof and provides the specific reason for additional payment; and

(2) If the provider or facility´s claim was submitted within 90 days of the last date of service or discharge covered by such claim, the written request for additional payment or adjustment must be submitted within the earlier of 12 months of the date both the

provider or facility and the insurer, network, panel, plan, or carrier or any agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by the provider or facility or 24 months have elapsed from the date of service or discharge.

(d) No carrier, plan, network, panel, or any agent thereof shall be required to respond to a provider or facility´s request for additional payment or to adjust any previously paid provider or facility´s claim or any part thereof following a final payment unless:

(1) The provider or facility makes a request in writing to the carrier, plan, network, panel, or any agent thereof specifically identifying the previously paid claim or any part thereof and provides the specific reason for additional payment; and

(2) If the provider or facility´s claim was submitted more than 90 days after the last date of service or discharge covered by such claim, the written request for additional payment or adjustment must be submitted within the earlier of six months of the date both the provider or facility and the insurer, network, panel, plan, or carrier or any agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by the provider or facility or 24 months have elapsed from the date of service or discharge.

(e) An enrollee who is not billed for services by any provider, facility, or agent thereof within 45 days of the date that the provider, facility, or agent thereof knew that further payment was due as the result of a post-payment audit, retroactive denial, or rejected request to adjust a previously paid claim shall be relieved of any and all legal obligations to respond to a request for additional payment.

(f) Notwithstanding any other provision in this article to the contrary, when precertification has been obtained for a service, the insurer, carrier, plan, network, panel, or agent thereof shall be prohibited from contesting, requesting payment, or reopening such claim or any portion thereof at any time following precertification except to the extent the insurer is not liable for the payment under Code Section 33-20A-7.1.

(g) Nothing in this article shall be construed as prohibiting reimbursement subject to Code Section 33-24-56.1.

(h) 'Agent' as used in this article shall not include an agent or agency as defined in Code Section 33-23-1.″

SECTION 10.

Said title is further amended by striking subsection (g) of Code Section 33-24-21.1, relating to group accident and sickness contracts, and inserting in lieu thereof a new subsection (g) to read as follows:

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

(1) Any qualifying eligible individual 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 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. The insurer must offer qualifying eligible individuals at least two distinct conversion options from which to choose. 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';

(2) Premiums for the enhanced 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 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 conversion policy rating purposes; and

(C) Any other factors deemed relevant by the Commissioner may be considered in determination of each enhanced 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 conversion policies may deviate from the group pool rate by not more than plus or minus 50 percent based upon the experience generated under the pool of enhanced conversion policies so long as rates do not deviate for similarly situated individuals covered through the pool of enhanced conversion policies;

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

SECTION 11.

This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004.

SECTION 12.

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