

Senate Bill 94

By: Senator Hill of the 32nd

**AS PASSED**

A BILL TO BE ENTITLED  
AN ACT

1 To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to  
2 revise the time periods and eligibility for continuation coverage under certain group accident  
3 and sickness insurance plans; to provide for additional continuation plan options; to require  
4 the Commissioner of Insurance to promulgate rules and regulations to provide for reporting  
5 and notification of eligibility requirements for participation in the Georgia Health Insurance  
6 Assignment System and the Georgia Health Benefits Assignment System; to provide that the  
7 Commissioner of Insurance shall be authorized to allow certain health reimbursement  
8 arrangement only plans that encourage employer financial support of health insurance or  
9 health related expenses to be approved for sale in connection with or packaged with  
10 otherwise approved individual health insurance policies; to provide for related matters; to  
11 repeal conflicting laws; and for other purposes.

12 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

13 style="text-align:center">**SECTION 1.**

14 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by  
15 revising Code Section 33-24-21.1, relating to conversion privilege and continuation right  
16 provisions in group accident and sickness contracts, as follows:

17 "33-24-21.1.

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

19 (1) 'Assistance eligible individual' shall have the same meaning as provided by  
20 Section 3001 of Title III of the federal American Recovery and Reinvestment Act of  
21 2009.

22 ~~(1)~~(2) 'Creditable coverage' under another health benefit plan means medical expense  
23 coverage with no greater than a 90 day gap in coverage under any of the following:

24 (A) Medicare or Medicaid;

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

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

63 ~~(6)~~(7) 'Qualifying eligible individual' means:

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

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

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

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

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

73 (a.1) Any group member or qualifying eligible individual who is an assistance eligible  
74 individual as provided by Section 3001 of Title III of the federal American Recovery and  
75 Reinvestment Act (P.L. 111-5), during the period permitted under such act whose coverage  
76 has been terminated and who has been continuously covered under the group contract or  
77 group plan, and under any contract or plan providing similar benefits that it replaces, for  
78 at least six months immediately prior to such termination, shall be entitled to have his or  
79 her coverage and the coverage of his or her eligible dependents continued under the  
80 contract or plan. Such coverage shall continue for the fractional policy month remaining,  
81 if any, at termination plus nine additional policy months upon payment of the premium to  
82 the insurer by cash, certified check, or money order, at the same rate for active group  
83 members set forth in the contract or plan, on a monthly basis in advance as such premium  
84 becomes due during this coverage period. For the period that the assistance eligible  
85 individual is eligible for the premium assistance subsidy as provided in Section 3001 of  
86 Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), such  
87 premium payment shall be calculated as 35 percent of the rate for active group members  
88 including any portion of the premium paid by a former employer or other person if such  
89 employer or other person no longer contributes premium payments for this coverage.

90 (a.2) The rights and benefits under this Code section attributable to Section 3001 of Title  
91 III of the federal American Recovery and Reinvestment Act (P.L. 111-5) shall expire when  
92 that act expires. Any extension of such benefits shall require an Act of the Georgia General  
93 Assembly. Under no circumstances shall the extended benefits for assistance eligible  
94 individuals become the responsibility of the State of Georgia or any insurer after September  
95 30, 2010.

96 (b) Each group contract or group plan delivered or issued for delivery in this state, other  
97 than a group accident and sickness insurance policy, contract, or plan issued in connection  
98 with an extension of credit, which provides hospital, surgical, or major medical coverage,  
99 or any combination of these coverages, on an expense incurred or service basis, excluding

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

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

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

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

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

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

136 assistance eligible individual or the date of the election as provided in this paragraph,  
137 whichever is later; and

138 (D) The individual or the employer of the individual contacts the insurer and informs  
139 the insurer that the individual wants to take advantage of the second election period for  
140 state continuation coverage under the provisions of Section 3001 of Title III of the  
141 federal American Recovery and Reinvestment Act (P.L. 111-5).

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

150 (4) Claims for a covered individual under continuation of coverage shall not be  
151 considered in rating or rerating the group premiums for the group from which the  
152 continuation of coverage is provided, except that the pooled experience for all of the  
153 insurer's continuation of coverage claims for fully insured claims may impact all such  
154 groups on an equal percentage basis.

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

166 (2) A qualifying eligible individual shall not be entitled to have coverage continued if  
167 the most recent creditable coverage within the coverage period was terminated based on  
168 one of the following factors: (A) failure of the qualifying eligible individual to pay  
169 premiums or contributions in accordance with the terms of the health insurance coverage  
170 or failure of the issuer to receive timely premium payments; (B) the qualifying eligible  
171 individual has performed an act or practice that constitutes fraud or made an intentional  
172 misrepresentation of material fact under the terms of coverage; or (C) any discontinued

173 group coverage is immediately replaced by similar group coverage including coverage  
174 under a health benefits plan as defined in the federal Employee Retirement Income  
175 Security Act of 1974, 29 U.S.C. Section 1001, et seq. This subsection shall not affect  
176 conversion rights available to a group member under any contract or plan.

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

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

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

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

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

192 (1) Any qualifying eligible individual whose insurance and its corresponding eligibility  
193 under the group policy, including any continuation available, elected, and exhausted  
194 under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act  
195 of 1986 (COBRA), has been terminated for any reason, including failure of the employer  
196 to pay premiums to the insurer, other than fraud or failure of the qualifying eligible  
197 individual to pay a required premium contribution to the employer or, if so required, to  
198 the insurer directly and who has at least 18 months of creditable coverage immediately  
199 prior to termination shall be entitled, without evidence of insurability, to convert to  
200 individual or group based coverage covering such qualifying eligible individual and any  
201 eligible dependents who were covered under the qualifying eligible individual's coverage  
202 under the group contract or group plan. Such conversion coverage must be, at the option  
203 of the individual, retroactive to the date of termination of the group coverage or the date  
204 on which continuation or COBRA coverage ended, whichever is later. The insurer must  
205 offer qualifying eligible individuals at least two distinct conversion options from which  
206 to choose. One such choice of coverage shall be comparable to comprehensive health  
207 insurance coverage offered in the individual market in this state or comparable to a  
208 standard option of coverage available under the group or individual health insurance laws  
209 of this state. The other choice may be more limited in nature but must also qualify as

210 creditable coverage. Each coverage shall be filed, together with applicable rates, for  
211 approval by the Commissioner. Such choices shall be known as the 'Enhanced  
212 Conversion Options';

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

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

222 (B) Each insurer's group pool shall consist of each insurer's total claims experience  
223 produced by all groups in this state, regardless of the marketing mechanism or  
224 distribution system utilized in the sale of the group insurance from which the qualifying  
225 eligible individual is converting. The pool shall include the experience generated under  
226 any medical expense insurance coverage offered under separate group contracts and  
227 contracts issued to trusts, multiple employer trusts, or association groups or trusts,  
228 including trusts or arrangements providing group or group-type coverage issued to a  
229 trust or association or to any other group policyholder where such group or group-type  
230 contract provides coverage, primarily or incidentally, through contracts issued or issued  
231 for delivery in this state or provided by solicitation and sale to Georgia residents  
232 through an out-of-state multiple employer trust or arrangement; and any other  
233 group-type coverage which is determined to be a group shall also be included in the  
234 pool for enhanced conversion policy rating purposes; and

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

244 (3) Any group member who is not a qualifying eligible individual and whose insurance  
245 under the group policy has been terminated for any reason, including failure of the  
246 employer to pay premiums to the insurer, other than eligibility for medicare (reaching a

247 limiting age for coverage under the group policy) or failure of the group member to pay  
248 a required premium contribution, and who has been continuously covered under the  
249 group contract or group plan, and under any contract or plan providing similar benefits  
250 which it replaces, for at least six months immediately prior to termination shall be  
251 entitled, without evidence of insurability, to convert to individual or group coverage  
252 covering such group member and any eligible dependents who were covered under the  
253 group member's coverage under the group contract or group plan. Such conversion  
254 coverage must be, at the option of the individual, retroactive to the date of termination  
255 of the group coverage or the date on which continuation or COBRA coverage ended,  
256 whichever is later. The premium of the basic converted policy shall be determined in  
257 accordance with the insurer's table of premium rates applicable to the age and  
258 classification of risks of each person to be covered under that policy and to the type and  
259 amount of coverage provided. This form of conversion coverage shall be known as the  
260 'Basic Conversion Option'; and

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

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

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

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

284 (k)(1) ~~This~~ Except as provided in paragraph (2) of this subsection, this Code section shall  
 285 apply to all group plans and group contracts delivered or issued for delivery in this state  
 286 on or after July 1, ~~1998~~ 2009, and to group plans and group contracts then in effect on the  
 287 first anniversary date occurring on or after July 1, ~~1998~~ 2009.

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

290 (l) As soon as practicable, but no later than 30 days after the effective date of this  
 291 subsection, the Commissioner shall develop and direct insurers to issue notices for  
 292 assistance eligible individuals regarding availability of expanded eligibility, second  
 293 election, and continuation coverage assistance to be sent to the last known addresses of  
 294 such assistance eligible individuals.

295 (m) Nothing in this chapter shall imply that individuals entitled to continuation coverage  
 296 who are not assistance eligible individuals shall receive benefits beyond the period of  
 297 coverage provided in paragraph (1) of subsection (c) of this Code section or that assistance  
 298 eligible individuals are entitled to any continuation benefit period beyond what is provided  
 299 by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of  
 300 2009."

## 301 SECTION 2.

302 Said title is further amended by adding a new Code section to read as follows:

303 "33-51-7.

304 (a) The Commissioner shall be authorized to allow health reimbursement arrangement  
 305 only plans that encourage employer financial support of health insurance or health related  
 306 expenses recognized under the rules of the federal Internal Revenue Service to be approved  
 307 for sale in connection with or packaged with individual health insurance policies otherwise  
 308 approved by the Commissioner.

309 (b) Health reimbursement arrangement only plans that are not sold in connection with or  
 310 packaged with individual health insurance policies shall not be considered insurance under  
 311 this title.

312 (c) Individual insurance policies offered or funded through health reimbursement  
 313 arrangements shall not be considered employer sponsored or group coverage for purposes  
 314 of this title, and nothing in this Code section shall be interpreted to require an insurer to  
 315 offer an individual health insurance policy for sale in connection with or packaged with a  
 316 health reimbursement arrangement or to accept premiums from health reimbursement  
 317 arrangement plans for individual health insurance policies."

318

**SECTION 3.**

319 This Act shall become effective upon its approval by the Governor or upon its becoming law  
320 without such approval.

321

**SECTION 4.**

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