House Bill 672

By: Representatives Petrea of the 166th and Stephens of the 164th

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 provide for an assigned risk plan for individual health insurance coverage; to provide for
3 legislative intent; to provide for definitions; to provide for insurer participation; to provide
4 for individual participation requirements; to provide for the Commissioner to develop the
5 assignment system; to provide for the creation of a standard health benefit plan; to provide
6 for the Commissioner's responsibilities and duties; to provide for the creation of the Georgia
7 Preexisting Condition Individual High Risk Pool; to provide for operation; to provide for
8 powers and authority; to provide for standards for agents; to provide for a board and its duties
9 and responsibilities; to provide for immunity; to provide for pool reports; to provide for the
10 Commissioner's authority; to repeal the High Risk Health Insurance Plan; to repeal the
11 Commission on the Georgia Health Insurance Risk Pool; to provide for rules and regulations;
12 to provide for a short title; to provide for penalties; to provide for related matters; to provide
13 for a contingent effective date; to repeal conflicting laws; and for other purposes.

14 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

15 **SECTION 1.**

16 This Act shall be known and may be cited as the "Free Market Solutions to Insure all
17 Georgians Act."

18 **SECTION 2.**

19 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
20 repealing Article 1 of Chapter 29A, relating to availability and assignment system for
21 individual health insurance coverage, and enacting a new Article 1 to read as follows:

22 "ARTICLE 1

23 33-29A-1.
24 It is the intention of this article together with Article 2 of this chapter to provide a new,
25 acceptable mechanism for the availability of individual health insurance coverage. These
26 articles shall be construed and administered so as to accomplish such intention.

27 33-29A-2.
28 (a) As used in this article, the term:
29 (1) 'Board' means the board of directors of the Georgia Health Insurance High Risk Pool
30 created pursuant to Code Section 33-29A-16.
31 (2) 'Dependent' means a spouse, an unmarried child under the age of 21 years, or an
32 unmarried child of any age who is medically certified as disabled and dependent upon his
33 or her parent.
34 (3) 'Eligible individual' means:
35 (A) A Georgia resident individual or a dependent of a Georgia resident who is under
36 the age of 65 years; is not eligible for coverage under a group health plan, Part A or
37 Part B of Title XVIII of the federal Social Security Act (medicare), or the state plan
38 under Title XIX of the federal Social Security Act (Medicaid) or any successor
39 program; and does not have other health insurance coverage;
40 (B) A Georgia resident individual or a dependent of a Georgia resident who does not
41 maintain health insurance coverage under a health benefit plan independent of coverage
42 provided pursuant to this article;
43 (C) A Georgia resident individual or dependent of a Georgia resident with a Tier 1
44 preexisting condition;
45 (D) An individual who is legally domiciled in Georgia on the date of application to
46 GHIAS; or
47 (E) A Georgia resident individual or a dependent of a Georgia resident who is a
48 federally eligible individual which means an individual who meets the eligibility
49 criteria set forth in the federal Health Insurance Portability and Accountability Act
50 (HIPAA) of 1996, P.L. 104-191, Section 2741(b).
51 (4) 'GHIAS' means the Georgia Health Insurance Assignment System created pursuant
52 to Code Section 33-29A-4.
53 (5) 'Health benefit plan' means any public or private health benefit plan including any
54 hospital or medical policy or certificate, subscriber contract provided by a hospital, or
55 health maintenance organization subscriber contract. Such term does not include policies
56 or certificates of insurance for specific diseases; hospital confinement indemnity; accident

57 only, credit, dental, vision, medicare supplement, long-term care, or disability income
58 insurance; student health benefits only; coverage issued as a supplement to liability
59 insurance; workers' compensation or similar insurance; automobile medical payment
60 insurance; or nonrenewable short-term coverage issued for a period of 12 months or less.
61 (6) 'Health care insurer' means an entity, including but not limited to insurance
62 companies, health care corporations, and preferred provider organizations, authorized by
63 this state to offer or provide health benefit plans, programs, policies, subscriber contracts,
64 or any other agreements of a similar nature which compensate or indemnify health care
65 providers for furnishing health care services.
66 (7) 'Operating loss' means losses incurred after a health care company has paid out
67 claims and accounted for administrative expenses for their insurance policies over a
68 certain period.
69 (8) 'Preexisting condition' as used in this article means any Tier 1 medical condition as
70 described in Code Section 33-29A-4 or department regulations for which an individual
71 has received medical advice or treatment prior to enrollment in a health benefit plan.
72 (b) Any other term used in this article and also defined in Section 2791 of the federal
73 Public Health Service Act, 42 U.S.C.A. Section 300gg-92, and not otherwise defined in this
74 article shall have the same meaning specified in such Section 2791.

75 33-29A-3.
76 Each health care insurer which is licensed to and does offer health insurance coverage in
77 the individual market in this state shall as a condition of such licensure agree to
78 participation in the assignment system provided by this article.

79 33-29A-4.
80 (a) Each eligible individual in this state shall be entitled to participate in the GHIAS
81 created pursuant to this Code section.
82 (b) The Commissioner shall develop the GHIAS system which shall provide for the
83 equitable assignment of eligible individuals who are entitled to and desirous of
84 participating in the system to health care insurers offering coverage in the individual
85 market in this state. Such assignment shall be based primarily on the number of individuals
86 provided individual health insurance coverage in this state by the health care insurer
87 assignee. The system shall include all other factors for equitable assignment, as determined
88 to be appropriate by the Commissioner.
89 (c) Upon assignment of an eligible individual to a health care insurer, the eligible
90 individual shall have the right to purchase and the health care insurer shall have the
91 obligation to sell the standard health benefit plan. Each eligible individual in this state

92 shall be entitled to participate in the GHIAS created pursuant to this Code section. Such
93 individual shall, however, disclose any and all preexisting conditions as described in this
94 article or Article 2 of this chapter at the time that he or she submits an application to the
95 GHIAS. Any individual who knew that he or she had such preexisting condition at the
96 time of his or her application to the GHIAS, and failed to disclose such preexisting
97 condition, may be denied coverage or have that coverage cancelled by the issuing health
98 care insurer.

99 (d)(1) The Commissioner shall develop the standard health benefit plan to be provided
100 by health care insurers to which eligible individuals are assigned pursuant to this article.
101 Except to the extent specifically provided to the contrary in this article, all laws of this
102 state relating to the normal provision of such coverage in the individual market shall
103 apply to the provision of such coverage under this article. The Commissioner shall fix
104 a premium to be charged for each such standard health benefit plan which shall be 120
105 percent of the average premium which is or would be charged by all issuers in the state
106 for the same or similar coverage issued other than under this chapter, as determined by
107 the Commissioner. The Commissioner may authorize a health care insurer to charge a
108 premium in excess of said 120 percent maximum premium if and only if the insurer
109 demonstrates to the Commissioner that the application of the 120 percent more probably
110 than not would result in aggregate operating losses for that health care insurer.

111 (2) The standard health benefit plan shall include coverage for Tier 1 preexisting
112 conditions which shall include acid reflux, acne, anxiety, nonrheumatoid arthritis, asthma,
113 celiac disease, heartburn, high cholesterol, hypertension, kidney stones, migraines, Lyme
114 disease, narcolepsy, obesity, postpartum depression, seasonal affective disorder, sleep
115 apnea, ulcers, and any other condition as determined by the Commissioner and that is not
116 classified as a Tier 2 preexisting condition in Code Section 33-29A-21.

117 (3) A guaranteed renewable option shall be offered on each standard health benefit plan.
118 At renewal, such option shall be surcharged for not more than a 15 percent rate increase
119 regardless of any new health condition diagnosed during the policy period.

120 (4) Every standard health benefit plan shall have a deductible amount equal to the
121 minimum amount required in federal law to qualify for a health savings account.

122 (5) Every standard health benefit plan shall provide minimum limits equal to or
123 exceeding the following amounts:

124 (A) Annual coverage of $1 million; and

125 (B) Lifetime coverage of $2 million.

126 (6) Every standard health benefit plan shall offer higher limits than the amounts listed
127 in subparagraphs (A) and (B) of paragraph (5) of this subsection, in exchange for a higher
128 premium charge.

129 (e) Nothing in this Code section shall be construed to require a health care insurer to offer
130 to an eligible individual any coverage other than the standard health insurance plan
131 developed under subsection (d) of this Code section. Nothing in this Code section shall be
132 construed to prohibit any insurer from offering to any individual any otherwise lawful
133 coverage.

134 33-29A-5.
135 (a) Any eligible individual who is and continues to be a resident of this state shall be
136 eligible for individual health insurance coverage under this article for the standard health
137 benefit plan if persuasive evidence is provided that such individual has been rejected by
138 three health care insurers within the last 90 days on the basis of a Tier 1 preexisting
139 condition listed in paragraph (2) of subsection (d) of Code Section 33-29A-4 or a condition
140 determined by the Commissioner to constitute a Tier 1 preexisting condition.
141 (b) A rejection or refusal by a health care insurer offering only stop-loss, excess loss, or
142 reinsurance coverage with respect to an applicant under subsection (a) of this Code section
143 shall not constitute persuasive evidence for purposes of such subsection.
144 (c) An individual shall not be eligible for coverage under the GHIAS if the individual is
145 an inmate or resident of a state or other public institution or a state, local, or private
146 correctional facility.
147 (d) Notwithstanding any other provision of this article, eligibility for continuation of
148 coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1986 shall
149 not render an individual ineligible for coverage under the GHIAS.
150 (e) Coverage shall cease:
151 (1) On the first day of the month following the date an individual is no longer a resident
152 of this state;
153 (2) On the first day of the month following the date an individual requests coverage to
154 end;
155 (3) Upon the death of the covered individual;
156 (4) At the option of the board, 30 days after the board or the board's representative makes
157 any inquiry concerning the individual's eligibility or place of residence to which the
158 individual does not reply; or
159 (5) Upon any other circumstance causing the individual to lose eligibility pursuant to this
160 article. Any such individual's participation in the GHIAS shall be terminated on the first
161 day of the month following the date when the individual becomes ineligible.

162 33-29A-6.
163 Any combination of one or more health care insurers may contract with each other for the
164 assumption by one or more health care insurers of the obligations otherwise imposed by
165 this article. Under any such contract, the responsibility for providing the coverage required
166 by this article shall be with a health care insurer licensed to do business in this state.

167 33-29A-7.
168 (a) The Commissioner shall select an organization through a competitive public bidding
169 process to administrate the GHIAS. The qualifications necessary for such organization
170 shall be determined at the Commissioner's discretion and in accord with federal and state
171 law. Such organization shall annually file a report with the Commissioner, from the date
172 of inception of the GHIAS, on the operations of the GHIAS and the fairness of the insurer
173 assignments based on insurer experience. Such report shall include an estimate of the
174 average premium charged by each participating insurer for a typical insured that does not
175 have a preexisting condition. The report shall contain such additional matters and
176 information as may be required by the Commissioner. Such report shall also be in such
177 form as approved by the Commissioner.
178 (b) The books of account, records, reports, and other documents of the organization shall
179 be made available for examination by the Commissioner at all reasonable times.
180 (c) The Commissioner may impose a moratorium upon the required issuance of coverage
181 by a health care insurer, if the Commissioner determines that the continuation of such
182 required issuance by that entity will endanger the solvency of that entity.

183 33-29A-8.
184 (a) The Commissioner shall adopt rules and regulations for the implementation of this
185 article and Article 2 of this chapter.
186 (b) Such regulations shall establish provisions whereby the Commissioner may, at the
187 Commissioner's discretion, impose an assessment upon the members of the GHIAS.
188 (c) The regulations developed by the Commissioner shall include provisions for
189 applications for the GHIAS to be submitted by licensed insurance agents.

190 33-29A-9.
191 (a) The organization selected by the Commissioner to administer the GHIAS shall submit
192 to the Commissioner the plan of operation of the organization and thereafter any
193 amendments thereto necessary or suitable to assure the fair, reasonable, and equitable
194 administration of the GHIAS. The Commissioner may approve the plan of operation if he
195 or she determines it to be suitable to assure the fair, reasonable, and equitable

196 administration of the GHIAS. The plan of operation shall become effective upon written
197 approval by the Commissioner.
198 (b) If the selected organization fails to submit a suitable plan of operation, the
199 Commissioner shall, after notice and hearing, adopt and promulgate a suitable temporary
200 plan of operation.

201 33-29A-10.
202 (a) Any individual health care insurer in this state may base its rates on all relevant rating
203 criteria that adhere to actuarial principles in rate-making. Such discretion applies to
204 voluntary market rates as well as rates used in the GHIAS or the pool, as defined in Code
205 Section 33-29A-15. Such permitted rating criteria shall include but is not limited to age,
206 gender, and health condition. Nothing in this article and Article 2 of this chapter shall,
207 however, be interpreted to allow health care insurers to charge persons a different rate for
208 the same coverage based on a race, color, national origin, or any other class of persons
209 protected by the laws of this state.
210 (b) Any applicant for a policy to be issued under the GHIAS, any person insured under
211 such plan, and any insurance company affected may appeal to the Commissioner from any
212 ruling of the organization selected by the Commissioner to administer the GHIAS. Any
213 person aggrieved by any act or order of the Commissioner under this article and Article 2
214 of this chapter may, within ten days after notice of such order or act, file a petition in the
215 superior court of the county of such person's residence."

216 **SECTION 2.**

217 Said title is further amended by repealing Article 2 of Chapter 29A, relating to the
218 Commission on the Georgia Health Insurance Risk Pool, and enacting a new Article 2 to read
219 as follows:

220 "ARTICLE 2

221 33-29A-15.
222 (a) As used in this article, the term:
223 (1) 'Agent' means an individual appointed or employed by an insurer who sells, solicits,
224 or negotiates insurance. Such term also means an individual insurance producer.
225 (2) 'Board' means the board of directors established in Code Section 33-29A-16.
226 (3) 'Dependent' means a spouse, an unmarried child under the age of 21 years, or an
227 unmarried child of any age who is medically certified as disabled and dependent upon his
228 or her parent.

229 (4) 'Eligible individual' means:
230 (A) A Georgia resident individual or a dependent of a Georgia resident who is under
231 the age of 65 years; is not eligible for coverage under a group health plan, Part A or
232 Part B of Title XVIII of the federal Social Security Act (medicare), or the state plan
233 under Title XIX of the federal Social Security Act (Medicaid) or any successor
234 program; and does not have other health insurance coverage;
235 (B) A Georgia resident individual or a dependent of a Georgia resident who does not
236 maintain health insurance coverage under a health benefit plan independent of coverage
237 provided pursuant to this article;
238 (C) A Georgia resident individual or dependent of a Georgia resident with a Tier 2
239 preexisting condition; or
240 (D) An individual who is legally domiciled in Georgia on the date of application to the
241 pool.
242 (5) 'Health benefit plan' means any hospital or medical policy or certificate, subscriber
243 contract provided by a hospital, or health maintenance organization subscriber contract.
244 Such term does not include policies or certificates of insurance for specific diseases;
245 hospital confinement indemnity; accident only, credit, dental, vision, medicare
246 supplement, long-term care, or disability income insurance; student health benefits only;
247 coverage issued as a supplement to liability insurance; workers' compensation or similar
248 insurance; automobile medical payment insurance; or nonrenewable short-term coverage
249 issued for a period of 12 months or less.
250 (6) 'Health care insurer' means an entity, including but not limited to insurance
251 companies, health care corporations, and managed care organizations, authorized by this
252 state to offer or provide health benefit plans, programs, policies, subscriber contracts, or
253 any other agreements of a similar nature which compensate or indemnify health care
254 providers for furnishing health care services.
255 (7) 'Pool plan' means the individual health benefit plan accepted for use in the pool.
256 (8) 'Plan of operation' means the plan of operation of the pool plan.
257 (9) 'Pool' means the Georgia Preexisting Condition Individual High Risk Pool created
258 under Code Section 33-29A-16.
259 (10) 'Preexisting condition' means any Tier 2 medical condition as described in Code
260 Section 33-29A-21 or department regulations for which an individual has received
261 medical advice or treatment prior to enrollment in a health benefit plan.
262 (b) Any other term used in this article and also defined in Section 2791 of the federal
263 Public Health Service Act, 42 U.S.C.A. Section 300gg-92, and not otherwise defined in
264 this article shall have the same meaning specified in such Section 2791.

265 33-29A-16.
266 (a) There is hereby created a body corporate and politic to be known as the 'Georgia
267 Preexisting Condition Individual High Risk Pool' which shall be deemed to be an
268 instrumentality of the state and a public corporation. The pool shall have perpetual
269 existence, and any change in name or composition of the pool shall in no way impair the
270 obligations of any contracts existing under this article. The pool shall perform an essential
271 governmental function in the exercise of powers conferred upon it in this article. Any
272 assessments imposed are collected pursuant to the operation of the pool and shall at all
273 times be free from taxation of every kind.
274 (b) There is also created a board of directors of the Georgia Health Insurance High Risk
275 Pool to be composed of eight members appointed as provided in this subsection and the
276 Commissioner, or his or her representative, who shall serve as an ex officio member. The
277 Commissioner shall appoint, with the approval of the Governor, one member who shall
278 represent domestic insurers licensed to transact accident and sickness insurance in this
279 state, one member who shall represent a domestic nonprofit health care service plan, one
280 member who shall represent insurance agents, one member who shall represent physicians,
281 one member who shall represent hospitals, and one member who shall be a Fellow of the
282 Casualty Actuarial Society. The Lieutenant Governor shall appoint one citizen of this state
283 who is familiar with health insurance matters. The Speaker of the House of
284 Representatives shall appoint one member who represents physicians. Members of the
285 board shall serve for terms of six years, except the Commissioner whose term shall be
286 concurrent with his or her term of office as Commissioner. The board shall select one of
287 its members to serve as chairperson. The members of the board shall be required to take
288 and subscribe before the Governor an oath to discharge the duties of their office faithfully
289 and impartially. This oath shall be in addition to the oath required of all civil officers. The
290 members of the board shall not be entitled to compensation for their services but shall be
291 entitled to reimbursement for their actual travel and expenses necessarily incurred in the
292 performance of their duties when funds are available for this purpose.
293 (c) The board shall establish a plan of operation and any amendments thereto necessary
294 or suitable to assure the fair, reasonable, and equitable administration of the pool. The plan
295 of operation and any amendments thereto shall be submitted to the Commissioner for his
296 or her evaluation and he or she shall make recommendations to the board if in the
297 Commissioner's judgment revisions are required to assure the fair, reasonable, and
298 equitable administration of the pool. The Commissioner shall, after notice and hearing,
299 approve the plan of operation, provided such is determined to be suitable to assure the fair,
300 reasonable, and equitable administration of the pool. The plan of operation shall become
301 effective upon approval in writing by the Commissioner consistent with the date on which

302 the coverage under this article may be made available. If the board fails to submit a
303 suitable plan of operation within 180 days after the appointment of the board or at any time
304 thereafter fails to submit suitable amendments to the Commissioner, the Commissioner
305 shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary
306 or advisable to effectuate the provisions of this Code section. Such rules shall continue in
307 force until modified by the Commissioner or superseded by a plan of operation submitted
308 by the board and approved by the Commissioner.
309 (d) In the plan of operation the board shall:
310 (1) Establish procedures for the handling and accounting of assets and moneys of the
311 pool;
312 (2) Establish procedures in accordance with Code Section 33-29A-19 for selecting an
313 administrator, which shall be an insurer licensed to transact accident and sickness
314 insurance in this state;
315 (3) Establish procedures for filling vacancies on the board of directors;
316 (4) Establish cost containment features designed to assist in controlling the costs of the
317 operation of the pool; and
318 (5) Develop and implement a program to publicize the existence of the pool, the
319 eligibility requirements, and the procedures for enrollment and to maintain public
320 awareness of the pool;
321 (6) Establish any procedures necessary for coordinating the activities of the pool with the
322 GHIAS established pursuant to Article 1 of this chapter;
323 (7) Establish procedures for charging insurance rates based on pool revenue expectations
324 required to maintain the pool on a long-term basis with a means test to be based on
325 income and assets and other criteria established by the board or federal law or regulation;
326 (8) Establish procedures for the board's hiring of all appropriate personnel necessary for
327 the implementation and operation of the pool and the research facility; and
328 (9) Provide for any additional matters necessary for the implementation and operation
329 of the pool and the market assistance research facility.
330 (e) The board shall have the general powers and authority granted under the laws of this
331 state to insurance companies licensed to transact accident and sickness insurance as defined
332 under Code Section 33-7-2 and, in addition thereto, the specific authority to:
333 (1) Enter into contracts as are necessary or proper to carry out the provisions and
334 purposes of this article, including the authority to enter into contracts with similar funds
335 or pools of other states for the joint performance of common administrative functions or
336 with persons or other organizations for the performance of administrative functions. The
337 board shall have the authority to establish reciprocal agreements with similar pools or
338 funds of other states and may agree to waive the residency requirement with respect to

339 persons who become residents of this state and were covered under a similar pool or fund
340 with which the board had established a reciprocal agreement;
341 (2) Bring or defend actions;
342 (3) Take such legal action as necessary to avoid the payment of improper claims against
343 the plan or the coverage provided by or through the plan;
344 (4) Establish appropriate rates; rate schedules; rate adjustments; expense allowances;
345 claim reserve formulas; cost containment features; review and auditing of claims; and any
346 other actuarial functions appropriate to the operation of the pool. Rates and rate
347 schedules may be adjusted for appropriate risk factors in accordance with established
348 actuarial and underwriting practices the laws of this state;
349 (5) Issue policies or certificates of insurance coverage in accordance with the
350 requirements of this article; and
351 (6) Establish rules, conditions, and procedures for reinsurance of risks in the pool.

352 33-29A-17.
353 Each eligible individual in this state shall be entitled to participate in the pool created
354 pursuant to this Code section. Such individual shall disclose any and all preexisting
355 conditions as described in this article or Article 1 of this chapter at the time that he or she
356 submits an application for insurance with the pool. Any individual who knew that he or
357 she had such preexisting condition at the time of his or her application to the pool, and
358 failed to disclose such preexisting condition, may be denied coverage or have that coverage
359 cancelled by the issuing health care insurer.

360 33-29A-18.
361 (a) Any individual health care insurer in this state may base its rates on all relevant rating
362 criteria that adhere to actuarial principles in rate-making. This includes voluntary market
363 rates as well as rates used in the Georgia Health Insurance Assignment System created
364 pursuant to Code Section 33-29A-4 or the pool. Such permitted rating criteria shall include
365 but is not limited to age, gender, and health condition. Nothing in this article shall,
366 however, be interpreted to allow health care insurers to charge persons a different rate for
367 the same coverage based on a race, color, national origin, or other class protected by the
368 laws of this state.
369 (b) Any applicant for a policy to be issued under the pool, any person insured under such
370 plan, and any insurance company affected may appeal to the Commissioner from any
371 ruling of the administrator or the board. Any person aggrieved by any order or act of the
372 Commissioner under this article may, within ten days after notice of such order or act, file
373 a petition in the superior court of the county of such person's residence.

374 33-29A-19.
375 (a) The Commissioner shall select an insurer or other organization through a competitive
376 public bidding process to administer claims payments and provide other functions for the
377 pool. The Commissioner shall evaluate bids submitted based on criteria established by the
378 Commissioner which shall include:
379 (1) The administrator's proven ability to handle individual accident and sickness
380 insurance;
381 (2) The efficiency of the administrator's claim-paying procedures;
382 (3) An estimate of total charges for administering the pool; and
383 (4) The administrator's ability to administer the pool in a cost-efficient manner.
384 (b)(1) The selected organization shall serve as the pool's administrator for a period of
385 three years subject to removal by the Commissioner for cause.
386 (2) At least one year prior to the expiration of each three-year period of service by the
387 administrator, the Commissioner shall invite all health care insurers and other eligible
388 organizations, including the organization serving as the current administrator of the pool,
389 to submit bids to serve as the administrator for the succeeding three-year period.
390 Selection of the administrator for the succeeding period shall be made at least six months
391 prior to the end of the current three-year period.
392 (c)(1) The administrator shall perform all eligibility and administrative claims payment
393 functions relating to the pool.
394 (2) The administrator shall establish a premium billing procedure for collection of
395 premiums from insured persons. Billings shall be made on a periodic basis as determined
396 by the board.
397 (3) The administrator shall perform all necessary functions to assure timely payment of
398 benefits to covered persons in the pool, including:
399 (A) Making available information relating to the proper manner of submitting a claim
400 for benefits to the pool and distributing forms upon which such submission shall be
401 made; and
402 (B) Evaluating the eligibility of each claim for payment for the pool.
403 (4) The administrator shall submit to the Commissioner regular reports regarding the
404 operation of the pool. The frequency, content, and form of the reports shall be as
405 determined by the Commissioner.
406 (5) Following the close of each calendar year, the administrator shall determine net
407 written and earned premiums, the expense of administration, and the paid and incurred
408 losses for the year and report this information to the board and the Commissioner on a
409 form as prescribed by the Commissioner.
410 (6) The administrator shall provide other functions as required by the Commissioner.

411 (7) The administrator and other appropriate personnel shall be paid as provided in the
412 plan of operation for the performance of necessary services.

413 33-29A-20.
414 (a) The board shall have the general powers and authority granted under the laws of this
415 state to health care insurers licensed to transact business. In addition thereto, the board
416 shall have the specific authority to:
417 (1) Enter into contracts as are necessary or proper to carry out the provisions and
418 purposes of this article, including the authority, with the approval of the Commissioner,
419 to enter into contracts with similar programs of other states for the joint performance of
420 common functions or with persons or other organizations for the performance of
421 administrative functions;
422 (2) Sue or be sued, including taking any legal actions necessary or proper to recover any
423 assessments and penalties for, on behalf of, or against the pool or any health care insurer;
424 (3) Establish rules, conditions, and procedures for subsidizing risks and obtaining
425 coverage under the pool;
426 (4) Establish actuarial functions as appropriate for the operation of the pool;
427 (5) Establish generic pool rates that consist of individual rating criteria independent of
428 an established means test that may include asset availability as well as annual income;
429 (6) Appoint appropriate legal, actuarial, and other committees as are necessary to provide
430 technical assistance in the operation of the pool, policy, and other contract design, and
431 any other function within the authority of the board;
432 (7) Establish procedures to offset net operating loss as follows:
433 (A) Lower the qualifying subsidy qualifications to retain necessary pool funds;
434 (B) Raise rates;
435 (C) File a request with the Governor to apply for additional Medicaid waivers to fund
436 subsidies to the pool or to individuals; or
437 (D) Apply for other federal funding; and
438 (8) Establish rules, policies, and procedures as are necessary or convenient for the
439 implementation and operation of the pool.
440 (b) Neither the board nor its employees shall be liable for any obligations of the pool. No
441 member or employee of the board shall be liable, and no cause of action of any nature shall
442 arise against them, for any act or omission related to the performance of his or her powers
443 and duties under this article, unless such act or omission constitutes willful or wanton
444 misconduct. The board may provide for indemnification of, and legal representation for,
445 its members and employees.

446 (c) No participation of a health care insurer in the pool; establishment of rates, forms, or
447 procedures; or other joint or collective action required under the provisions of this article
448 shall be grounds for any legal action, criminal or civil liability, or penalty against the pool
449 or any of its health care insurers, either jointly or separately.

450 33-29A-21.

451 (a) The board, as part of the plan of operation, shall establish a methodology for
452 determining premium rates to be charged to individuals under this article. Such
453 methodology shall include a system for classification of individuals with Tier 2 preexisting
454 conditions described in this Code section or determined as such by the Commissioner.
455 Such methodology shall provide for the development of base premium rates, subject to the
456 approval of the Commissioner, which shall be set at levels which reasonably approximate
457 gross premiums charged to individuals by health care insurers outside of the pool for health
458 benefit plans with benefits similar to those offered within the pool.

459 (b) Tier 2 preexisting conditions include, but are not limited to, chemical dependency,
460 angina pectoris, anorexia nervosa, aortic aneurysm, aplastic anemia, arteriosclerosis,
461 artificial heart value or heart valve replacement, ascites, cardiomyopathy or primary
462 cardiomyopathy, chronic obstructive pulmonary disease, chronic pancreatitis, Crohn's
463 disease, cystic fibrosis, dermatomyositis, emphysema or pulmonary emphysema,
464 Friedreich's disease or ataxia, Hodgkin's disease, hydrocephalus, intermittent claudication,
465 kidney failure, lead poisoning with cerebral involvement, leukemia, amyotrophic lateral
466 sclerosis, lupis erythematosus, disseminate LE, motor or sensory aphasia, multiple or
467 disseminated sclerosis, muscular atrophy or dystrophy, myasthenia gravis, myocardial
468 infarction, myotonia, quadriplegia, peripheral arteriosclerosis, polyarteritis, polycystic
469 kidney, postero-lateral sclerosis, psychotic disorders, silicosis, splenic anemia, True Banti's
470 syndrome, Banti's disease, rheumatoid arthritis, sickle cell anemia disease, Stills disease,
471 stroke, syringomelia, spina bifida or myelomeningocele, tabes dorsalis, thalassemia,
472 Cooley's or Mediterranean anemia, ulcerative colitis, and Wilson's disease.

473 (c) The pool shall provide coverage for only the Tier 2 portion of an eligible individual's
474 health insurance coverage.

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

480 (e) The Commissioner may consider adjustments to the premium rates charged by the pool
481 to reflect the use of effective cost containment arrangements.

482 33-29A-22.

483 (a) Any eligible individual who is and continues to be a resident shall be eligible for
484 coverage under the pool if evidence is provided that:

485 (1) Such individual has been rejected by three health care insurers on the basis of a Tier 2
486 preexisting condition listed in subsection (b) of Code Section 33-29A-21 or a condition
487 determined by the Commissioner to constitute a Tier 2 preexisting condition; or

488 (2) Three health care insurers refused to issue health benefit plan coverage substantially
489 similar to coverage offered under an equivalent pool plan.

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

493 (c) An individual shall not be eligible for coverage under the GHIAS if the individual is
494 an inmate or resident of a state or other public institution or a state, local, or private
495 correctional facility.

496 (d) Notwithstanding any other provision of this article, eligibility for continuation of
497 coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1986 shall
498 not render an individual ineligible for coverage under the GHIAS.

499 (e) Coverage shall cease:

500 (1) On the first day of the month following the date an individual is no longer a resident
501 of this state;

502 (2) On the first day of the month following the date an individual requests coverage to
503 end;

504 (3) Upon the death of the covered individual;

505 (4) At the option of the administrator, 30 days after the administrator or other person
506 designated by the board makes any inquiry concerning the individual's eligibility or place
507 of residence to which the individual does not reply; or

508 (5) Upon any other circumstance causing the individual to lose eligibility pursuant to this
509 article. Any such individual's participation in the pool shall be terminated on the first day
510 of the month following the date when the individual become ineligible.

511 33-29A-23.

512 (a) The department shall create a market assistance research facility to support eligible
513 individuals and insurance agents find less expensive Tier 2 preexisting condition coverage
514 with a specialty carrier than that which may be available through the pool.

515 (b) The department shall maintain a list of specialty carriers licensed in this state that
516 provide coverage for one or more Tier 2 preexisting conditions.

517 33-29A-24.
518 (a) In addition to the submission of any rules and regulations related in this article to the
519 General Assembly as required by Code Section 50-13-4, the department shall submit the
520 full text of the plan of operation within 30 days of the Commissioner's approval of such
521 plan of operation.
522 (b) The rules and regulations developed by the Commissioner shall include a requirement
523 that applications to the pool must be submitted by insurance agents licensed in accord with
524 the requirements of this state.

525 33-29A-25.
526 (a) The pool shall be authorized to receive donations or gifts from individuals, private
527 organizations, foundations, or other sources and shall be authorized to receive state funds
528 or any Medicaid or other federal funds which may become available. Any funds received
529 as donations or gifts shall be deemed trust funds to be held and applied solely for the
530 purposes of this article.
531 (b) The General Assembly shall be authorized to appropriate moneys to the pool.
532 (c) Within one year of the effective date of this article, the Commissioner shall file a report
533 with the General Assembly which shall include the Commissioner's recommendation of
534 moneys necessary to fund the pool for the proceeding fiscal year. Thereinafter, the
535 Commissioner shall file such report by December 31 of every year."

536 **SECTION 4.**

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

539 **SECTION 5.**

540 This Act shall become effective only upon the effective date of a specified appropriation of
541 funds for purposes of this Act, as expressed in a line item making specific reference to such
542 Act in a General Appropriations Act enacted by the General Assembly and only if the United
543 States Department of Health and Human Services Centers for Medicare and Medicaid
544 Services approves a waiver pursuant to Section 1115 of the federal Social Security Act.

545 **SECTION 6.**

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