



STATE OF GEORGIA

**Office of Insurance and Safety Fire Commissioner
Department of Insurance**

REQUEST FOR PROPOSALS

For

Georgia High Risk Pool Feasibility Study

RFP NUMBER 2008 - PS - 001

For all questions about this Request for Proposals contact:

Ron Jackson, Assistant Commissioner

rjackson@oci.ga.gov

Fax: (404) 657-9831

RELEASED ON:

October 21, 2008

DUE ON:

November 12, 2008

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1. INTRODUCTION

1.1 Purpose of Project

The purpose of this Request for Proposals (“RFP”) is to engage the services of a qualified Offeror to conduct a study as to the cost and feasibility of creating a High Risk Pool in Georgia and to present the information contained therein to the Department of Insurance (“Department”) and any legislative committee reviewing the subject.

1.2 Minimum Qualifications and Requirements

Offerors submitting proposals must possess the following minimum qualifications:

- 1.2.1 The Offeror’s representative responsible for this project must meet the Qualification Standards of the American Academy of Actuaries for issuing a Statement of Actuarial Opinion regarding the work product required by this RFP.
- 1.2.2 The Offeror must have demonstrated prior experience working with high risk pools and other health insurance coverage mechanisms.
- 1.2.3 The Offeror must have access to Georgia-specific data sufficient to produce reliable analytic results that consider the specific population and environment of Georgia.

Offerors must be familiar with high risk pool proposals, including the NAIC Model Health Plan for Uninsurable Individuals Act, and must review this RFP in its entirety, including the following attachments:

- 1.2.4. The terms and conditions of Federal Grant No. 1G0CMS030205/01 which will fund this project in its entirety. (Attachment “A”)
- 1.2.5. 42 U.S.C. § 300gg-45(a) and (d) setting forth the federal statutory authority for the Federal Grant. (Attachment “B”)
- 1.2.6. 42 U.S.C. § 300gg-44(c)(2) setting forth the definition of a “qualified high risk pool. (Attachment “B”)

- 1.2.7. O.C.G.A. §§ 33-44-1 through 33-44-10 setting forth the “Georgia High Risk Health Insurance Plan” (Attachment “C”)
- 1.2.8 Georgia House Bill 1351 (Attachment “D”)
- 1.2.9 Sample Contract (Attachment “E”)

1.3 Overview of RFP Procedures and Schedule

- 1.3.1 Pursuant to 45 CFR 92.36(b), this RFP is to be conducted in accordance with applicable policies and procedures for procurement under Georgia law.
- 1.3.2 Pursuant to O.C.G.A. § 50-5-57, the professional actuarial services required for this project are exempt from state purchasing requirements. To complete the acquisition described in this RFP, The Department will utilize a competitive bidding procedure as described at Paragraph 4.
- 1.3.3 The Department reserves the right to amend this RFP prior to the proposal due date. Any amendments and additional information will be posted to the RFP section of the Departments web site, which Offerors are encouraged to visit frequently:

<http://www.gainsurance.org/other/procurement.aspx>
- 1.3.4 A submitted proposal may be withdrawn prior to the due date by a written request to the Department Staff member designated at Section 1.4.4. A request to withdraw a proposal must be signed by a representative authorized to bind the Offeror.
- 1.3.5 The cost for preparing the proposal is the sole responsibility of the Offeror. The Department will not provide reimbursement for such costs.

1.3.6 The Department intends that this RFP will be governed by the following sequentially ordered schedule.

| <u>Date</u> | <u>Event</u> |
|-------------------|---|
| October 21, 2008 | Issuance of RFP |
| November 3, 2008 | Deadline for Written Questions |
| November 5, 2008 | Response to Written Questions Posted |
| November 12, 2008 | Proposals Due at 1:00 p.m. and Public Opening of Technical Proposals. |
| November 22, 2008 | Notification and Contract Execution |
| December 1, 2008 | Effective Date of Contract |

1.4 Restrictions on Communications with Staff

- 1.4.1** From the issue date of this RFP until an Offeror is selected and the selection is announced, Offerors are not allowed to communicate for any reason with any Department staff except through the Staff member named herein or as provided by existing work agreements.
- 1.4.2** It is the responsibility of each Offeror to read and understand the contents of this RFP. All questions must be submitted in writing to the Staff member named herein. Questions submitted via e-mail are preferred. No questions other than written will be accepted. No response other than written will be binding upon the Department.
- 1.4.3** Questions must include the company name of the Offeror and the referenced RFP section.

1.4.4 Questions must be directed to the following Staff member no later than November 3, 2008.

Ron Jackson, Assistant Commissioner
Georgia Department of Insurance
Suite 708, West Tower
2 Martin Luther King, Jr. Drive
Atlanta, Georgia 30334
rjackson@oci.ga.gov
Fax: (404) 657-9831

2. BACKGROUND

2.1 Legislative History

- 2.1.1 In 1989, the Georgia General Assembly passed Senate Bill 267 creating the “Georgia High Risk Health Insurance Plan” for the purpose of providing coverage to eligible high-risk individuals.¹ However, the July 1, 1989 effective date only applied to those provisions providing for the appointment of a board of directors and the board’s establishment of a method of operation of the plan.² All other provisions of this law were to become effective only upon the General Assembly’s appropriation of the necessary funding for the plan. To date, no such funds have been appropriated. Meanwhile, the General Assembly has continued to consider other legislative proposals for the creation of a high risk pool (or similar mechanisms).

During the 2007³ and 2008⁴ sessions of the Georgia General Assembly legislation was introduced essentially proposing to insure the high-risk population by replacing Georgia’s State Alternative Mechanism under HIPAA (i.e., the mechanism applicable to group health continuation and conversion) with a broader pooled program administered by a joint underwriting authority. Under such proposals, the resulting assignment mechanism would generally place everyone -- including those with federal HIPAA protections and high-risk individuals -- into one pool.

This Georgia High Risk Pool Feasibility Study is needed to provide policymakers and interested parties with reliable data regarding the feasibility and cost of establishing a high risk mechanism.

3. SCOPE OF WORK

3.1 Requirements

Please restate each question (including the section number) with your response thereto. The Offeror selected to conduct this project will be required to:

- 3.1.1 Estimate the number of uninsurable individuals in Georgia who would be:

(a) Eligible to enroll in a qualified high-risk pool; and

¹ See O.C.G.A. §§ 33-44-1 through 33-44-10. (See Attachment “C”)

² All other provisions of this law were to become effective only upon the General Assembly’s appropriation of the necessary funding for the Plan. To date, no such funds have been appropriated.

³ Senate Bill (“SB”) SB 151 and House Bill (“HB”) 752.

⁴ HB 1351.

- (b) The number of eligible individuals likely to enroll in a qualified high-risk pool.
- 3.1.2** Discuss and evaluate the effects or implications on costs and enrollment in the high risk pool of allowing pre-existing exclusions for those pool entrants who do not have HIPAA portability protections, and advise as to federal implications and administrative complexities of permitting such exclusions, particularly with respect to the high-risk pool and its operation.
- 3.1.3** Estimate the financial impact of a high-risk pool on:
- a. The uninsurable population in Georgia;
 - b. The individual health insurance market in Georgia; and
 - c. The group health insurance market in Georgia.
- 3.1.4** Describe the expected benefit structure of a qualified high-risk pool and how such benefits would compare to typical individual and group health plans in Georgia.
- 3.1.5** Estimate the expected premium rates for a qualified high risk pool when expected premiums are equal to the following percentages of the standard risk rate:
- a. 125 percent;
 - b. 150 percent;
 - c. 175 percent; and
 - d. 200 percent.
- 3.1.6** Estimate the range of expected premiums taking into consideration age and gender.
- 3.1.7** Calculate the differences in estimated enrollment that will exist depending upon the rates to be charged to participants.
- 3.1.8** Use two (2) scenarios, one assuming that health care providers treating persons (all types of providers, services and supplies) covered under the high risk pool are paid at Medicare rates, and one assuming that providers are paid at prevailing Georgia PPO rates, and estimate the “gap” between (i) premiums collected and (ii) claims plus administrative expenses that will need to be funded by other sources and project this difference for a

ten (10) year period on a total dollar basis and on a per member per month basis.

- 3.1.9** Estimate for the two (2) scenarios above the amount and distribution of plan costs (total dollar basis) among affected parties depending upon the various funding alternatives, projected over a ten (10) year period under the following funding methods:
- a.** Percent of premium assessments on health insurers;
 - b.** Per-life assessments on health insurers, stop-loss, and third party administrators that administer health plans (with no duplication of assessments), and the State Employees' Health Plan; and
 - c.** Another form of broad-based funding which has been successfully utilized by another state high-risk pool to spread costs of the plan over citizens within that state.
- 3.1.10** Estimate the financial impact that the two (2) funding methods listed above will have upon the cost of health plans and health insurance (outside of the high risk pool) and any resulting impact on the number of insured persons in Georgia. Suggest and discuss any alternative funding mechanism that may have a broader base and therefore lesser financial impact on any individual person or entity.
- 3.1.11** Estimate administrative costs to start-up a qualified high risk pool and to operate the pool over a ten (10) year period.
- 3.1.12** Provide ten (10) year projections of expected migration of individuals between non-group coverage, group coverage, the high risk pool, and the uninsured and uninsurable populations that will occur as a result of the implementation of a high risk pool. Include with the projections a discussion and an analysis of factors such as market segmentation, adverse selection, crowd-out, change in benefit levels, change in cost sharing, change in premium rates, change in utilization, and change in the local competitive environments for individual and group insurers can impact the effects of establishing a high risk pool.
- 3.1.13** Discuss options for special treatment of individuals who will be eligible to enroll in a qualified high risk pool plan at the time it first opens for enrollment (e.g., a reduced waiting period for coverage of pre-existing conditions) and estimate the cost of such provisions.
- 3.1.14** Identify and briefly discuss approaches that could be implemented to control the claims experience of a high risk pool.

- 3.1.15 Identify and discuss the possible migration from other types of potential programs that reduce the number of uninsured to a high risk pool. Also, discuss the impact the high risk pool would have on such programs.
- 3.1.16 Compare and contrast characteristics embedded in the proposed high risk pool, including but not limited to eligibility criteria and rating methodology, with other state high risk pools. Suggest changes to any characteristic that is identified as a negative characteristic in another state high risk pool plan.
- 3.1.17 Discuss and quantify the effect on rates and high risk pool funding of the following limitations:
- a. Preexisting condition limitation (12/12);
 - b. Lifetime benefit limit of \$1,000,000;
 - c. Annual benefit limit of \$5,000 for out of pocket expenses;
 - d. The Board's ability to impose a cap on enrollment (and various options for triggering the imposition of a cap.);
 - e. Capping of assessment rate (e.g., \$2.00 per month, per covered individual insured, but not to exceed \$8.00 per family policy.)
- 3.1.18 Discuss and quantify how carriers in other states with high risk pools have or have not tightened their underwriting guidelines when a high risk pool was established.
- 3.1.19 Discuss and quantify the sensitivity of changes in carriers' underwriting guidelines to all assumptions as they relate to the financial viability of the high risk pool. Compare these results to other states with high risk pools.
- 3.1.20 Discuss and quantify the effect that expanding eligibility criteria to additionally capture the underinsured population would have upon the high risk pool's enrollment levels and premium rates.
- 3.1.21 Discuss and quantify the affect on expected enrollment, rates and high risk pool funding if a premium subsidy was offered to eligible, low-income individuals.

NOTE: An Offeror should devote no more than 15% of their allotted time to the requests set forth under Section 3.1.22.

3.1.22 Determine to what extent proposals to utilize the State Alternative Mechanism (e.g., HB1351 (See Exhibit “D”)) as a means to insure high risk individuals would permit the State of Georgia to comply with HIPAA’s requirements to provide a program of guaranteed issue individual health coverage for qualified eligible individuals in Georgia who exhaust group coverage. This analysis should also discuss:

- a.** Plan choice(s) for potential enrollees, including any requirements applicable to potential enrollees with HIPAA protections;
- b.** Premium relationships to standard health insurance premium rates available in the Georgia health insurance market;
- c.** The spreading of risk across participating carriers;
- d.** Estimate the financial impact such an approach would have upon the cost of health plans and health insurance (outside the proposed alternative mechanism) in Georgia;
- e.** The potential for ERISA Self-Funded Employer Group Health Benefit Plan participation or contribution toward the costs of such a mechanism pursuant to any state law or regulation; and
- f.** Any information regarding similar proposals or mechanisms in other state jurisdictions.

4. PROCUREMENT AND EVALUATION PROCESSES

The following is a general description of the process by which an Offeror will be selected to provide the requested services.

4.1 Overview of the Evaluation Process

- 4.1.1 RFP is issued to prospective Offerors.
- 4.1.2 Offerors are provided an opportunity to submit questions regarding the RFP.
- 4.1.3 Separate Technical Proposals and Cost Proposals will be received from each Offeror. Each Offeror must submit one (1) original and four (4) copies each proposal in separate sealed packages. **No cost information may be contained in the Technical Proposal. No technical information may be contained in the Cost Proposal.** Each original proposal must be signed and dated by a representative authorized to bind the Offeror. **Unsigned, undated proposals will not be considered.**
- 4.1.4 All proposals must be received by the Department not later than the date and time specified on the cover sheet of this RFP.
- 4.1.5 At that date and time the sealed Technical Proposal from each Offeror will be publicly opened and the name of each Offeror announced publicly. Cost Proposals will remain sealed and opened at a later date.
- 4.1.6 Technical Proposals will be evaluated by the Evaluation Committee.
- 4.1.7 Upon completion of the technical evaluation, the Cost Proposals of those Offerors whose proposals have been deemed acceptable will be publicly opened. The total cost or hourly rate offered by each Offeror will be tabulated and become a matter of public record.
- 4.1.8 At their option, the Evaluation Committee may request oral presentations or discussion with any or all Offerors for the purposes of clarification of any part of a proposal. However, the Evaluation Committee is not required to request clarification. Therefore, proposals should be complete and reflect the Offeror's best available terms. **NOTE: This RFP is a request for offers and the Department reserves the right to reject any and all offers.**

4.2 Evaluation Criteria

The Evaluation Committee will utilize the following criteria to determine which proposals satisfy the RFP. Any award of the contract shall be based upon the highest final score.

4.2.1 Technical Proposal - **80 Percent**

4.2.2 Cost Proposal – **20 Percent**

4.3 Proposal Instructions

Separate Technical Proposals and Cost Proposals will be received from each Offeror. Each Offeror must submit one (1) original and four (4) copies each proposal in separate sealed packages. No cost information may be contained in the Technical Proposal. No technical information may be contained in the Cost Proposal. Each original proposal must be signed and dated by a representative authorized to bind the Offeror. Unsigned, undated proposals will not be considered. An Offeror's separate and sealed Technical and Cost Proposals shall respectively include the following:

4.3.1 Technical Proposal:

- a. A cover letter providing an outline of the proposal and bearing the signature of an individual authorized to bind the Offeror.
- b. Organizational information, including:
 - i. Full name and address of the Offeror;
 - ii. Names of the individual(s) that prepared the proposal;
 - iii. The name and contact information for a contact person who has the authority to respond to questions regarding the proposal;
 - iv. A profile of the Offeror, including firm size, available references, and the number of years of experience in providing actuarial services;

- v. A statement that the Offeror agrees to comply with the terms and conditions of Federal Grant No. 1G0CMS030205/01, which will fund this project in its entirety.
- vi. A statement of the Offeror's ability to provide the services and information specified in the Scope of Work (Section 3);
- vii. A staffing plan that specifies the personnel that will provide the requested services and sets forth:
 - (a) Each individual's responsibilities;
 - (b) Each individual's relevant education, training, work experience, and specific experience with high risk pools, including the information necessary to demonstrate the capability to satisfy the minimum requirements and qualifications set forth at Section 1 of this RFP; and
 - (c) References for the Project Leader.
- c. A Work Plan and Schedule for completing the project and submitting the final report.
- d. A narrative description of the Offeror's planned approach to providing the services and information specified in the Scope of Work (Section 3). This description shall include:
 - i. A description of the sources of information that will form the bases of the Offeror's conclusions contained in its final report; and
 - ii. A description of the actuarial confidence level with which the conclusions contained in the final report will be rendered.
- e. Recommendation of any analyses not specified in this RFP's Scope of Work section that the Offeror

believes should be included and an explanation why such analyses would add value to the final report.

- f. A description of the Offeror's ability to travel to meet with the Department or legislative officials to discuss and present the Offeror's findings.

4.3.2. Cost Proposal:

- a. A signed cover letter indicating the total cost offered and separately stating:
 - i. Personnel costs, including the staff level of each team member, the corresponding hourly rates, and the anticipated staff level participation on the project;
 - ii. Travel and out-of-pocket expenses;
 - iii. Subcontractor costs (if any); and
 - iv. Any other costs.
- b. An acknowledgement that the contract will be funded in its entirety by Federal Grant No. 1G0CMS030205/01 and that the contract period will end March 31, 2009.
 - i. **NOTE: Currently, the Department has allocated up to \$135,000 for the study that will be performed pursuant to a contract issued as a result of this RFP. However, actual payments will be made in accordance with the fees specified in the Offeror's proposal.**

ATTACHMENT "A"

TERMS AND CONDITIONS OF FEDERAL GRANT

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

SEP 21 2007

RECEIVED

Mr. Ronald V. Jackson
Assistant Commissioner
Georgia Office of Insurance and Safety Fire Commissioner
Suite 708, West Tower
20 Martin Luther King, Jr. Drive
Atlanta, Georgia 30334

OCT 01 2007

**OFFICE OF COMMISSIONER
OF INSURANCE
EXECUTIVE DIVISION**

Dear Mr. Jackson:

We are pleased to inform you that the grant application submitted by the Georgia Office of Insurance and Safety Fire Commissioner in response to the Centers for Medicare & Medicaid Services (CMS) Federal grant announcement entitled "Seed Grants to States for Qualified High Risk Pools" has been approved.

The approved grant amount is \$150,000 for the costs to perform a feasibility study related to the creation and initial operation of a Qualified High Risk Pool in your State. Please find enclosed the Financial Assistance Award, and the Special Terms and Conditions defining the nature, character of involvement, and requirements of the grantee. This award is subject to our receipt of your written notification of acceptance of the Special Terms and Conditions set forth in the enclosure within thirty days of your receipt of this letter.

All questions concerning this letter and other technical matters can be directed to the CMS Project Officer Ms. Jessica Kahn. Ms. Kahn's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: 410-786-9361
Facsimile: 410-786-5834
E-mail: Jessica.Kahn@cms.hhs.gov

Official correspondence regarding the award should be submitted to Ms. Joi Grymes, CMS Grants Management Specialist, Office of Acquisitions and Grants Management. A copy of such correspondence should be sent to Ms. Kahn. Ms. Grymes' contact information is as follows:

Page 2 – Mr. Ronald V. Jackson

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: C2-21-15
Baltimore, MD 21244-1850
Telephone: 410-786-7251
Facsimile: 410-786-9098
E-mail: Joi.Grymes@cms.hhs.gov

We extend our congratulations on this award and look forward to working with you on this grant.

Sincerely,

A handwritten signature in black ink that reads "Jean K. Sheil". The signature is written in a cursive style with a large initial "J".

Jean K. Sheil
Director
Family and Children's Health Programs

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



STANDARD TERMS AND CONDITIONS

With the acceptance of a grant or cooperative agreement from CMS, the grantee has the responsibility to be aware of and comply with the terms and conditions of award.

Individual awards are based on the application submitted to, and as approved by, CMS and are subject to the terms and conditions incorporated either directly or by reference in the following:

- The grant program legislation and program regulation cited in the Notice of Grant Award.
- The restrictions on the expenditure of Federal funds in the appropriation acts, to the extent those restrictions are pertinent to the award.
- 45 CFR Part 74 and 45 CFR Part 92 as applicable.
- The Notice of Award including all terms and conditions cited on the document or attachments.
- DHHS Grants Policy Statement.
- All requirements referenced in the Grant Solicitation

45 CFR Part 74 and 45 CFR Part 92 (Regulations Governing CMS Grants)

Regulations found at Title 45, Code of Federal Regulations (CFR), Part 74 and Part 92, are the rules and requirements that govern the administration of Department of Health and Human Services (DHHS) Grants.

Part 74 is applicable to all recipients except those covered by Part 92, which governs awards to state and local governments.

These regulations are a term and condition of award. Grant recipients must be aware of and comply with the regulations. (May be accessed by internet from DHHS at <http://www.hhs.gov/grantsnet>.)

Grant Payment

Payments under these awards are made available through the Payment Management System (PMS). PMS is administered by the Division of Payment Management <http://www.dpm.psc.gov>. They will forward instructions for obtaining payments. Inquiries should be directed to:

Director, Division of Payment Management, OS/ASAM/PSC/FMS/DPM
P.O. Box 6021
Rockville, MD 20852
Telephone: 1-877-614-5533

DHHS Grants Policy Statement

The Department of Health and Human Services Grants Policy Statement is intended to make available in a single document the general terms and conditions of HHS discretionary grant and cooperative agreement awards. This document may be accessed by internet from DHHS at <http://www.hhs.gov/grantsnet>

Reporting Requirements

Financial Reports - The Grantee agrees to submit the Financial Status Report (FSR) SF-269A, (short form only) to the CMS Grants Management Officer with a copy to the CMS Project Officer as stipulated in the Special Terms and Conditions. Unless specified as quarterly or semi-annual in the Special Terms and Conditions, the FSR reports are due annually and at the end of the project. The FSR will account for all uses of grant monies during the previous period and project uses of grant money for the ensuing period. Quarterly and semi-annual reports are due 30 days after the end of the reporting period. Annual reports are due 90 days after the budget period ending date. Final FSR reports are due 90 days after the project period ending date and encompass costs throughout the project. **Grantees shall liquidate all obligations incurred under the award not later than 90 days after the end of the project period. Before the FSR submission, all obligations must be liquidated. IMPORTANT- The final FSR submitted to this office must agree with the final expenditures reported on the PMS 272 to the Payment Management Systems (PMS). It is the Grantee's responsibility to reconcile reports submitted to PMS and to the CMS.**

Use Standard Form 269A, which is available online at: <http://www.whitehouse.gov/omb/grants/sf269a.pdf> . Please provide to the CMS Grants Management Specialist the name and contact information, including email address, of the fiscal agent/officer responsible for completing the SF-269a and PMS-272.

Completing the SF-269a – Points to Remember

- The report must be completed on a cumulative basis. The purpose of Columns I, II, and III is to show the effect of this reporting period's transactions on a cumulative financial status.
- If this is the first reporting period, use only **Column III Cumulative**.
- If this is the second (or more) reporting period, input the current reporting period's information in **Column II This Period** and copy the information from **Column III Cumulative** of your last previous report into **Column I Previously Reported** of this report. Add Columns I and II to get the cumulative total in Column III.
- Enter the sum of the total federal funds authorized under the Grant Number for line 10.h, "*Total Federal Funds Authorized for this Funding Period*". This will include all accepted original awards, supplements or continuations. This will normally match the total on your latest Notice of Award (NOA).

Progress Reports – The Grantee agrees to submit progress reports to the CMS Grants Management Officer with a copy to the CMS Project Officer as stipulated in the special terms and conditions. Unless specified as quarterly or semi-annual in the Special Terms and Conditions, progress reports are due annually. These reports are to be consistent with a format and content specified by CMS. CMS reserves the right to require the grantee to provide additional details and clarification on the content of the report. Quarterly and semi-annual reports are due 30 days after the end of the reporting period. Annual reports are due 90 days after the budget period ending date.

Final Report – The Grantee agrees to submit a final report to the CMS Grants Management Officer with a copy to the CMS Project Officer within 90 days after the project period ending date of the last year. The Grantee may use the CMS' "Author's Guidelines: Grants and Contracts Final Report" in the preparation of the final report. This document can be found at the following website:
<http://www.cms.hhs.gov/ResearchDemoGrantsOpt/Downloads/authorsguidelines.pdf>

A draft final report should be submitted to the CMS Project Officer for comments. CMS's comments should be taken into consideration by the Grantee for incorporation into the final report. CMS reserves the right to require the Grantee to provide additional details and clarification on the content of the report.

The final report may not be released or published without permission from the CMS Project Officer within the first four (4) months following the receipt of the report by the CMS Project Officer.

The final report will contain a disclaimer that the opinions expressed are those of the Grantee and do not necessarily reflect the opinion of CMS.

Failure to submit reports (i.e., financial, progress, or other required reports) on time may be basis for withholding financial assistance payments, suspension, termination or denial of refunding. A history of such unsatisfactory performance may result in designation of "high risk" status for the recipient organization and may jeopardize potential future funding from DHHS.

Use of Federal Funding

When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds, including but not limited to State and local governments and recipients of Federal research grants shall clearly state (1) the percentage of total costs of the program or project which will be financed with Federal money, (2) the dollar amount of Federal funds for the program or project, and (3) the percentage and dollar amount of the total costs or the program or project that will be financed by nongovernment sources.

Project and Data Integrity

The Grantee shall protect the confidentiality of all project-related information that identifies individuals.

The Grantee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS Project Officer shall not direct the interpretation of the data used in preparing these documents or reports.

At any phase in the project, including the project's conclusion, the Grantee if so requested by the Project Officer, must deliver to CMS materials, systems, or other items applied, developed, refined or enhanced in the course of or under the award. The Grantee agrees that CMS shall have royalty-free, nonexclusive and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal government purposes.

Use of Data and Work Products

At any phase of the project, including the project's conclusion, the Grantee, if so requested by the CMS Project Officer, shall submit copies of analytic data file(s) with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired or generated under the award and/or data furnished by CMS. The content, format, documentation, and schedule for production of the data file(s) will be agreed

upon by the Principal Investigator and the CMS Project Officer. The negotiated format(s) could include both file(s) that would be limited to CMS's internal use and file(s) that CMS could make available to the general public.

All data provided by CMS will be used for the research described in this grant only. The Grantee will return any data provided by CMS or copies of data at the conclusion of the project.

For six (6) months after completion of the project, the Grantee shall notify the CMS Project Officer prior to formal presentation of any report or statistical or analytical material based on information obtained through this award. Formal presentation includes papers, articles, professional publication, speeches, and testimony. In the course of this research, whenever the Principal Investigator determines that a significant new finding has been developed, he/she will communicate it to the CMS Project Officer before formal dissemination to the general public.

Audit Requirements

Audit requirements for Federal award recipients are defined in OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations.

An organization is required to have a non-Federal audit if, during its fiscal year, it expended a total of \$500,000 (\$300,000 for fiscal years ending before December 31, 2003) or more in Federal awards. Federal awards are defined in OMB Circular A-133 to include Federal financial assistance and Federal cost reimbursement contracts received both directly from a Federal awarding agency as well as indirectly from a pass-through entity.

45 CFR 74.26(d) discusses the requirements and available non-Federal audit options for Department of Health and Human Service awards. Two audit options are available to commercial organizations. One option is a financial related audit as defined in the Government Auditing Standards, GPO stock #020-000-00-265-4 (commonly known as the Yellow Book) of all DHHS awards; the second option is an audit that meets the requirements of OMB Circular A-133.

Commercial organizations that receive annual DHHS awards totaling less than the OMB Circular A-133's audit requirement threshold are exempt from a non-Federal audit for that year, but must make records available for audit or review as requested by CMS or other designated officials.

OMB Circular A-133 now requires that all auditees submit a completed data collection form (SF-SAC) in addition to the audit report. For questions concerning the submission process or to obtain a copy of the form, you may call the Federal Audit Clearinghouse (888-222-9907).

Information can also be found on the internet at <http://harvester.census.gov/sac/>. Audit reports for both CMS and other DHHS awards shall be submitted to the Federal Audit Clearinghouse at the address shown below:

Federal Audit Clearinghouse
Bureau of the Census
1201 E. 10th Street
Jeffersonville, IN 47132

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

TITLE: Seed Grants to States for Qualified High Risk Pools

AWARDEE: Georgia Office of Insurance and Safety Fire Commissioner

PROGRAM COMPLIANCE

1. The grantee is required to adhere to all the provisions specified in 45 CFR Part 92 - Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments can be located at www.access.gpo.gov/nara/cfr/waisidx_03/45cfr92_03.html.
2. The grantee will maintain all program and fiscal records as specified in 45 CFR Part § 92 .42.

FINANCIAL REQUIREMENTS

3. All funds provided under this grant will be used by the grantee exclusively for the implementation of a study on the feasibility of creating a qualified high-risk pool as defined in section 2744(c)(2) and 2745(g) of the Public Health Service Act. Any funds that are remaining after the completion of the feasibility study or are not used toward the study will be returned to the United States Treasury within the timeframe specified by the Centers for Medicare & Medicaid Services (CMS).
4. If the grantee, any other State Agency or any other agent for the State should supplement the existing application, or should submit a separate application for a full grant for the creation and the initial operation of a high risk pool, the amount of funds awarded and expended for the feasibility study will be subtracted from the eligibility limit of \$1.0 million for the full grant.
5. All funds received under this grant will be "earmarked" in the event the funds are transferred to a state general fund or placed in a reserve fund. This allows for proper identification if the funds are required to be returned to the United States Treasury or to CMS.
6. Pursuant to 45 CFR 92.21(h)(2)(i), grantee will remit quarterly to CMS any interest earned on grant funds pending disbursement. Grantee may keep interest amounts up to \$100.00 per year for administrative expenses.

REPORTING REQUIREMENTS

7. **Program Progress Reports** - The grantee will submit written progress reports no later than 30 days from the end of each project operating quarter. The first report is due no later than 30 days after the end of the

first quarter in which grants funds were expended. The program progress reports shall include at a minimum:

- (1) A comparison of the actual accomplishments to the objectives established for the period;
- (2) The reason for slippage, if established objective were not met; and
- (3) The status of the expenditure of funds.

The grantee should refer to 45 CFR §92.40(b)(2) for the performance reports required contents. The reports will continue to be submitted until all grant funds have been expended. The contents of these reports will be included in the Secretary's annual report to Congress. A final report will be due 90 days from the end of the last quarter when the final funds were expended or termination of grant support. All reports will be submitted to Jessica Kahn, Project Officer at the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop S2-01-16, Baltimore, MD 21244. A copy of the report will be sent to the Joi Grymes, Grants Management Specialist, CMS, Office of Acquisition & Grants Management, Mail Stop C2-21-15.

8. **Feasibility Study Report** - The grantee will submit at the time the results and report of the study is released to the grantee's Governor or designee, a copy of the report will be mailed to the CMS Project Officer, Jessica Kahn, at the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop S2-01-165, Baltimore, MD 21244. A copy of the report will be sent to Joi Grymes, Grants Management Specialist, CMS, Office of Acquisition & Grants Management, Mail Stop C2-21-15. The contents of this report will be included in the Secretary's annual report to Congress. A final report will be due 90 days from the end of the last quarter when the final funds were expended or termination of grant support.
9. **Financial Progress Reports** - The grantee will submit a financial status report related to all grant funds using the Federal Standard Form 269 no later than 30 days from the end of each project operating quarter. The first report is due no later than 30 days after the end of the first quarter in which grant funds were expended. The grantee should refer to 45 CFR §92.41(b) for financial reporting requirements. Accounting will be on a cash basis. The contents of these reports will be included in the Secretary's annual report to Congress. A final report will be due 90 days from the end of the quarter when the final funds were expended or termination of grant support. All reports will be submitted to Joi Grymes, Grants Management Specialist, CMS, Office of Acquisition & Grants Management, Mail Stop C2-21-15. A copy of the report will be sent to Jessica Kahn, Project Officer at the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop S2-01-16, Baltimore, MD 21244.

**Department of Health and Human Services
Centers For Medicare Medicaid Services
Notice of Award (NOA)**

1. RECIPIENT

SAI NUMBER:

PMS DOCUMENT NUMBER:
1G0C30205A

| | | | | | | | |
|---|--|---|---|---|---|--|--|
| 1. AWARDING OFFICE: Centers For Medicare & Medicaid Services | | 2. ASSISTANCE TYPE: Discretionary Grant | | 3. AWARD NO.: 1G0CMS030205/01 | | 4. AMEND. NO.: | |
| 5. TYPE OF AWARD: DEMONSTRATION | | | 6. TYPE OF ACTION: New | | | 7. AWARD AUTHORITY: TAA Reform Act of 2002 | |
| 8. BUDGET PERIOD: 09/30/2007 THRU 03/31/2009 | | | 9. PROJECT PERIOD: 09/30/2007 THRU 03/31/2009 | | | 10. CAT NO.: 93781 ... | |
| 11. RECIPIENT ORGANIZATION: Insurance & Safety Fire Commissioner, Georgia Insurance Department 2 Martin Luther King Jr. Dr. Ste. 708 Atlanta GA 30334 Ron Jackson, Assistant Commissioner | | | | | 12. PROJECT / PROGRAM TITLE: Study and Review of the Cost and Feasibility of Creating a Georgia High-Risk Pool | | |
| 13. COUNTY: | | 14. CONGR. DIST.: 5 | | 15. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR: Ron Jackson, Assistant Commissioner | | | |

| 16. APPROVED BUDGET: | | 17. AWARD COMPUTATION: | | | |
|------------------------------------|-------------------|--|------------|-----------------------|--------------------------|
| Personnel..... | \$ 0 | A. NON-FEDERAL SHARE..... | \$ 0 | 0.00 % | |
| Fringe Benefits..... | \$ 0 | B. FEDERAL SHARE..... | \$ 150,000 | 100.00 % | |
| Travel..... | \$ 0 | 18. FEDERAL SHARE COMPUTATION: | | | |
| Equipment..... | \$ 0 | A. TOTAL FEDERAL SHARE..... | \$ 150,000 | | |
| Supplies..... | \$ 0 | B. UNOBLIGATED BALANCE FEDERAL SHARE..... | \$ | | |
| Contractual..... | \$ 0 | C. FED. SHARE AWARDED THIS BUDGET PERIOD. | \$ 150,000 | | |
| Facilities/Construction..... | \$ 0 | 19. AMOUNT AWARDED THIS ACTION: | | \$ 150,000 | |
| Other..... | \$ 150,000 | 20. FEDERAL \$ AWARDED THIS PROJECT PERIOD: | | \$ 150,000 | |
| Direct Costs..... | \$ 150,000 | 21. AUTHORIZED TREATMENT OF PROGRAM INCOME: | | | |
| Indirect Costs..... | \$ 0 | 22. APPLICANT EIN: | | 23. PAYEE EIN: | 24. OBJECT CLASS: |
| At % of \$ | | 1-586002001-A1 | | 1-586002001-A1 | 41.45 |
| In Kind Contributions..... | \$ 0 | | | | |
| Total Approved Budget(**).. | \$ 150,000 | | | | |

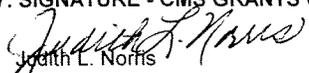
25. FINANCIAL INFORMATION:

DUNS: 807479316

| ORGN | DOCUMENT NO. | APPROPRIATION | CAN NO. | NEW AMT. | UNOBLIG. | NONFED % |
|------|--------------|---------------|--------------|-----------|----------|----------|
| CMS | 1G0C30205A | 75-6/7-0516 | 2007 5992060 | \$150,000 | | |

26. REMARKS: (Continued on separate sheets)

Paid by DHHS Payment Management System (PMS), see attached for payment information.
This award is subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable to you based on your recipient type and the purpose of this award.
This includes requirements in Parts I and II (available at <http://www.hhs.gov/grantsnet/adminis/gpd/index.htm>) of the HHS GPS.
Although consistent with the HHS GPS, any applicable statutory or regulatory requirements, including 45 CFR Part 74 or 92, directly apply to this award apart from any coverage in the HHS GPS.
This grant is subject to the requirements set forth in 45 CFR part 74 (for non-profit organizations and educational institutions) or 45 CFR Part 92 (for state, local, and federally recognized tribal governments).
Initial expenditure of funds by the grantee constitutes acceptance of this award.

| | | | | |
|--|--|-----------------------------|--|--|
| 27. SIGNATURE - CMS GRANTS OFFICER  Judith L. Norris | | DATE: SEP 21 2007 | 28. SIGNATURE(S) CERTIFYING FUND AVAILABILITY Signature Not Required | |
| 29. SIGNATURE AND TITLE - PROGRAM OFFICIAL(S) Jessica Kahn, Signature Not Required | | DATE: | | |

1.RECIPIENT

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE MEDICAID SERVICES
FINANCIAL ASSISTANCE AWARD**

SAI NUMBER:

PMS DOCUMENT NUMBER:
1G0C30205A

| | | | | |
|---|--|---|---|--|
| 1. AWARDING OFFICE: Centers For Medicare & Medicaid Services | | 2. ASSISTANCE TYPE: Discretionary Grant | 3. AWARD NO.: 1G0CMS030205/01 | 4. AMEND. NO. |
| 5. TYPE OF AWARD: DEMONSTRATION | | 6. TYPE OF ACTION: New | | 7. AWARD AUTHORITY: TAA Reform Act of 2002 |
| 8. BUDGET PERIOD: 09/30/2007 THRU 03/31/2009 | | 9. PROJECT PERIOD: 09/30/2007 THRU 03/31/2009 | | 10. CAT NO.: 93780 |
| 11. RECIPIENT ORGANIZATION: Insurance & Safety Fire Commissioner, Georgia, Insurance Department | | | | |

26. REMARKS: (Continued from previous page)

No future support is anticipated.(**) Reflects only federal share of approved budget.

For administrative assistance, please contact your Grants Management Specialist: Joi Grymes, 410-786-7251 or Joi.Grymes@cms.hhs.gov.

For technical assistance, please contact your Project Officer: Jessica Kahn, 410-786-9361 or Jessica.Kahn@cms.hhs.gov.

Transmittal Number 7527206001 (For CMS purposes only)

ATTACHMENT "B"

42 U.S.C. § 300gg-45(a) and (d)

&

42 U.S.C. § 300gg-44(c)(2)

TITLE 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A - PUBLIC HEALTH SERVICE
SUBCHAPTER XXV - REQUIREMENTS RELATING TO HEALTH INSURANCE
COVERAGE

Part B - Individual Market Rules

subpart 1 - portability, access, and renewability requirements

§ 300gg-45. Promotion of qualified high risk pools

(a) Seed grants to States

The Secretary shall provide from the funds appropriated under subsection (c)(1) of this section a grant of up to \$1,000,000 to each State that has not created a qualified high risk pool as of August 6, 2002, for the State's costs of creation and initial operation of such a pool.

(b) Matching funds for operation of pools

(1) In general

In the case of a State that has established a qualified high risk pool that—

(A) restricts premiums charged under the pool to no more than 150 percent of the premium for applicable standard risk rates;

(B) offers a choice of two or more coverage options through the pool; and

(C) has in effect a mechanism reasonably designed to ensure continued funding of losses incurred by the State after the end of fiscal year 2004 in connection with operation of the pool;

the Secretary shall provide, from the funds appropriated under subsection (c)(2) of this section and allotted to the State under paragraph (2), a grant of up to 50 percent of the losses incurred by the State in connection with the operation of the pool.

(2) Allotment

The amounts appropriated under subsection (c)(2) of this section for a fiscal year shall be made available to the States in accordance with a formula that is based upon the number of uninsured individuals in the States.

(c) Funding

Out of any money in the Treasury of the United States not otherwise appropriated, there are authorized and appropriated—

(1) \$20,000,000 for fiscal year 2003 to carry out subsection (a) of this section; and

(2) \$40,000,000 for each of fiscal years 2003 and 2004 to carry out subsection (b) of this section.

Funds appropriated under this subsection for a fiscal year shall remain available for obligation through the end of the following fiscal year. Nothing in this section shall be construed as providing a State with an entitlement to a grant under this section.

(d) Qualified high risk pool and State defined

For purposes of this section, the term "qualified high risk pool" has the meaning given such term in section 300gg-44 (c)(2) of this title and the term "State" means any of the 50 States and the District of Columbia.

(July 1, 1944, ch. 373, title XXVII, § 2745, as added Pub. L. 107-210, div. A, title II, § 201(b), Aug. 6, 2002, 116 Stat. 959.)

Construction

Nothing in the amendments made by title II of Pub. L. 107-210, other than provisions relating to COBRA continuation coverage and reporting requirements, to be construed as creating a new mandate on any party regarding health

NB: This unofficial compilation of the U.S. Code is current as of Jan. 2, 2006 (see <http://www.law.cornell.edu/uscode/uscpint.html>).

insurance coverage, see section 203(f) of Pub. L. 107-210, set out as a Construction of 2002 Amendment note under section 2918 of Title 29, Labor.

TITLE 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A - PUBLIC HEALTH SERVICE
SUBCHAPTER XXV - REQUIREMENTS RELATING TO HEALTH INSURANCE
COVERAGE

Part B - Individual Market Rules

subpart 1 - portability, access, and renewability requirements

§ 300gg-44. State flexibility in individual market reforms

(a) Waiver of requirements where implementation of acceptable alternative mechanism

(1) In general

The requirements of section 300gg-41 of this title shall not apply with respect to health insurance coverage offered in the individual market in the State so long as a State is found to be implementing, in accordance with this section and consistent with section 300gg-62 (b) of this title, an alternative mechanism (in this section referred to as an “acceptable alternative mechanism”)—

- (A)** under which all eligible individuals are provided a choice of health insurance coverage;
- (B)** under which such coverage does not impose any preexisting condition exclusion with respect to such coverage;
- (C)** under which such choice of coverage includes at least one policy form of coverage that is comparable to comprehensive health insurance coverage offered in the individual market in such State or that is comparable to a standard option of coverage available under the group or individual health insurance laws of such State; and
- (D)** in a State which is implementing—
 - (i)** a model act described in subsection (c)(1) of this section,
 - (ii)** a qualified high risk pool described in subsection (c)(2) of this section, or
 - (iii)** a mechanism described in subsection (c)(3) of this section.

(2) Permissible forms of mechanisms

A private or public individual health insurance mechanism (such as a health insurance coverage pool or programs, mandatory group conversion policies, guaranteed issue of one or more plans of individual health insurance coverage, or open enrollment by one or more health insurance issuers), or combination of such mechanisms, that is designed to provide access to health benefits for individuals in the individual market in the State in accordance with this section may constitute an acceptable alternative mechanism.

(b) Application of acceptable alternative mechanisms

(1) Presumption

(A) In general

Subject to the succeeding provisions of this subsection, a State is presumed to be implementing an acceptable alternative mechanism in accordance with this section as of July 1, 1997, if, by not later than April 1, 1997, the chief executive officer of a State—

- (i)** notifies the Secretary that the State has enacted or intends to enact (by not later than January 1, 1998, or July 1, 1998, in the case of a State described in subparagraph (B)(ii)) any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998,¹ (or, in the case of a State described in subparagraph (B)(ii), July 1, 1998); and
- (ii)** provides the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

(B) Delay permitted for certain States

(i) Effect of delay

In the case of a State described in clause (ii) that provides notice under subparagraph (A)(i), for the presumption to continue on and after July 1, 1998, the chief executive officer of the State by April 1, 1998—

(I) must notify the Secretary that the State has enacted any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of July 1, 1998; and

(II) must provide the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

(ii) States described

A State described in this clause is a State that has a legislature that does not meet within the 12-month period beginning on August 21, 1996.

(C) Continued application

In order for a mechanism to continue to be presumed to be an acceptable alternative mechanism, the State shall provide the Secretary every 3 years with information described in subparagraph (A)(ii) or (B)(i)(II) (as the case may be).

(2) Notice

If the Secretary finds, after review of information provided under paragraph (1) and in consultation with the chief executive officer of the State and the insurance commissioner or chief insurance regulatory official of the State, that such a mechanism is not an acceptable alternative mechanism or is not (or no longer) being implemented, the Secretary—

(A) shall notify the State of—

(i) such preliminary determination, and

(ii) the consequences under paragraph (3) of a failure to implement such a mechanism; and

(B) shall permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) in a manner so that may be an acceptable alternative mechanism or to provide for implementation of such a mechanism.

(3) Final determination

If, after providing notice and opportunity under paragraph (2), the Secretary finds that the mechanism is not an acceptable alternative mechanism or the State is not implementing such a mechanism, the Secretary shall notify the State that the State is no longer considered to be implementing an acceptable alternative mechanism and that the requirements of section 300gg-41 of this title shall apply to health insurance coverage offered in the individual market in the State, effective as of a date specified in the notice.

(4) Limitation on secretarial authority

The Secretary shall not make a determination under paragraph (2) or (3) on any basis other than the basis that a mechanism is not an acceptable alternative mechanism or is not being implemented.

(5) Future adoption of mechanisms

If a State, after January 1, 1997, submits the notice and information described in paragraph (1), unless the Secretary makes a finding described in paragraph (3) within the 90-day period beginning on the date of submission of the notice and information, the mechanism shall be considered to be an acceptable alternative mechanism for purposes of this section, effective 90 days after the end of such period, subject to the second sentence of paragraph (1).

(c) Provision related to risk

(1) Adoption of NAIC models

The model act referred to in subsection (a)(1)(D)(i) of this section is the Small Employer and Individual Health Insurance Availability Model Act (adopted by the National Association of Insurance Commissioners on June 3, 1996) insofar as it applies to individual health insurance coverage or the Individual Health Insurance Portability Model Act (also adopted by such Association on such date).

(2) Qualified high risk pool

For purposes of subsection (a)(1)(D)(ii) of this section, a “qualified high risk pool” described in this paragraph is a high risk pool that—

(A) provides to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion with respect to such coverage for all eligible individuals, and

(B) provides for premium rates and covered benefits for such coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect as of August 21, 1996).

(3) Other mechanisms

For purposes of subsection (a)(1)(D)(iii) of this section, a mechanism described in this paragraph—

(A) provides for risk adjustment, risk spreading, or a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers; or

(B) is a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

Footnotes

¹ So in original. The comma probably should not appear.

(July 1, 1944, ch. 373, title XXVII, § 2744, as added Pub. L. 104–191, title I, § 111(a), Aug. 21, 1996, 110 Stat. 1984; amended Pub. L. 104–204, title VI, § 605(b)(1), Sept. 26, 1996, 110 Stat. 2942.)

Codification

August 21, 1996, referred to in subsec. (b)(1)(B)(ii), was in the original “the date of enactment of this Act”, which was translated as meaning the date of enactment of Pub. L. 104–191, which enacted this subchapter, to reflect the probable intent of Congress.

Amendments

1996—Subsec. (a)(1). Pub. L. 104–204 made technical amendment to reference in original act which appears in text as reference to section 300gg–62 (b) of this title.

Effective Date of 1996 Amendment

Section 605(c) of Pub. L. 104–204 provided that: “The amendments made by this section [enacting section 300gg–51 of this title and amending this section and sections 300gg–61 and 300gg–62 of this title] shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998.”

Effective Date

Section applicable with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs, see section 111(b) of Pub. L. 104–191, set out as a note under section 300gg–41 of this title.

ATTACHMENT "C"

GEORGIA HIGH RISK HEALTH INSURANCE PLAN

CHAPTER 44

HIGH RISK HEALTH INSURANCE PLAN

Sec.

- 33-44-1. (For effective date, see note.) Short title.
- 33-44-2. (For effective date, see note.) Definitions.
- 33-44-3. (For effective date, see note.) Georgia High Risk Health Insurance Plan created; board of directors; method of operation for plan; powers of plan.
- 33-44-4. (For effective date, see note.) Eligibility for coverage; termination of coverage; application for coverage.
- 33-44-5. (For effective date, see note.) Selection of insurer to administer claims payments; period of service; duties and expenses of administrator.
- 33-44-6. (For effective date, see note.) Net premiums; revision of schedule of benefits and cost containment features.
- 33-44-7. (For effective date, see note.) Major medical expense coverage.
- 33-44-8. (For effective date, see note.) Liability of plan and board of directors.
- 33-44-9. (For effective date, see note.) Exemption from taxes.
- 33-44-10. (For effective date, see note.) Donations and gifts; appropriations.

Delayed effective date. - Ga. L. 1989, p. 1701, § 2, provided that the enactment of this chapter by the Act shall become effective on July 1, 1989, only for the purposes of the appointment of the board of directors and the establishment of elements of the method of operation of the plan by the board. The Act shall become effective for all purposes only upon the appropriation of funds by the General Assembly necessary to carry out the purposes of the Act. No such funds were appropriated during the 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, or 2008 sessions of the General Assembly.

Code Commission notes. - This chapter was enacted as Chapter 43 of Title 33, but has been renumbered as Chapter 44 of Title 33, pursuant to Code Section 28-9-5, since Ga. L. 1989, p. 1276, § 3, also enacted a Chapter 43 of Title 33. References in this chapter to Code sections within the chapter have also been changed to reflect the renumbering of the chapter.

33-44-1. (For effective date, see note.) Short title.

This chapter shall be known and may be cited as the "Georgia High Risk Health Insurance Plan."

(Code 1981, § 33-44-1, enacted by Ga. L. 1989, p. 1701, § 1.)

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

33-44-2. (For effective date, see note.) Definitions.

As used in this chapter, the term:

(1) "Accident and sickness insurance" means that type of insurance as defined in Code Section 33-7-2 but does not include short-term disability, fixed indemnity, limited benefit, or credit insurance coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) "Benefits" means the coverages to be offered by the plan to eligible persons pursuant to Code Section 33-44-7.

(3) "Board" means the board of directors of the plan.

(4) "Commissioner" means the Commissioner of Insurance.

(5) "Department" means the Department of Insurance.

(6) "Health maintenance organization" means any organization authorized to transact business in this state pursuant to Chapter 21 of this title.

(7) "Hospital" means any institution or medical facility as defined in Code Section 31-7-1.

(8) "Insurance arrangement" means any plan, program, contract, or any other arrangement under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust or third-party administrator, health care services or benefits in a manner other than through an insurer.

(9) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement as defined in this Code section.

(10) "Insurer" means any insurance company authorized to transact accident and sickness insurance business in this state, any nonprofit medical service corporation, any nonprofit hospital service corporation, any health care plan, and any health maintenance organization authorized to transact business in this state.

(11) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. Section 1395, et seq., as amended.

(12) "Method of operation" means the method of operation of the plan, including articles, bylaws, and operating rules adopted by the board pursuant to Code Section 33-44-3.

(13) "Physician" means a person licensed to practice medicine under Chapter 34 of Title 43.

(14) "Plan" means the Georgia High Risk Health Insurance Plan as created in Code Section 33-44-3.

(Code 1981, § 33-44-2, enacted by Ga. L. 1989, p. 1701, § 1; Ga. L. 1990, p. 8, § 33.)

Code Commission notes. - Pursuant to Code Section 28-9-5, in 1996, "Section" was inserted in paragraph (11).

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

33-44-3. (For effective date, see note.) Georgia High Risk Health Insurance Plan created; board of directors; method of operation for plan; powers of plan.

(a) There is created a body corporate and politic to be known as the "Georgia High Risk Health Insurance Plan" which shall be deemed to be an instrumentality of the state and a public corporation. The Georgia High Risk Health Insurance Plan shall have perpetual existence and any change in the name or composition of the plan shall in no way impair the obligations of any contracts existing under this chapter. The Georgia High Risk Health Insurance Plan is assigned to the Department of Insurance for administrative purposes only as prescribed in Code Section 50-4-3.

(b) There is created a board of directors of the Georgia High Risk Health Insurance Plan to be composed of ten members appointed as provided in this subsection and the Commissioner of Insurance, who shall serve as an ex officio member. The Commissioner shall appoint, with the approval of the Governor, one member who shall represent domestic insurers licensed to transact accident and sickness insurance in this state, one member who shall represent a domestic nonprofit health care service plan, and one member who shall be a hospital administrator. The Governor shall appoint two members who shall be consumers, one member who shall represent employers who have more than 25 employees, one member who shall represent employers who

have less than 25 employees, one member who shall represent health maintenance organizations, one member who shall be a licensed physician, and one member who shall either be a representative of the Department of Human Resources or a representative of a government agency involved directly or indirectly in state-wide health planning. All members of the board shall serve for terms of six years, except the Commissioner whose term shall be concurrent with his term of office as Commissioner. The board shall select one of its members to serve as chairman. The members of the board of directors shall be required to take and subscribe before the Governor an oath to discharge the duties of their office faithfully and impartially. This oath shall be in addition to the oath required of all civil officers. The members of the board of directors shall not be entitled to compensation for their services but shall be entitled to reimbursement for their actual travel and expenses necessarily incurred in the performance of their duties when funds are available for this purpose.

(c) The board of directors shall establish a method of operation for the plan and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the plan. The method of operation and any amendments thereto shall be submitted to the Commissioner for his evaluation and he shall make recommendations to the board of directors if he feels revisions are required to assure the fair, reasonable, and equitable administration of the plan. The Commissioner shall, after notice and hearing, approve the method of operation, provided such is determined to be suitable to assure the fair, reasonable, and equitable administration of the plan. The method of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this chapter may be made available. If the plan fails to submit a suitable method of operation within 180 days after the appointment of the board of directors or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Code section. Such rules shall continue in force until modified by the Commissioner or superseded by a method of operation submitted by the board and approved by the Commissioner.

(d) In the method of operation the directors shall:

(1) Establish procedures for the handling and accounting of assets and moneys of the plan;

(2) Select an administrator, which shall be an insurer licensed to transact accident and sickness insurance in this state, in accordance with Code Section 33-44-5;

(3) Establish procedures for filling vacancies on the board of directors;

(4) Establish a fixed benefit schedule for the payment of benefits and cost containment features designed to assist in controlling the costs of the plan; and

(5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and the procedures for enrollment and to maintain public awareness of the plan.

(e) The plan shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact accident and sickness insurance as defined under Code Section 33-44-2 and, in addition thereto, the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority to enter into contracts with similar funds or pools of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions. The plan shall have the authority to establish reciprocal agreements with similar pools or funds of other states and may agree to waive the residency requirement specified in subsection (a) of Code Section 33-44-4 with respect to persons who become residents of this state and were covered under a similar pool or fund with which the plan had established a reciprocal agreement;

(2) Bring or defend actions;

(3) Take such legal action as necessary to avoid the payment of improper claims against the plan or the coverage provided by or through the plan;

(4) Establish appropriate rates; rate schedules; rate adjustments; expense allowances; agents' referral fees; claim reserve formulas; cost containment features, including, but not limited to, second opinions for surgeries, review and auditing of claims, precertification of hospital admissions and surgeries, and preferred providers; and any other actuarial functions appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(5) Issue policies or certificates of insurance coverage in accordance with the requirements of this chapter; and

(6) Establish rules, conditions, and procedures for reinsurance of risks of the plan.

(Code 1981, § 33-44-3, enacted by Ga. L. 1989, p. 1701, § 1; Ga. L. 1990, p. 8, § 33.)

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

33-44-4. (For effective date, see note.) Eligibility for coverage; termination of coverage; application for coverage.

(a) Any individual person who has been a resident of this state for at least six months prior to the application for coverage shall be eligible for coverage under the plan, except the following:

(1) Any person who is at the time of plan application eligible for health care benefits under Article 7 of Chapter 4 of Title 49, the "Georgia Medical Assistance Act of 1977";

(2) Any person having terminated coverage in the plan unless 12 months have elapsed since such termination;

(3) Any person on whose behalf the plan has paid out \$500,000.00 in benefits; and

(4) Inmates of public institutions and persons eligible for public programs.

(b) Any person who ceases to meet the eligibility requirements of this Code section may be terminated at the end of the policy period.

(c) Any eligible person may apply for coverage under the plan. If such coverage is applied for within 30 days after the involuntary termination of previous accident and sickness insurance coverage and if premiums are paid to the plan for the entire coverage period to be issued, the effective date of the coverage under the plan shall be the date of termination of the previous coverage.

(Code 1981, § 33-44-4, enacted by Ga. L. 1989, p. 1701, § 1.)

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

33-44-5. (For effective date, see note.) Selection of insurer to administer claims payments; period of service; duties and expenses of administrator.

(a) The board of directors shall select an insurer through a competitive bidding process to administer claims payments of the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The insurer's proven ability to handle individual accident and sickness insurance;

(2) The efficiency of the insurer's claim-paying procedures;

(3) An estimate of total charges for administering the plan; and

(4) The insurer's ability to administer the pool in a cost-efficient manner.

(b)(1) The administrator shall serve for a period of three years subject to removal for cause.

(2) At least one year prior to the expiration of each three-year period of service by the administrator, the board shall invite all insurers, including the insurer serving as the current administrator, to submit bids to serve as the administrator for the succeeding three-year period. Selection of the administrator for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(c)(1) The administrator shall perform all eligibility and administrative claims payment functions relating to the plan.

(2) The administrator shall establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board.

(3) The administrator shall perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including:

(A) Making available information relating to the proper manner of submitting a claim for benefits to the plan and distributing forms upon which such submission shall be made; and

(B) Evaluating the eligibility of each claim for payment by the plan.

(4) The administrator shall submit to the board regular reports regarding the operation of the plan. The frequency, content, and form of the reports shall be as determined by the board.

(5) Following the close of each calendar year, the administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form as prescribed by the Commissioner.

(6) The administrator shall be paid as provided in the method of operation for its expenses incurred in the performance of its services.

(Code 1981, § 33-44-5, enacted by Ga. L. 1989, p. 1701, § 1.)

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

33-44-6. (For effective date, see note.) Net premiums; revision of schedule of benefits and cost containment features.

(a) Following the close of each fiscal year, the plan administrator shall determine the net premiums, which shall be total premiums less administrative expense allowances, the plan expenses of administration, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses, and shall report such information to the board of directors.

(b) The board of directors may revise the fixed schedule of benefits and cost containment features provided under the plan as necessary to ensure that the plan maintains adequate resources for continued operation.

(Code 1981, § 33-44-6, enacted by Ga. L. 1989, p. 1701, § 1.)

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

33-44-7. (For effective date, see note.) Major medical expense coverage.

(a) The plan shall offer major medical expense coverage to every eligible person. Major medical expense coverage offered by the plan shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (3) of subsection (d) of this Code section, up to an annual limit of \$100,000.00 and up to a lifetime limit of \$500,000.00 per covered individual. The annual limit and maximum lifetime limit provided under this subsection shall not be altered by the board, and no actuarial equivalent benefit may be substituted by the board.

(b) As used in this Code section, the term "covered expenses" shall mean the scheduled benefits established for the following services and articles when determined by the board to be medically necessary:

(1) Hospital services;

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than dental, which services are rendered by a physician or by other licensed professionals at his direction;

(3) Drugs requiring a physician's prescription;

(4) Services of a licensed skilled nursing facility for not more than 120 days during a policy year;

(5) Services of a home health agency for not more than 120 services during a policy year;

(6) Use of radium or other radioactive materials;

(7) Oxygen;

(8) Anesthetics;

(9) Prostheses other than dental;

(10) Rental or purchase of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which it is prescribed;

(11) Diagnostic X-rays and laboratory tests;

(12) Oral surgery for excision of partially or completely unerupted, impacted teeth or for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) Services of a licensed physical therapist;

(14) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(15) Services for diagnosis and treatment of mental and nervous disorders; and

(16) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, which services are rendered by health care professionals licensed pursuant to Chapter 30, 35, or 39 of Title 43.

(c) Covered expenses shall not include the following:

(1) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;

(2) Care which is primarily for custodial or domiciliary purposes;

(3) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician;

(4) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the scheduled benefits established by the board or

for any charge not medically necessary;

(5) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;

(6) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred;

(7) Dental care except as provided in paragraph (12) of subsection (b) of this Code section;

(8) Eyeglasses and hearing aids;

(9) Illness or injury due to acts of war;

(10) Services of blood donors and any fee for failure to replace the first three pints of blood provided to an eligible person each policy year; and

(11) Personal supplies or services provided by a hospital or nursing home or any other nonmedical or nonprescribed supply or service.

(d)(1) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

(2) The board of directors shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the plan coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for coverage under the plan shall not be less than 125 percent of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this chapter; provided, however, that in no event shall plan rates exceed 150 percent of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for his review and evaluation and he may make recommendations to the board concerning rates for coverage under the plan.

(3) The plan coverage defined in this Code section shall provide optional deductibles of \$500.00 or \$1,500.00 per annum per individual and coinsurance of 20 percent, such coinsurance and deductibles in the aggregate not to exceed \$2,000.00 per individual nor \$4,000.00 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

(e) Plan coverage shall exclude all charges or expenses incurred during the first six months following the effective date of coverage and charges or expenses incurred which are in excess of \$10,000.00 per insured individual during the seventh through twelfth months following the

effective date of coverage as to any condition which during the six-month period immediately preceding the effective date of coverage:

(1) Had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or

(2) For which medical advice, care, or treatment was recommended or received.

Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior accident and sickness insurance coverage which was involuntarily terminated, provided that application for plan coverage is made not later than 30 days following such involuntary termination, and in such case, coverage under the plan shall be effective from the date on which such prior coverage was terminated.

(f)(1) Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other accident and sickness insurance or insurance arrangement and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid.

(2) The administrator or the board of directors of the plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not covered expenses. Benefits due from the plan may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(Code 1981, § 33-44-7, enacted by Ga. L. 1989, p. 1701, § 1; Ga. L. 1990, p. 8, § 33.)

Code Commission notes. - Pursuant to Code Section 28-9-5, in 1989, a misspelling of "domiciliary" was corrected in paragraph (e)(2).

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

33-44-8. (For effective date, see note.) Liability of plan and board of directors.

The establishment of rates, forms, procedures, or fixed schedules of benefits or any other similar action required by this chapter shall not be the basis of any legal action, criminal or civil

liability, or penalty against the plan or the board of directors of the plan.

(Code 1981, § 33-44-8, enacted by Ga. L. 1989, p. 1701, § 1.)

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

33-44-9. (For effective date, see note.) Exemption from taxes.

The plan established pursuant to this chapter shall be exempt from any and all taxes levied by this state or any of its political subdivisions.

(Code 1981, § 33-44-9, enacted by Ga. L. 1989, p. 1701, § 1.)

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

33-44-10. (For effective date, see note.) Donations and gifts; appropriations.

(a) The plan shall be authorized to receive donations or gifts from individuals, private organizations, foundations, or other sources and shall be authorized to receive state funds or any federal funds which may become available. Any funds received as donations or gifts shall be deemed trust funds to be held and applied solely for the purposes of this chapter.

(b) The General Assembly shall be authorized, but in no event shall be required, to appropriate moneys to the plan.

(Code 1981, § 33-44-10, enacted by Ga. L. 1989, p. 1701, § 1.)

Editor's notes. - For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

ATTACHMENT "D"

GEORGIA HOUSE BILL 1351

House Bill 1351

By: Representative Knox of the 24th

A BILL TO BE ENTITLED
AN ACT

1 To amend Chapter 29A of Title 33 of the Official Code of Georgia Annotated, relating to
2 individual health insurance coverage, so as to provide for changes to definitions; to change
3 participation requirements in the health insurance assignment system; to change participation
4 requirements in the health benefits assignment system; to provide for the Commissioner to
5 file new plans; to provide for the Commissioner to conduct an audit of product offerings in
6 the individual health insurance market; to provide for exclusion of coverage period for
7 preexisting conditions; to provide for related matters; to repeal conflicting laws; and for other
8 purposes.

9 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

10 **SECTION 1.**

11 Chapter 29A of Title 33 of the Official Code of Georgia Annotated, relating to individual
12 health insurance coverage, is amended by revising Article 1, relating to availability and the
13 assignment system, as follows:

14 "ARTICLE 1

15 33-29A-1.

16 (a) It is the intention of this chapter together with Code Section 33-24-21.1 to provide an
17 acceptable alternative mechanism for the availability of individual health insurance
18 coverage, as contemplated by Section 2741 of the federal Public Health Service Act, 42
19 U.S.C.A. Section 300gg-41. This chapter shall be construed and administered so as
20 accomplish such intention.

21 (b) Any reference in this chapter to any federal statute shall refer to that federal statute as
22 it existed on January 1, 1997, including its amendment by the federal Health Insurance
23 Portability and Accountability Act of 1996, P.L. 104-191.

1 33-29A-2.

2 (a) As used in this chapter, the terms:

3 (1) 'Creditable coverage' and 'eligible individual' have the same meaning as specified in
4 Sections 2701 and 2741 of the federal Public Health Service Act, 42 U.S.C.A. Sections
5 300gg and 300gg-41 except that a person shall not be an eligible individual under this
6 chapter if such person is eligible for or has declined any continuation or conversion
7 coverage or has terminated any such coverage prior to its exhaustion in the last six
8 months, but such person shall be deemed eligible if he or she has been declined twice
9 attempting to obtain individual health insurance in the same period of time.

10 (2) 'Health insurance issuer' and 'health maintenance organization' have the same
11 meaning as specified in Section 2791 of the federal Public Health Service Act, 42
12 U.S.C.A. Section 300gg-92.

13 (3) 'Health insurer' means any health insurance issuer which is not a managed care
14 organization.

15 (4) 'Managed care organization' means a health maintenance organization or a nonprofit
16 health care corporation.

17 (b) Any other term which is used in this chapter and which is also defined in Section 2791
18 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-92, and not otherwise
19 defined in this chapter shall have the same meaning specified in said Section 2791.

20 33-29A-3.

21 Each health insurer and managed care corporation which is licensed to and does offer
22 health insurance coverage ~~in the individual market~~ in this state shall as a condition of such
23 licensure agree to participation in its respective assignment system provided by this
24 chapter. This Code section shall not apply to an entity which offers only excepted benefits
25 as specified in Section 2791(c) of the federal Public Health Service Act, 42 U.S.C.A.
26 Section 300gg-91(c).

27 33-29A-4.

28 (a) Each eligible individual in this state whose most recent creditable coverage was
29 provided by an entity other than a managed care organization shall be entitled to participate
30 in the Georgia Health Insurance Assignment System (sometimes referred to as GHIAS in
31 this chapter) created pursuant to this Code section. Each eligible individual in this state
32 whose most recent creditable coverage was provided by a managed care organization shall
33 be entitled to participate in the Georgia Health Benefits Assignment System created
34 pursuant to Code Section 33-29A-5. Each eligible individual in this state who has been
35 uninsured for a period of 12 months or more shall be entitled to elect to participate in the

1 Georgia Health Insurance Assignment System or in the Georgia Health Benefits
2 Assignment System.

3 (b) The Commissioner shall develop the GHIAS system which shall provide for the
4 equitable assignment of eligible individuals who are entitled to and desirous of
5 participating in the system to health insurers offering coverage in the individual market in
6 the state. Such assignment shall be based primarily on the pro rata volume of individual
7 health insurance business done in this state by each such health insurer. The system may
8 include other factors for equitable assignment, as determined to be appropriate by the
9 Commissioner, including but not limited to the geographic area or areas in the state
10 normally served by a health insurer.

11 (c) Upon assignment of an eligible individual to a health insurer, the eligible individual
12 shall have the right to purchase and the health insurer shall have the obligation to sell ~~either~~
13 ~~of the standard health insurance policies~~ policy provided for in subsection (d) of this Code
14 section at a premium not to exceed the maximum specified in said subsection or as
15 provided for in Code Section 33-29A-8.

16 (d) The Commissioner shall develop ~~two~~ at least one standard health insurance ~~policies~~
17 policy to be provided by health insurers to which eligible individuals are assigned pursuant
18 to this Code section. The actuarial value of the benefits under ~~each~~ such coverage shall be
19 at least 85 percent of the average actuarial value of the benefits provided by all individual
20 health insurance coverage issued by all issuers in the state. Except to the extent specifically
21 provided to the contrary in this chapter, all laws of this state relating to the normal
22 provision of such coverage in the individual market shall apply to the provision of such
23 coverage under this chapter. The Commissioner shall fix a maximum premium to be
24 charged for ~~each~~ such standard policy which shall be not more than 150 percent of the
25 average premium which is or would be charged by all issuers in the state for the same or
26 similar coverage issued other than under this Code section, as determined by the
27 Commissioner. The Commissioner may authorize a health insurer to charge a premium in
28 excess of said 150 percent maximum if and only if the insurer demonstrates to the
29 Commissioner that the application of the 150 percent maximum would endanger the
30 financial solvency of that health insurer.

31 (e) Nothing in this Code section shall be construed to require a health insurer to offer to
32 an eligible individual any coverage other than ~~one of the two~~ standard health insurance
33 ~~plans~~ plan developed under subsection (d) of this Code section, except to the extent
34 required under federal law to offer at least two choices of coverage to an eligible
35 individual. Nothing in this Code section shall be construed to prohibit any insurer from
36 offering to any individual any otherwise lawful coverage.

1 33-29A-5.

2 (a) Each eligible individual in this state whose most recent creditable coverage was
3 provided by a managed care organization shall be entitled to participate in the Georgia
4 Health Benefits Assignment System (sometimes referred to as GHBAS in this chapter)
5 created pursuant to this Code section. Each eligible individual in this state whose most
6 recent creditable coverage was provided by an entity other than a managed care
7 organization shall be entitled to participate in the Georgia Health Insurance Assignment
8 System created pursuant to Code Section 33-29A-4. Each eligible individual in this state
9 who has been uninsured for a period of 12 months or more shall be entitled to elect to
10 participate in the Georgia Health Insurance Assignment System or in the Georgia Health
11 Benefits Assignment System.

12 (b) The Commissioner shall develop the GHBAS system which shall provide for the
13 equitable assignment of eligible individuals who are entitled to and desirous of
14 participating in the system to managed care organizations doing business in the state. Such
15 assignment shall be based primarily on the pro rata volume of ~~individual~~ business done in
16 this state by each such managed care organization and the geographic area or areas in the
17 state normally served by a managed care organization. The system may include other
18 factors for equitable assignment, as determined to be appropriate by the Commissioner. No
19 managed care organization shall be required to provide coverage outside the geographic
20 area or areas normally served by that managed care organization. However, where this
21 geographic limitation makes it impossible to assign to a managed care organization its
22 equitable share of eligible individuals, a managed care organization may be required by the
23 Commissioner to contract for provision of coverage of eligible individuals, as provided for
24 in Code Section 33-29A-6.

25 (c) Upon assignment of an eligible individual to a managed care organization, the eligible
26 individual shall have the right to purchase and the managed care organization shall have
27 the obligation to sell enrollment in ~~either of~~ the standard health benefit ~~plans~~ plan provided
28 for in subsection (d) of this Code section at a premium not to exceed the maximum
29 specified in said subsection or as provided for in Code Section 33-29A-8.

30 (d) The Commissioner shall develop ~~two~~ at least one standard health benefit ~~plans~~ plan to
31 be provided by managed care organizations to which eligible individuals are assigned
32 pursuant to this Code section. The actuarial value of the benefits under ~~each~~ such health
33 benefit plan shall be at least 85 percent of the average actuarial value of the benefits
34 provided by all health benefit plans issued in the individual market by all managed care
35 organizations in the state. Except to the extent specifically provided to the contrary in this
36 chapter, all laws of this state relating to the normal provision of such coverage in the
37 individual market shall apply to the provision of such coverage under this chapter. The

1 Commissioner shall fix a maximum premium to be charged for ~~each~~ such standard health
2 benefit plan which shall be not more than 150 percent of the average premium which is or
3 would be charged by all managed care organizations in the state for the same or similar
4 coverage issued other than under this Code section, as determined by the Commissioner.
5 The Commissioner may authorize a managed care organization to charge a premium in
6 excess of said 150 percent maximum if and only if the managed care organization
7 demonstrates to the Commissioner that the application of the 150 percent maximum would
8 endanger the financial solvency of that managed care organization.

9 (e) Nothing in this Code section shall be construed to require a managed care organization
10 to offer to an eligible individual any coverage other than ~~one of the two~~ standard health
11 benefit plans plan developed under subsection (d) of this Code section, except to the extent
12 required under federal law to offer at least two choices of coverage to an eligible
13 individual. Nothing in this Code section shall be construed to prohibit any managed care
14 organization from offering to any individual any otherwise lawful coverage.

15 33-29A-6.

16 Any combination of one or more health insurers and one or more managed care
17 organizations may contract with each other for the assumption by one or more health
18 insurers of the obligations otherwise imposed by this chapter on one or more managed care
19 organizations. Under any such contract the responsibility for providing the coverage
20 required by this chapter shall be with a health insurer licensed to do business in this state.
21 Where the obligations of a managed care organization are contractually assumed by a
22 health insurer, the assuming health insurer may substitute coverage under a standard policy
23 of health insurance for coverage under a standard health benefit plan, and provision of such
24 substituted coverage shall satisfy the obligation otherwise owed to an affected eligible
25 individual.

26 33-29A-7.

27 The Commissioner may impose a moratorium upon the required issuance of coverage by
28 a health insurer or managed care organization, if the Commissioner determines after public
29 notice and hearing that the continuation of such required issuance by that entity will
30 endanger the solvency of that entity.

31 33-29A-8.

32 (a) The Commissioner shall adopt rules and regulations for the implementation of this
33 chapter. Notwithstanding any provision of Chapter 2 of this title or any other law to the
34 contrary, such rules and regulations shall be adopted in exact compliance with the

1 procedures specified in Article 1 of Chapter 13 of Title 50, the 'Georgia Administrative
2 Procedure Act.' In addition to any other materials submitted under subsection (e) of Code
3 Section 50-13-4, there shall be so submitted the full text of the Georgia Health Insurance
4 Assignment System, the Georgia Health Benefits Assignment System, the standard health
5 insurance ~~policies~~ policy provided for in Code Section 33-29A-4, and the standard health
6 benefit ~~plans~~ plan provided for in Code Section 33-29A-5. The Commissioner shall file
7 new plan designs allowed for assignment coverage pursuant to subsection (c) of this Code
8 section no later than January 15, 2009.

9 (b) The rules and regulations developed by the Commissioner shall include provisions for
10 applications for GHIAS and GHBAS to be submitted by licensed insurance agents and for
11 such agents to be compensated at a commission rate of not less than 3 percent from the
12 premiums received by the issuing health insurer or managed care organization. For
13 purposes of applications for GHIAS and GHBAS, licensed agents shall not be subject to
14 the certificate of authority requirements of Code Section 33-23-26.

15 (c) The Commissioner shall, by December 31, 2008, conduct an audit of product offerings
16 in the individual health insurance market in order to provide that assignment coverage
17 issued pursuant to this chapter reflects those otherwise available to consumers outside this
18 chapter, including, but not limited to, wellness incentives, consumer directed health plans,
19 disease management programs, and other risk reduction methodologies available through
20 private market insurers in this state. Such plans may be offered by insurers and managed
21 care organizations required to accept assignments under this chapter in lieu of the standard
22 plans provided in subsection (d) of Code Sections 33-29A-4 and 33-29A-5 as long as such
23 plans meet requirements provided under the guidelines of the federal Health Insurance
24 Portability and Accountability Act of 1996, P.L. 104-191, and as long as they are approved
25 for such use by the Commissioner and are offered at rates not exceeding the limits
26 established for the standard plans.

27 (d) Individuals deemed eligible as a result of being declined for coverage in the individual
28 health insurance market as provided in subsection (a) of Code Section 33-29A-4 shall be
29 subject to a 12 month exclusion of coverage for preexisting conditions that have been
30 treated in the most recent 12 months prior to seeking coverage in the assignment system
31 if such individuals do not have 18 months of continuous prior creditable coverage with no
32 gap in coverage over 120 days."

33 SECTION 2.

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

ATTACHMENT "E"

STATE CONTRACT

State of Georgia
Agency Contract - Service/Maintenance

This is a Request for Proposal to supply the service(s) on the attached listing for the Agency indicated.

1. PRICES

Bidders are requested to quote net prices as indicated on attached listing.

2. EXCEPTIONS

Any award made by the State hereunder shall bind the bidder to the terms, conditions and specifications set forth in this Request for Proposal. Bidders whose bids do not conform to said terms, conditions and specifications in one or more particulars should so note on a separate sheet labeled "Exceptions to Terms and Conditions." While the State reserves the right to make an award to a nonconforming bidder when its best interest would be served by doing so, such awards will not be readily made, and bidders are urged to conform to the terms, conditions and specifications set out herein to the greatest extent possible. No exceptions will be considered to have been taken by a bidder unless it is properly set out as provided above, and no exception will be deemed to have been accepted by the State unless incorporated in the Execution copy of the Contract.

Vendor Data Sheet
Agency Contract - Service/Maintenance

1. Firm: _____
Address: _____

2. Orders to be mailed to:
Firm: _____
Address: _____

3. Payments to be made to:
Firm: _____
Address: _____

4. Contract Administrator:
Name: _____
Title: _____
Address: _____

Telephone: _____
Toll Free Phone (if available): 1+ _____
Fax Number: _____
E-mail Address: _____

NOTE: ALL EXCEPTIONS to the terms and conditions should be noted on a separate sheet as in accordance to paragraph 2 of the Request for Proposal.

State of Georgia
Service/Maintenance Contract

This Contract entered into on the _____ day of _____, 20____, by (Office of Insurance and Safety Fire Commissioner, Department of Insurance) hereinafter referred to as "Agency," and (Contractor Name), hereinafter referred to as Contractor. The term of this Contract shall commence on _____ and terminate on _____.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, it is agreed as follows:

1. INCORPORATION BY REFERENCE

The terms, conditions and specifications of **Request for Proposal (RFP) 2008-PS-1** (hereinafter "RFP"), and Contractor's response to said RFP, are incorporated by reference and made a part hereof just as if they had been fully set out herein.

2. PURPOSE OF AGREEMENT

Contractor will provide the services specified in the RFP to the Agency at the prices specified in Contractor's response to the RFP.

3. PAYMENT

The Agency shall pay the amount set out in the attached Schedule for any service provided. Payments shall be made each month according to approved invoice.

4. PRICE

The prices quoted and listed on the attached RFP shall be firm throughout the term of this Contract.

5. DELIVERY

The services shall be rendered by the Contractor within the time and to the location specified by the Agency.

6. NON-EXCLUSIVE CONTRACT

This Contract is entered into solely for the convenience of the Agency, and it in no way precludes the Agency from obtaining like services from other vendors.

7. COMPLIANCE WITH STATUTES

The Contractor shall comply with all laws, ordinances, rules and regulations of any governmental entity pertaining to the provision of any services to the Agency pursuant to this Contract.

8. APPLICABLE LAW

This Contract shall be governed in all respects by the laws of the State of Georgia.

9. TRADING WITH STATE EMPLOYEES

This Contract does not and will not violate the provisions of the Official Code of Georgia Annotated Section 45-10-20 et. seq.

10. ADDITIONAL TERMS

The Agency shall not be bound by any terms and conditions included in any Contractor packaging, invoice, catalog, brochure, technical data sheet, or other document which attempts to impose any condition in variance with or in addition to the terms and conditions contained herein.

11. RENEWAL

The parties may mutually agree in writing to renew this Contract for up to _____ additional one (1) year terms.

12. EXTENSION

In the event this Contract shall terminate or be likely to terminate prior to the award of a new Contract for this service the parties may mutually agree in writing to extend this Contract for such period as may be necessary.

13. CANCELLATION

The Agency reserves the right to cancel this Contract by giving the Contractor _____ days written notice of its intent to do so.

14. ASSIGNMENT AND DELEGATION

This Contract or any performance required by it shall not be assigned or delegated in whole or in part without the express written consent of the Agency.

15. WAIVER

The waiver by the Agency of the breach of any provision contained in this Contract shall not be deemed to be a waiver of such provision on any subsequent breach of the same or any other

provision contained in the Contract. No such waiver or waivers shall serve to establish a course of performance between the parties contradictory to the terms hereof.

16. INDEMNIFICATION AGREEMENT

Contractor hereby waives, releases, relinquishes, discharges and agrees to indemnify, protect, save harmless, the State of Georgia (including the State Tort Claims Trust Fund and other self insured funds) and all of its State entities, and all respective officers, employees, directors and agents of and from any and all claims, demands, liabilities, losses, costs or expenses for any loss including but not limited to bodily injury (including death), personal injury, property damage, expenses, and attorneys' fees, caused by, growing out of, or otherwise happening in connection with this Contract, due to any act or omission on the part of the Contractor, its agents, employees or others working at the direction of Contractor or on its behalf, or due to any breach of this Contract by the Contractor, or due to the application or violation of any pertinent Federal, State or local law, rule or regulation by the Contractor. This indemnification applies whether: (a) the activities involve third parties or employees or agents of the Contractor or of the State entity; (b) the State is partially responsible for the situation giving rise to the claim; provided, however, this indemnification does not apply to the extent of the sole negligence of the State of Georgia and its officers or employees. This indemnification extends to the successors and assigns of the Contractor, and this indemnification survives the termination of the Contract and the dissolution or, to the extent allowed by law, the bankruptcy of the Contractor. If and to the extent such damage or loss as covered by this indemnification is covered by the State Tort Claims Fund (the "Fund") established and maintained by the State of Georgia Department of Administrative Services (DOAS), the Contractor agrees to reimburse the Fund for such monies paid out by the Fund. To the full extent permitted by the Constitution and the laws of the State of Georgia and the terms of the Fund, the Contractor and its insurers waive any right of subrogation against the State of Georgia, its officers, employees and agents, the Fund and insurers participating there under, to the full extent of this indemnification.

17. TIME OF THE ESSENCE

Time is of the essence in this Contract. Any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

18. ENTIRE AGREEMENT

This Contract, as executed and approved, shall constitute the entire agreement between the parties, and no change in or modification of this Contract shall be binding upon the Agency unless the change or modification shall be in writing, consented to and approved by the Agency.

IN WITNESS WHEREOF, the parties have executed this Contract on the date first written above.

Contractor Name

Signature of Contractor's Authorized Representative

Agency Name

Signature of Agency's Authorized Representative