

Chapter 120-2-79

HEALTH PLAN PURCHASING COOPERATIVES

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120-2-79-.01 Statutory Authority

This Regulation applies to any health plan purchasing cooperative as defined in O.C.G.A. §33-30A-1.

Authority-O.C.G.A. §§33-2-9 and 33-30A-1 et seq.

120-2-79-.02 Scope and Purpose

- (1) This Regulation applies to any health plan purchasing cooperative as defined in O.C.G.A. §33-30A-1.
- (2) The purposes of this Regulation include:
 - (a) Providing disclosure of contracts between insurance carriers and health plan purchasing cooperatives, both to potential insureds and to the Commissioner;

- (b) Promoting the overall responsibility of health plan purchasing cooperatives;
- (c) Subjecting persons administering health plan purchasing cooperatives to the jurisdiction of the Commissioner of Insurance; and
- (d) Regulating health plan purchasing cooperatives in conformity with the general purposes of the Georgia Insurance Code.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.03 Definitions

As used in this Regulation Chapter, the term:

- (1) “Employer-sponsored Health Benefit Arrangement” means any program of delivery, funding, or sponsorship of major medical, hospital, or medical and hospital expense coverage, or any type of coverage considered a health benefit plan as defined by O.C.G.A. §33-30A-1(3) offered by an employer for the benefit of its eligible employees and dependents.
- (2) “Market Type” means any one of the following types of entities:
 - (a) small employers as defined in O.C.G.A. §33-30A-1(7);
 - (b) large employers, which shall mean all employers which do not meet the definition of small employer in O.C.G.A. §33-30A-1(7) because such employers employed more than 50 eligible employees during 50 percent or more of its working days during the previous calendar quarter; or
 - (c) individuals offered membership in the health plan purchasing cooperative pursuant to O.C.G.A. §33-30A-4(a)(4).
- (3) “Member” means any employer (or individual pursuant to O.C.G.A. §33-30A-4(a)(4)) which has entered into a contract with a health plan purchasing cooperative, has met the membership criteria of the health plan purchasing cooperative, including payment of any applicable membership fees, and maintains at least one health benefit plan offered through the health plan purchasing cooperative as its employer-sponsored health benefit arrangement for its employees.
- (4) “Participating Carrier” means any insurer or carrier as defined in O.C.G.A. §33-30A-1(2), with a certificate of authority to issue insurance in the State of Georgia, which has entered into a contract or agreement with a health plan purchasing cooperative to offer one or more health benefit plans to members of such purchasing cooperative.

Authority-O.C.G.A. §§33-2-9 and 33-30A-9.

120-2-79-.04 Application and Issuance of Certificate of Authority

- (1) It is unlawful for any person or entity to act as or hold itself out to be a health plan purchasing cooperative in this State without a valid certificate of authority issued by the Commissioner of Insurance. To qualify for and hold a certificate of authority to act as a health plan purchasing cooperative in this State, a health plan purchasing cooperative must otherwise be in compliance with O.C.G.A. §33-30A-1 et seq., this Regulation Chapter, and the bylaws of the health plan purchasing cooperative.
- (2) The health plan purchasing cooperative shall file with the Commissioner an application for a certificate of authority upon a form to be furnished by the Commissioner. The application shall include or have attached the following information and documents:
 - (a) All basic organizational documents of the health plan purchasing cooperative including certificate of existence, the articles of incorporation, and other applicable documents, and all amendments to those documents;
 - (b) The bylaws, rules and regulations, statements of policy or similar documents regulating the conduct or the internal affairs of the health plan purchasing cooperative;
 - (c) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of the affairs of the health plan purchasing cooperative, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers of the corporation, the membership of any advisory group or groups, and any other person who exercises control or influence over the affairs of the health plan purchasing cooperative;
 - (d) Audited annual statements or reports for each of the three most recent years, compiled by a certified public accountant, or such other information as the Commissioner may require in order to review the current financial condition of the applicant which ultimately reflects a minimum net worth amount of \$200,000;
 - (e) If the applicant is not currently acting as a health plan purchasing cooperative, a statement of the amounts and sources of the funds available for organizational expenses and the proposed arrangements for reimbursement and compensation of incorporators or other principals;
 - (f) Fees required of a health plan purchasing cooperative as provided in the application materials;
 - (g) A business plan detailing the operation of the health plan purchasing cooperative in Georgia that includes the applicant's method(s) of solicitation, names of insurers and insurance products offered through the cooperative and the geographic area(s) the health plan purchasing cooperative is intending to serve;
 - (h) A copy of the guarantee of uninterrupted coverage as stipulated by O.C.G.A. §33-30A-8(c); and

- (i) Copies of all agreements between the health plan purchasing cooperative and the carrier(s) as stipulated by O.C.G.A. §33-30A-4(f) as well as any administrator agreement(s) and/or agent agreement(s) used in the operations of the applicant.
- (3) The applicant shall make available for inspection by the Commissioner or his or her authorized representative copies of all contracts with participating carriers or members of the health plan purchasing cooperative.
- (4) The Commissioner may not issue a certificate of authority if he or she determines that the health plan purchasing cooperative, or any principal thereof is not competent, trustworthy, financially responsible, has worked as a responsible officer of an insurer whose certificate of authority was refused, revoked, or suspended, has had an agent's license refused, revoked, or suspended by any state, or, pursuant to O.C.G.A. §33-30A-7(d), has or had a financial interest in the operations of the health plan purchasing cooperative. As partial verification, the applicant is required to submit an investigative background report, supplied by an outside agency, directly to the department to support individual biographical affidavit(s) submitted by all directors, officers and/or principals representing the applicant. The report must include 10 years of data with specific review of all local, state and federal courts in areas where the individual has resided. Furthermore, the report should contain a credit report on the individual.
- (5) A certificate of authority issued under this section shall remain valid, unless suspended or revoked by the Commissioner, so long as the health plan purchasing cooperative continues in business in this state in compliance with O.C.G.A. Title 33, Chapter 30A and this Regulation Chapter, and annually renews its certificate of authority in a timely manner.
- (6) A health plan purchasing cooperative shall, as part of its application for licensure, disclose its written conditions of membership referred to in O.C.G.A. §33-30A-4(b)(1) to the Commissioner for approval. Any material change to such conditions shall also be filed with the Commissioner for approval at least sixty (60) days prior to use.

Authority-O.C.G.A. §§33-2-9, 33-30A-4, 33-30A-5, 33-30A-7, 33-30A-8, 33-30A-9.

120-2-79-.05 Health Plan Purchasing Cooperatives Surety Bond and Insurance

- (1) At application and renewal every health plan purchasing cooperative shall file with the Commissioner a surety bond executed by a corporate surety insurer authorized to transact insurance in this state in favor of the Commissioner of Insurance of the State of Georgia, continuous in form and in an amount equal to at least ten percent of the amount of the funds handled or managed annually by the health plan purchasing cooperative, or if no funds were handled during the preceding year, ten percent of the amount of funds reasonably estimated to be handled during the current calendar year. In no event will the surety bond be less than \$100,000.
- (2) The bond shall inure to the benefit of any person damaged by any fraudulent act or conduct of the health plan purchasing cooperative and must be conditioned upon faithful accounting and application of all money coming into the health plan purchasing cooperative's possession in connection with its activities as a health plan purchasing cooperative.

- (3) The bond remains in force until released by the Commissioner or canceled by the insurer. Without prejudice to any liability previously incurred, the insurer may cancel the bond upon advanced written notice to the health plan purchasing cooperative and by certified mail to the Commissioner (Attn: Regulatory Services Division). A health plan purchasing cooperative's certificate of authority shall be suspended if it does not file with the Commissioner a replacement bond before the date of cancellation of the previous bond. A replacement bond must meet all requirements of this section for the initial bond.
- (4) Each health plan purchasing cooperative shall obtain and maintain surety bond coverage or other appropriate liability insurance, written by an insurer carrier authorized to transact insurance in this state, in an amount of at least \$100,000. A copy of this policy must be filed with the Commissioner at application and renewal.
- (5) Any policy written in accordance with paragraph (4) of this Rule shall be for a term of at least one year and shall contain provisions that:
 - (a) cancellation or termination of the policy is not effective except upon sixty (60) days written notice by registered or certified mail to the other party to the policy and to the Commissioner (Attn: Regulatory Services Division); and
 - (b) the policy is automatically renewable at the expiration of the policy period except upon sixty (60) days written notice by registered or certified mail by the party not renewing the policy to the other party to the policy and to the Commissioner (Attn: Regulatory Services Division).
- (6) Upon written approval by the Commissioner, an eligible surplus lines carrier may write bonds or policies required by this Rule.
- (7) Compliance by the health plan purchasing cooperative with this Rule is a prerequisite to approval by the Commissioner of its application for a certificate of authority.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.06 Written Agreement Necessary

No health plan purchasing cooperative shall act as such without a written agreement between the health plan purchasing cooperative and each participating carrier, and such written agreement shall be retained as part of the official records of the carrier and the health plan purchasing cooperative for the duration of the agreement and five years thereafter. Such written agreement shall contain provisions that comply with the requirements of this Regulation Chapter as they pertain to agreements between the health plan purchasing cooperative and participating carriers.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 And 33-30A-9.

120-2-79-.07 Maintenance of Information; Books and Records; Annual Report to the Carrier(s); Return Credits

- (1) Every health plan purchasing cooperative shall maintain at its principal administrative office for the duration of the written agreement referred to in §120-2-79-.06 and five years thereafter books and records of all transactions between it, carriers and insured persons. The Commissioner shall have access to such books and records for the purpose of examination, audit and inspection. Any trade secrets contained therein, including but not limited to the identity and addresses of policyholders and certificate holders, shall be confidential, except the Commissioner may use such information in any proceedings instituted against the health plan purchasing cooperative. The participating carrier shall retain the right to continuing access to such books and records of the health plan purchasing cooperative sufficient to permit the carrier to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the carrier and health plan purchasing cooperative on the proprietary rights of the parties in such books and records.
- (2) Health plan purchasing cooperatives shall maintain detailed books and records that reflect all transactions specifically in regard to premiums, premium taxes, agent commissions, fees, contributions received and deposited.
- (3) The detailed preparation, journalizing, and posting of such books and records shall be made in accordance with the terms and conditions of the service agreement or contract between the health plan purchasing cooperative and the carrier, and in accordance with the "Employee Retirement and Income Security Act of 1974," 88 Stat. 829, 29 U.S.C. §1001 et seq., as amended and to enable the carrier to complete the National Association of Insurance Commissioners' (NAIC) annual financial statement.
- (4) Health plan purchasing cooperatives shall maintain a cash receipts register of all premiums or contributions received. The minimum detail required in the register shall be date received and deposited, the mode of payment, the policy number, name of policyholder and names of certificate-holders and individual premium amounts and agent.
- (5) The description of a disbursement shall be in sufficient detail to identify the source document substantiating the purpose of the disbursement, and shall include all of the following:
 - (a) The check number;
 - (b) The date of disbursement;
 - (c) The person to whom the disbursement was made;
 - (d) The amount disbursed, provided that if the amount disbursed does not agree with the amount billed or authorized, the health plan purchasing cooperative shall prepare a written record as to the application for the disbursement; and
 - (e) Ledger account number.
- (6) If the disbursement is for the earned fee or commission, a written record reflecting the identifying deposit from which the fee was matched shall support the disbursement.

- (7) Evidential matter shall support all journal entries for receipts and disbursements. The evidential matters must be referenced in the journal entry so that it may be traced for verification.
- (8) The health plan purchasing cooperative shall prepare and maintain monthly financial institution account reconciliations if such service is requested by a participating carrier as provided in the agreement by and between the health plan purchasing cooperative and the carrier.
- (9) The health plan purchasing cooperative shall prepare an annual report to be filed with each participating carrier within ninety days of the end of the fiscal year of the plan, which discloses at least all of the following:
 - (a) The total premiums or contributions received from the member employers, covered persons, or beneficiaries;
 - (b) The total fees withdrawn by the health plan purchasing cooperative pursuant to the written service agreement or contract; and
 - (c) Any additional information required by the written agreement or contract.
- (10) A copy of the annual report described in paragraph (9) shall be retained as part of the official record of the health plan purchasing cooperative for at least five (5) years.
- (11) Return premiums or contributions shall be paid to the participating carrier, or credited to the account of the participating carrier within thirty (30) days after receipt by the health plan purchasing cooperative. If the return premium or contribution is credited to the carrier, the credit must be shown and applied to the next billing statement sent by the carrier.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.08 Payment to Health Plan Purchasing Cooperative

Payment to the health plan purchasing cooperative of any premiums or charges for a health benefit plan by or on behalf of the insured or member shall be deemed to have been received by the participating carrier, and the payment of return premiums or claims by the carrier to the health plan purchasing cooperative shall not be deemed payment to the insured or claimant. Nothing herein shall permit or authorize purchasing cooperatives to process or administer claims or to accept claims payments, nor limit any right of a participating carrier to take action against the health plan purchasing cooperative resulting from its failure to make payments to the participating carrier.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.09 Premium Collection

- (1) All insurance charges, fees, or premiums collected by a health plan purchasing cooperative on behalf of or for a participating carrier, and return premiums received from such carrier, shall be held by the health plan purchasing cooperative in a fiduciary capacity. Such funds

shall be immediately remitted to the person or persons entitled thereto, or shall be deposited promptly in a fiduciary bank account established and maintained by the health plan purchasing cooperative. If charges or premiums so deposited have been collected on behalf of or for more than one carrier, the health plan purchasing cooperative shall cause the bank in which such fiduciary account is maintained to keep records clearly recording the deposits in and withdrawals from such account on behalf of or for each carrier. The health plan purchasing cooperative shall promptly obtain and keep copies of all such records and, upon request of a participating carrier, shall furnish such carrier with copies of such records pertaining to deposits and withdrawals on behalf of or for such carrier. Withdrawals from such account shall be made, as provided in the written agreement or contract between the health plan purchasing cooperative and a participating carrier, for: (1) remittance to a carrier, entitled thereto; (2) deposit in an account maintained in the name of such carrier; (3) payment to a policyholder for remittance to the carrier entitled thereto; or (4) remittance of return premiums to the person or persons entitled thereto.

- (2) In collecting premiums, a health plan purchasing cooperative must bill separately and explicitly to distinguish premium charges from administrative fees collected for the operation of the health plan purchasing cooperative. Any funds collected as premiums shall be held separately and accounted for or reported separately from funds collected from membership or administrative fees charged to members by the health plan purchasing cooperative.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.10 Renewal; Annual Report; Semi-annual Financial Statements; Membership Reporting

- (1) Each authorized health plan purchasing cooperative shall file with the Commissioner a full and true report of its financial condition, transactions, and affairs. The report shall be filed annually on or before May 1 or within such extension of time therefore as the Commissioner for good cause may have granted and shall be for the preceding calendar year. The report shall be in such form and contain such matters as the Commissioner prescribes and shall be verified by at least two officers of the health plan purchasing cooperative filing the report. The second financial condition filing shall be filed on or before October 1 or within such extension of time therefore as the Commissioner for good cause may have granted and shall be for the second quarter for the current calendar year.
- (2) Each authorized health plan purchasing cooperative shall file with the Commissioner a semiannual financial statement in such form as the Commissioner prescribes. Such statement shall be verified by at least two officers of the health plan purchasing cooperative filing the report.
- (3) Each authorized health plan purchasing cooperative shall file with the Commissioner an annual independent audit by a certified public accountant in accordance with O.C.G.A. §33-30A-4(d)(2).
- (4) The annual report shall include the complete names, addresses, NAIC company and NAIC group number of all participating carriers with which the health plan purchasing cooperative had a contract or service agreement during the preceding fiscal year.

- (5) The annual report shall show a detailed accounting of the specific services offered as well as evidence of proper handling of premium collection and record keeping in accordance with O.C.G.A. §33-30A-4 (d)(3).
- (6) The annual report shall provide verification of the continuation of the surety bond or other appropriate liability coverage, as stipulated in this regulation.
- (7) Along with the annual report shall be a written disclosure relating to paragraphs (a) through (I) of §120-2-79-.04. This disclosure must include copies of any changes in documentation that occurred during the previous year's operation.
- (8) Each health plan purchasing cooperative shall file with the Commissioner of Insurance on or before May 1st in each year, a certification executed by an authorized officer of the health plan purchasing cooperative wherein it is stated that the advertisements disseminated by the health plan purchasing cooperative during the preceding calendar year complied, or were made to comply in all respects, with the advertising laws, rules and regulations of this State.
- (9) Fees shall be required for the renewal of the health plan purchasing cooperative as provided in the application materials.
- (10) In addition, the health plan purchasing cooperative shall maintain information on members of the health plan purchasing cooperative on an annual basis, by market type, total individuals enrolled in coverage through the health plan purchasing cooperative, broken down by total employees, total dependents, and total individuals in each category by health benefit plan, or any other reporting information deemed appropriate by the Commissioner. The Commissioner shall prescribe a reporting format for such information. All purchasing cooperatives shall disclose such information in the prescribed format no later than May 1st of every year for every previous year's operations.

Authority-O.C.G.A. §§33-2-9, 33-8-1, 33-30A-4, 33-30A-5 and 33-30A-9.

120-2-79-.11 Approval of Advertising and Enrollment Materials

- (1) A health plan purchasing cooperative shall file any enrollment or marketing materials which provide the standardized information on each health benefit plan as specified in O.C.G.A. §33-30A-4(b)(2) for distribution to cooperative members at least ninety (90) days prior to their use. Such materials shall include, but are not limited to, information distributed to members on how to file or appeal grievances with participating carriers or the health plan purchasing cooperative, and any comparisons between health benefit plans using measures of performance such as medical outcomes and consumer satisfaction which clearly describe the indicators of comparison and the approved methodology used for such comparison.
- (2) Each health plan purchasing cooperative shall maintain at its principal administrative office a complete file of all advertisements and enrollment materials, regardless of who wrote or developed them, created or designed, which are used in the course of the health plan purchasing cooperative's business in this state, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by the Office of Commissioner of Insurance. All such advertisements

shall be maintained in said file for a period of not less than five (5) years.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.12 Delivery of Policies and Notices

Any policies, certificates, booklets, termination notices, or other written communications delivered by the participating carrier to the health plan purchasing cooperative for delivery to its policyholders or certificate holders shall be delivered by the health plan purchasing cooperative promptly after receipt of instructions from the carrier to deliver them.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.13 Notification Required

The health plan purchasing cooperative shall provide, upon enrollment, a written notice approved by the participating carrier, to individuals covered by such carrier, advising them of the identity of and relationship between the health plan purchasing cooperative, the member employer, and the carrier. Where a health plan purchasing cooperative collects funds, it must identify and state separately in writing to the member or person paying any charge or premium for health benefit plan coverage, the amount of any such charge or premium specified by the carrier for such coverage, and, separately, the amount charged for administrative fees by the health plan purchasing cooperative.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.14 Areas of Service

- (1) As part of its application for a certificate of authority, a health plan purchasing cooperative shall file with the Commissioner a description of the entire service area of the health plan purchasing cooperative. All changes to a service area shall be filed for approval with the Commissioner at least sixty (60) days prior to such effective change.
- (2) A health plan purchasing cooperative serving any part of a single metropolitan statistical area in Georgia, as most recently defined and established by the U. S. Office of Management and Budget, shall serve every county which is either entirely or partially located within such single metropolitan statistical area. A health plan purchasing cooperative may serve contiguous counties outside of the single metropolitan statistical area; however:
 - (a) If such contiguous county is located in another single metropolitan service area not served by the health plan purchasing cooperative (regardless of whether or not it is part of a consolidated metropolitan statistical area), the health plan purchasing cooperative may not serve such county unless it serves the entire single metropolitan statistical area in which it is located; and
 - (b) If such contiguous county is partially located in the single metropolitan service area served by the health plan purchasing cooperative, and partially located in another

single metropolitan service area not served by the health plan purchasing cooperative, the health plan purchasing cooperative may then serve only the entire contiguous county that is partially in each single metropolitan service area.

- (3) Nothing in this section shall prevent a health plan purchasing cooperative from serving a consolidated metropolitan statistical area in the state (as defined by the U. S. Office of Management and Budget), or two or more entire single metropolitan statistical areas.
- (4) All references to metropolitan statistical area in this Rule shall equally apply to a primary metropolitan statistical area as defined by the U. S. Office of Management and Budget.
- (5) A health plan purchasing cooperative may offer coverage in one or more counties in adjoining states contiguous to the borders of Georgia.

Authority-O.C.G.A. §33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.15 Choice of Health Benefit Plans; Enrollment

- (1) A health plan purchasing cooperative shall contract with at least two (2) unaffiliated carriers with Certificates of Authority from the Commissioner for participation in the health plan purchasing cooperative to ensure that employers and enrollees have a choice from among a reasonable number of competing carriers and types of health benefit plans. The Commissioner may, upon a demonstration of good cause by the health plan purchasing cooperative, waive the requirement to have at least two (2) unaffiliated participating carriers throughout any or all portions of the health plan purchasing cooperative's service area.
- (2) A health plan purchasing cooperative may establish criteria relating to choice of health benefit plans offered by the health plan purchasing cooperative. Provided that the criteria is consistent and uniform with regard to market type, a health plan purchasing cooperative may require each member of a specific market type to choose one plan for all eligible employees, or may permit all eligible employees of all members of a specific market type to choose one plan out of all plans offered by the health plan purchasing cooperative, or may permit any additional limitations by members on employee choice of health benefit plans, provided that such limitations apply consistently to all members in a specific market type without regard to health status related factors.
- (3) Criteria described in paragraph (2) of this Rule shall include procedures for annual or rolling open enrollment periods in which members or employees may elect to enroll in any health benefit plan available through the health plan purchasing cooperative. Such criteria shall describe enrollment procedures for newly eligible employees and late entrants, and shall demonstrate compliance with Rule 120-2-67 regarding crediting of prior coverage.
- (4) Health plan purchasing cooperatives, subject to any written agreement with a participating carrier or licensed third-party administrator to the contrary, shall be responsible for the issuance of certifications of creditable coverage pursuant to Rule 120-2-67-.12.

Authority-O.C.G.A. §33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.16 Additional Powers of and Restrictions on Purchasing Cooperative

(1) A health plan purchasing cooperative may do any of the following:

- (a) Set reasonable fees, which may vary by employer size, for membership in the health plan purchasing cooperative that will finance reasonable and necessary costs incurred in administering the health plan purchasing cooperative;
- (b) Contract with independent third parties licensed by the Commissioner for any service necessary to carry out the powers and duties authorized or required by Title 33, Chapter 30A of the Official Code of Georgia and this Regulation Chapter;
- (c) Contract with licensed insurance agents to market and service health benefit plans made available through the health plan purchasing cooperative to its members, provided that compensation for agents shall not vary based on the actual or expected experience or health status of the member or persons to which coverage is sold;
- (d) Establish written standards to be met by participating carriers, including but not limited to benefit design, access, quality assurance, data collection, and cost, and accept or reject proposals from carriers for participation in the health plan purchasing cooperative based on such articulated standards, provided that carriers shall be responsible for determining the benefits, rates and underwriting criteria applicable to health benefit plans and for securing reinsurance, if any;
- (e) Negotiate with participating carriers the administrative expense component of the premium rates charged for coverage offered through the health plan purchasing cooperative;
- (f) Provide other services to members pursuant to O.C.G.A. §33-30A-2(b) provided that any insurance coverage offered by the health plan purchasing cooperative shall have complied with all applicable requirements of Title 33 of the Official Code of Georgia; and
- (g) Establish written standards with participating carriers for the intake, processing, and resolution of member grievances pertaining to a health benefit plan and addressed or appealed to the health plan purchasing cooperative.

(2) A health plan purchasing cooperative shall not:

- (a) Exclude from membership, or prevent continuation of membership for, a small employer who has met the conditions of membership established pursuant O.C.G.A. §33-30A-4(b)(1), agrees to pay and in fact does pay fees for membership and the premium for health benefit plan coverage through the health plan purchasing cooperative, and abides by the bylaws and rules of the health plan purchasing cooperative;

- (b) the event that a health plan purchasing cooperative elects to accept other classes of membership pursuant to O.C.G.A. §33-30A-4 (3) or (4), exclude any employer or individual in such a class from membership, or prevent continuation of membership, in the health plan purchasing cooperative, provided that the employer or individual has met the conditions of membership established pursuant to O.C.G.A. §33-30A-4(b)(1), agrees to pay fees for membership and the premium for health benefit plan coverage through the health plan purchasing cooperative, and abides by the bylaws and rules of the health plan purchasing cooperative;
- (c) Exclude from coverage or decline for coverage an eligible employee or dependent of an eligible employee;
- (d) Place any insurance coverage on behalf of a member with a carrier that is not authorized or approved by the Commissioner to do business in Georgia;
- (e) Provide for any self-insurance or reinsurance of benefits provided to any member, or collection of members or eligible individuals, or any other arrangement covering health care expenses which is not through a health benefit plan from an insurer, health maintenance organization, or health care corporation holding an appropriate certificate of authority from the Commissioner;
- (f) Charge a fee not directly related to the operation of the health plan purchasing cooperative;
- (g) Engage in any unfair trade practice defined in Chapter 6 of Title 33 of the Official Code of Georgia;
- (h) Fail to submit requested documentation to the Office of Commissioner of Insurance that pertains to this Regulation Chapter, or applicable provisions of the Official Code of Georgia, or any complaints or inquiries regarding the business practices of a health plan purchasing cooperative within a reasonable time frame as determined by the Commissioner; and
- (i) Intentionally misrepresent or withhold any data or information that has been provided by the member and is pertinent to the lawful underwriting criteria of a health benefit plan, or intentionally misrepresent the terms or existence of any such health benefit plan in any way.

Authority-O.C.G.A. §33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.17 Rating.

- (1) Small Employer Rating Requirements. Participating carriers offering coverage to small employers through a health plan purchasing cooperative must comply with the rating requirements of Rule 120-2-10-.12(5) and must consistently use the same set of rating factors otherwise used for small group health insurance coverage issued outside of a health plan purchasing cooperative in developing rates for health benefit plans issued or renewed through the health plan purchasing cooperative. Small employer members shall be considered small groups, and experience from health benefit plans issued by a participating

carrier to small employer members of a health plan purchasing cooperative shall be part of that carrier's small group pool. Participating carriers shall adhere to every provision of Rule 120-2-10-.12(5) in the following manner, unless specifically directed otherwise by the following:

- (a) Every small employer member covered by a participating carrier shall be treated as a small group for purposes of Rule 120-2-10-.12(5), in which premiums for small employers are based on pool rates and deviated by any of the allowable factors, and individual employees are subject to premium quotes made for each small employer; or
- (b) In lieu of subparagraph (a), all rates for use with all employees and dependents of employees of small employer members in a health plan purchasing cooperative may be developed on a composite basis for factors specified in Rule 120-2-10-.12(5)(b), provided that:
 - (2) A participating carrier may use small group rating factors for age, sex, and family size or composition to apply to composite rates on an individual or family basis, in standard age ranges approved by the health plan purchasing cooperative, with which employees and dependents may then be quoted standard rates on age, sex, or family characteristics;
 - (3) A participating carrier shall develop composite rates by calculating a single, standard deviation from the small group pool rate for the actual or anticipated experience of all employees and dependents of employees of all small employer members covered or expected to be covered by the participating carrier in the health plan purchasing cooperative which is not greater than plus or minus 25 percent of the small group rate (or plus or minus 35 percent if the small group pool is rated in accordance with Rule 120-2-10-.12(5)(h)(1));
 - (4) A participating carrier not subject to Rule 120-2-10-.12(5)(h)(1) may use select and substandard rating related to new entrants to the participating carrier's health benefit plan in accordance with Rule 120-2-10-.12(5)(f) and must apply such rating uniformly and consistently to all individuals covered by that participating carrier through the health plan purchasing cooperative and consistent with the select and substandard rating methodology applied to its entire small group pool;
 - (5) If a participating carrier uses select and substandard rating as in subparagraph (1)(b)3 of this Rule, it may impose a waiting period for coverage of new entrants pursuant to Rule 120-2-10-.12(5)(a) if permitted by the health plan purchasing cooperative; and
 - (6) If a participating carrier is not permitted by the health plan purchasing cooperative to impose a waiting period as otherwise permitted in subparagraph (1)(b)(4) of this Rule, the carrier may not impose a select or substandard rate on any purchasing cooperative health benefit plan.
 - (a) For the purposes of Rule 120-2-10-.12(5)(g), the anticipated group premiums from health benefit plans issued by a participating carrier in one or more purchasing cooperatives using the methodology in either subparagraph (a) or (b) shall be included in the determination of anticipated pool premiums. Premium deviations related to coverage issued to a health plan purchasing cooperative shall be considered in offsetting upward and downward deviations resulting from the application of rating factors to all small groups.

(b) The health plan purchasing cooperative and a participating carrier may negotiate only the administrative expense component of the small group pool rate in determining the rate or rates charged for health benefit plans in the health plan purchasing cooperative, where the carrier can demonstrate net administrative cost savings for its health plan purchasing cooperative business. For the purposes of this paragraph, administrative expenses are limited to marketing expenses, acquisition expenses, the cost of paying claims, commissions, profits, and maintenance expenses.

(7) Large Employer Rating Requirements. All large employer members covered in a health plan purchasing cooperative shall be considered as separate from the participating carrier's small group pool for compliance with Rule 120-2-10-.12, and may be considered separate from small employer members in the health plan purchasing cooperative for rating purposes. In particular:

(a) If employees are permitted to select a health benefit plan, employees of all large employer members may be rated on composite basis adjusted on by age, sex, and family characteristics, provided that a health plan purchasing cooperative may permit each participating carrier to adjust composite rates applicable to a particular large employer for the specific risk characteristics and expected experience of the large employer, or

(b) If an employer selects a health benefit plan on behalf of all eligible employees, each large employer member may be experience rated as otherwise permitted by state law.

(8) In the event a health plan purchasing cooperative permits enrollment of individuals as permitted in O.C.G.A. §33-30-4(a)(4), such individuals shall be subject to Rule 120-2-10-.12(8) and shall be rated as a small group, except that carriers subject to subparagraph (1)(b) of this Rule shall offer coverage to such individuals at the same composite rates (adjusted for age, sex, and family size) offered to other employees.

(9) With regard to compliance with Rule 120-2-10-.12 in any respect, a participating carrier offering a health benefit plan in a health insurance purchasing cooperative shall determine compliance based on final rates certified to and accepted by the health plan purchasing cooperative for the duration of the rate guarantee period agreed to by the carrier and purchasing cooperative. A participating carrier may only adjust rates during the negotiated rate guarantee period in accordance with Rule 120-2-10-.12(5)(a)1. Nothing in this Regulation Chapter shall prevent a health plan purchasing cooperative from negotiating any specific rate guarantee period with participating carriers, provided that such periods are at least six months and are established consistently for all participating carriers.

(10) In the event a health insurance purchasing cooperative and participating carriers agree to apply a different rating methodology from that established by this Rule, or a risk adjustment mechanism to adjust payments to participating carriers based on disproportionate shares of high- or low-risk enrollees, the health plan purchasing cooperative shall file with the Commissioner such proposal, along with certifications from the participating carriers party to such proposal, for approval. The proposal shall demonstrate compliance with the provisions of Rule 120-2-10-.12 with regard to rating of small employer members, or employees in small employer members, and assure consistent application of such mechanism to all members of the health plan purchasing cooperative within each market

type. The proposal shall be developed and certified by a qualified actuary. Any risk adjustment mechanism shall be based on valid data from participating carriers and shall utilize factors actuarially related to risk.

- (11) The health insurance purchasing cooperative shall keep all documentation pertaining to choice of benefits, materials used to instruct members of such choices, premium tables and other rating disclosures, and any rating mechanism developed in conjunction with participating carriers, for review by the Commissioner upon request. Such documentation must include rating materials demonstrating compliance with this Rule.
- (12) Upon application and renewal for its certificate of authority, a health plan purchasing cooperative shall provide a certification by a responsible officer of the health plan purchasing cooperative as to compliance with the rating provisions of this Rule. Such certification shall include documentary evidence or certifications from participating carriers that such carriers are also complying with the provisions of this Rule as they apply to small employer members. Additionally, the certification submitted by the health plan purchasing cooperative shall designate whether the health plan purchasing cooperative complies, in its arrangements with participating carriers, with either subparagraph (1)(a) or (1)(b) of this Rule as they apply to small employer members, and shall designate the method of compliance with paragraphs (2) and (3) of this Rule as they apply to members of other market types (if applicable). A health plan purchasing cooperative subject to paragraph (5) of this Rule shall amend its certification as appropriate pursuant to its proposal upon application, and shall certify continued compliance with its originally approved rating proposal upon renewal.

Authority-O.C.G.A. §33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.18 Contribution and Participation Rules

- (1) A health plan purchasing cooperative may set contribution rules for members in each market type served by the cooperative, which require a minimum percentage of premium contribution from each member for each eligible employee or dependent. A health plan purchasing cooperative may set separate minimum contribution rules for employees and dependents.
- (2) A health plan purchasing cooperative may set minimum employee participation rules for members of each market type served by the cooperative, and shall consistently require such minimum participation levels for members of each market type. In any case, the minimum participation rule for small employers shall meet the requirements of Rule 120-2-10-.12(9).

Authority-O.C.G.A. §33-2-9 and 33-30A-9.

120-2-79-.19 Contracts with Members and Participating Carriers

- (1) Contracts or written service agreements between the health plan purchasing cooperative and a participating carrier shall:
 - (a) Establish, on a consistent and uniform basis, a policyholder, which shall be either the health plan purchasing cooperative or each of its members;

- (b) Provide that the participating carrier will issue a certificate of coverage, or equivalent document, specifying the essential features of coverage under the health benefit plan to each enrolled employee; and
 - (c) Specify how all premiums will be transmitted, applicable penalties and grace periods for payments, and underwriting criteria or other standards pertaining to the business underwritten by such carrier in the health plan purchasing cooperative.
- (2) On a consistent basis for all members, contracts between the health plan purchasing cooperative and a member shall:
- (a) For administrative purposes, establish, on a uniform basis for each market type, either the health plan purchasing cooperative, in trust, or the member as the policyholder of the health benefit plan on behalf of eligible employees and dependents;
 - (b) Provide that the participating carrier will issue a certificate of coverage, or equivalent document, specifying the essential features of coverage under the health benefit plan to each enrolled eligible employee;
 - (c) Provide that the member must establish an employer-sponsored health benefit arrangement for its employees (or, in the case of an individual member, obtain coverage for himself or herself) only through health benefit plans offered by the health plan purchasing cooperative;
 - (d) Establish applicable penalties and grace periods for a member to make premium payments to the health plan purchasing cooperative, guidelines on how all premiums will be transmitted, and standards for the collection of membership or administrative fees for the operation of the health plan purchasing cooperative; and
 - (e) Describe the terms of membership and renewal of membership and coverage under a health benefit plan.
- (3) A health plan purchasing cooperative shall file with the Commissioner for approval a sample of each type of contract proposed for use with members and carriers.
- (4) Participating carriers shall file with the Commissioner for approval any contract or policy of insurance to be delivered to a health plan purchasing cooperative or its members as a health benefit plan or as an additional insurance benefit, unless such policy has previously been approved by the Commissioner for use. Any amendments, riders, or exclusions added to a previously approved policy or contract applicable to health plan purchasing cooperative members shall be filed for approval.

Authority-O.C.G.A. §33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.20 Renewability; Termination of Agreement

- (1) For purposes of renewability, health plan purchasing cooperatives, members, and participating carriers shall be subject to Rule 120-2-67-.09 with regard to renewability and non-termination of coverage, and coverage under a health plan purchasing cooperative shall be considered coverage under a true association for such purposes. In particular:
 - (a) With respect to Rule 120-2-67-.09, the health plan purchasing cooperative shall be considered the policyholder;
 - (b) The written agreement or contract between the health plan purchasing cooperative and participating carriers shall specify the terms of renewal and shall define the date of renewal; and
 - (c) The health plan purchasing cooperative is responsible for assuring continuity and renewal of coverage for members under Rule 120-2-67-.09 in the event a participating insurer no longer participates in a health plan purchasing cooperative, and shall not exclude a member from coverage under any health benefit plan at any time.
- (2) A member of a health plan purchasing cooperative may have its coverage under a health benefit plan nonrenewed, canceled, or terminated pursuant to the written agreement or contract between the health plan purchasing cooperative and a participating carrier, only if:
 - (a) the member has failed to pay premiums, contributions, membership or administrative fees, as applicable, in accordance with the terms of membership or the health benefit plan, including any timeliness requirements, subject to applicable State law;
 - (b) The member has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of membership or the health benefit plan;
 - (c) The member has violated the applicable minimum contribution or participation rules as set by the health plan purchasing cooperative, provided that the health plan purchasing cooperative or participating carrier submits written notice to each affected member and provides such member sixty (60) days in which to bring the member into compliance prior to cancellation; or
 - (d) None of the member's employees or enrollees live, reside, or work in the service area of the provider network, only if the health benefit plan is issued by a health maintenance organization or a provider-sponsored health care corporation, unless there is at least one insured employee or enrollee who has agreed to return to the service area of a health maintenance organization in accordance with the Rule 120-2-33-.06(5).

- (3) If a health plan purchasing cooperative, because of insolvency or nonrenewal, suspension, or revocation of its certificate of authority, fails to continue to make coverage available to member small employers through participating carriers, all participating carriers at the time of such failure shall, subject to guidelines established by the Commissioner for the assumption, rehabilitation, or liquidation of the particular health plan purchasing cooperative, or in any decision to revoke or suspend the certificate of authority, do one of the following:
 - (a) In the event of a health plan purchasing cooperative which allowed employer choice, continue covering and renewing each member as a policyholder pursuant to Rule 120-2-67-.09; or
 - (b) In the event of a health plan purchasing cooperative which allowed employee choice, not discontinue coverage until the renewal date that otherwise would have applied to the health plan purchasing cooperative or to each member, and then
 - (1) With regard to every small employer member, offer the option to purchase all group policies currently being offered to or renewed by small employers in this State;
 - (2) With regard to every large employer member, offer the option to purchase any other group policy from the carrier currently being offered to or renewed by a large employer in this State; or
 - (3) With regard to every individual member pursuant to O.C.G.A. §33-30A-4(4), offer the option to purchase any other individual policy most similar to the group policy under which the individual was covered, or any other similar group policy currently being offered to or renewed by small employers in this State.
- (4) With regard to compliance with subparagraph (3)(b), a participating carrier which is a health maintenance organization or provider-sponsored health care corporation shall not be required to offer coverage to a member without any employees who live, work, or reside in the service area of the carrier, or offer coverage to an individual member who does not live, work, or reside in the service area of the carrier.
- (5) In the event the participating carrier completes its obligation to issue a health benefit plan under the terms of an agreement with a health plan purchasing cooperative which opts not to renew the agreement, the participating carrier shall:
 - (a) Provide notice of the decision at least 180 days prior to the nonrenewal of any health benefit plan (or the first nonrenewal of any member under such health benefit plan) to the members and enrollees;
 - (b) Not terminate coverage prior to the renewal date of the health benefit plan, or the renewal date of any member covered under the health benefit plan provided that such renewal date is at least 180 days after the date of notice stipulated in subparagraph (5)(a) of this Rule; and

- (c) Be prohibited from writing new business through the health plan purchasing cooperative consistent with the Portability and Renewability requirements in the federal Health Insurance Portability and Accountability Act of 1996 and applicable laws and Rules and Regulations of the State of Georgia.
- (5) Upon such time as notice is sent by a carrier in accordance with subparagraph (5)(a) of this Rule, the health plan purchasing cooperative shall make available through all other participating carriers any other coverage to affected members and enrollees to assure continuity of coverage within the health plan purchasing cooperative.
- (6) Subject to paragraphs (3) and (4), no health plan purchasing cooperative shall have the unilateral authority to move the coverage of a member group to a new carrier.
- (7) Any individual in this state, insured through a health benefit plan offered by a health plan purchasing cooperative and whose coverage under such plan terminates as a result of termination of employment or cessation of membership or the employer's membership in the health plan purchasing cooperative without replacement group coverage, regardless of the situs of the group policy, shall be entitled to continuation and conversion rights as required under O.C.G.A. §33-24-21.1, Rules 120-2-10-.11 and 120-2-10-.11A, and under the federal Consolidated Omnibus Budget Reconciliation Act of 1986.
- (8) Where a health benefit plan is discontinued and replaced, the individual carriers shall be entitled to all takeover rights provided under Rule 120-2-10-.10.

Authority-O.C.G.A. §33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.21 Examination by Commissioner; On-Site Visits

- (1) A health plan purchasing cooperative shall, at the request of the Commissioner, respond in writing within fifteen (15) working days to any complaint received by the Commissioner concerning the health plan purchasing cooperative. If, in the Commissioner's discretion, the frequency or severity of such complaints or infractions justify an examination of the health plan purchasing cooperative's practices and procedures, any such examination by the Commissioner, or any person designated by the Commissioner, shall be at the expense of the health plan purchasing cooperative. In addition to any other remedy available to the Commissioner, failure by the health plan purchasing cooperative to willingly and fully cooperate with this rule may result in either suspension, revocation or refusal to renew a certificate of authority by the Commissioner.
- (2) The Commissioner or his or her designated representative is authorized to make a complete on-site examination of the affairs of each health plan purchasing cooperative as often as is deemed necessary. Whenever the Commissioner shall deem it expedient, he or she shall examine, by use of an examiner duly authorized by him or her, the affairs, transactions, accounts, records, documents, assets, liabilities, of a health plan purchasing cooperative and any other facts relative to its business methods, management, and dealings with policyholders, certificate holders, and members.

- (3) Any health plan purchasing cooperative being examined shall provide to the Commissioner or his or her designee convenient and free access, at all reasonable hours at their offices, to all books, records, documents and other papers relating to the health plan purchasing cooperative's business affairs.
- (4) At the direction of the Commissioner, the health plan purchasing cooperative shall pay the fees and expenses of the examination. The examiner shall file a consolidated account for the examination with the Commissioner.
- (5) Nothing in this Rule shall limit or abridge any other investigatory powers of the Commissioner vested in him or her by Title 33 of the Official Code of Georgia.

Authority-O.C.G.A. §§33-2-9, 33-30A-5 and 33-30A-9.

120-2-79-.22 Penalties.

Any health plan purchasing cooperative, carrier, agent, representative, officer or employee of such carrier, failing to comply with the requirements of this Regulation Chapter shall be subject to such penalties as may be appropriate under the insurance laws of this State.

Authority---O.C.G.A. §33-2-9.

120-2-79-.23 Severability

If any rule or portion of a Rule in this chapter or the applicability thereof to any particular circumstances is held invalid by a court of competent jurisdiction, the remainder of the Rules or the applicability of such provision to other persons or circumstances shall not be affected.

Authority-O.C.G.A. §33-2-9, 33-30A-5 and 33-30A-9.