



NOTICE OF PUBLIC HEARING

PLEASE TAKE NOTICE THAT on March 24, 2010, at 11:00 a.m., in the Board Room at the Department of Community Health, #2 Peachtree Street, 5th Floor, Atlanta, Georgia, a public hearing will be held for the presentation of proposed administrative rule changes.

The chapter affected by the proposed changes of administrative rules & regulations is listed below:

Ga. Admin. Comp. Ch. 111-4-1; State Health Benefit Plan

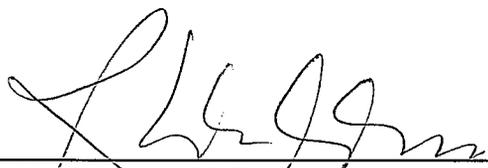
- 111-4-1-.01 *Definitions*
- 111-4-1-.02 *Organizations*
- 111-4-1-.10 *Plan Benefits*
- 111-4-1-.11 *Claims*

All interested persons are hereby given the opportunity to participate by submitting data, views or arguments (orally or in writing). Oral comments may be limited to 10 minutes per person. If you need auxiliary aids or services because of a disability, please contact the Office of General Counsel at (404) 657-7195 at least (3) three business days prior to the hearing.

Written comments must be submitted to the Department or postmarked no later than the close of business at 5:00 p.m. on March 25, 2010. Comments may be faxed to (404) 656-0663, emailed to pjohnson@dch.ga.gov or mailed to the address above, attention Office of General Counsel.

Unless revision of the proposed rule changes is indicated as a result of the public comments, it is the intent of the Department of Community Health to ask the Board of Community Health to approve the rule(s) as promulgated herein for final adoption on April 8, 2010.

This 16th day of February, 2010.



Rhonda M. Medows, M.D.

RMM:pmj

Attachments

**Rule 111-4-1-.01
Definitions**

SYNOPSIS

The purpose of the rule change is to avoid conflicts with federal law, reflect changes in state law, and modify definitions to reflect changes to Rule 111-4-1-.02, Organizations, and Rule 111-4-1-.10, Plan Benefits.

EXPLANATION OF CHANGES

Rule 111-4-1-.01 (10) "Board of Community Health" or "Board" and Rule 111-4-1-.01(15) "Commissioner" have been modified to include the appropriate citations to O.C.G.A. Sections 31-2-3 and 4, respectively. These Code Sections were renumbered when the Department of Community Health was re-established to include the Public Health Division.

Rule 111-4-1-.01 (26) "Employing Entity" has been modified to include Contract Employers, and thereby clarify that certain obligations imposed on Employing Entities are also imposed by law on Contract Employers.

Rule 111-4-1-.01 (36) "Medicare Advantage" has been modified to refer to relevant federal law, and to eliminate language that may conflict with that law.

Rule 111-4-1-.01 (38) "Option" has been modified to eliminate references to specific plan design terms.

Rule 111-4-1-.01(45) "Pre-Existing Condition" has been modified to clarify that the definition of "Pre-Existing Condition" is established by federal law, and to eliminate language that may conflict with that law.

Rule 111-4-1-.01(50) "Regular Insurance" has been modified to reflect that different requirements apply to Medicare Advantage Options, and to define "Regular Insurance" as SHBP Options that are not Medicare Advantage Options. Formerly, "Regular Insurance" listed specific terms, such as "PPO" and "HMO," which have many different meanings in the industry.

111-4-1-.01 Definitions.

- (1) **"Accredited School"** for the purpose of determining eligibility under these regulations means any one of the following types of schools:
 - (a) Any secondary educational or secondary institution with postsecondary programs accredited or pre-accredited by accrediting associations that are recognized by the United States Secretary of Education; or
 - (b) Any professional, technical, occupational and specialized school accredited or pre-accredited by national specialized accrediting agencies recognized by the United States Secretary of Education; or
 - (c) Any specialty or other school administered by the Department of Education or Post Secondary Vocational Board of the State of Georgia; or
 - (d) Any school that has applied for or is a "candidate for" accreditation under Sections 111-4-1-.01 (1)(a) or 111-4-1-.01 (1)(b) of these regulations; or
 - (e) Any institution of higher education as defined by the Higher Education Act of 1965 (20 USCS 1141).
- (2) **"Active"** means that the Employee is receiving compensation or is on Approved Leave of Absence Without Pay through a department, school system, Local Employer, agency, authority, board, commission, county department of family and children services, county department of health, community service board, or Contract Employer and for whom the Employee's cost of Coverage is stated as a payroll Deduction or Reduction.
- (3) **"Acts"** or **"The Acts"** or **"The Health Insurance Acts"** mean the legislative Acts that establish the Health Insurance Plans for State Employees, Teachers, and Public School Employees and are designated in the Official Code of Georgia Annotated as Article 1 of Chapter 18 of Title 45 and Articles 880 and 910 of Chapter 2 of Title 20.
- (4) **"Administrator"** means the Department of Community Health or the Commissioner of the Department of Community Health.
- (5) **"Administrative Services"** means the services that are provided by contract for a self-insured Health Benefit Plan.
- (6) **"Approved Leave of Absence Without Pay"** means a period of time approved by the appropriate organizational official during which the Employee is absent from work and is not in pay status.
- (7) **"Annual Required Contribution"** means an actuarially determined amount to pay for future OPEB liability over a period of years.
- (8) **"Beneficiary"** means an Employee, Surviving Spouse, divorced or legally separated Spouse, or eligible Dependent child who loses Coverage under these regulations.
- (9) **"Benefits"** mean the schedule of Benefits of health care services eligible for approval of payments under the Options approved by the Board.

(10) **“Board of Community Health”** or **“Board”** means the governing body authorized to exercise jurisdiction over the SHBP pursuant to O.C.G.A. §§ 31-5A-2-3 and 31-5A-4.

(11) **“Cafeteria Plan”** means a plan which meets the requirements of the regulations of the Internal Revenue Service under Internal Revenue Code (IRC) 125.

(12) **“Certificated Capacity”** means the Employee holds valid certification; is not assigned to a position that requires certification as a qualification; the Employee’s compensation is determined, at least in part, based upon the certificate; and the Employee is a member of the Teachers Retirement System or other Public School Teacher retirement system.

(13) **“Certificated Position”** means the Employee holds valid certification; is assigned to a position that requires certification as a qualification; the Employee’s compensation is determined, at least in part, based upon the certificate; and the Employee is a member of the Teachers Retirement System or other Public School Teachers retirement system.

(14) **“Claim”** means any bill, invoice, or other written statement from a specific provider for health care services or supplies submitted in accordance with the requirements of the SHBP for a specific eligible Member.

(15) **“Commissioner”** means the Commissioner of the Department of Community Health as created by O.C.G.A. § 31-25A-6.

(16) **“Contract Employee”** means a person employed by one of the entities that contracts with the Board of Community Health to provide health benefit Coverage under the SHBP, and who is not considered to be an independent contractor.

(17) **“Contract Employer”** means one of the organizational entities that has elected to contract with the Board of Community Health for inclusion of their Employees in the SHBP.

(18) **“Contribution”** means the amount or percentage of salaries to be paid by an Employing Entity or State Department of Education for Employees and Retirees for health benefit Coverage.

(19) **“Coverage”** means the type, Tier, and Option of contract offered to a Enrolled Member.

(20) **“Covered Dependent”** means any individual eligible under these regulations and for whom the Premium has been paid by the Employee, Retiree, or Extended Beneficiary.

(21) **“Creditable Coverage”** means health insurance that may serve to reduce a Pre-existing Condition limitation period. Creditable Coverage shall include health plan offerings under the following type plans: group health plans; individual health policies; Health Maintenance Organizations (HMOs); Medicaid; Medicare; or other governmental health programs. Disease specific policies (i.e., cancer insurance), disability insurance, and insurance that provides incidental health insurance (i.e., auto insurance) is not Creditable Coverage.

(22) **“Deduction”** or **“Reduction”** means the Premium amount to be remitted to the Administrator as the Employee’s or Retiree’s share of the cost of the elected Coverage.

(23) **“Dependent”** means any eligible Spouse, Dependent child, full-time student, or totally disabled child or other child(ren) if the children live with the Member permanently and are legally dependent on the Member for financial support.

(24) **“Disabled Student”** means a full-time student who withdraws from all or part of coursework because of an illness or injury provided the student will be registered to return to full-time status during the succeeding quarter or semester (or the Fall quarter if the Summer quarter is the succeeding quarter). The Administrator has the discretion to determine, based on the record, that a child is a full-time student when there is documentation that the registered hours are less than the normal institution’s full-time requirements during periods of full-time status or period of disability.

(25) **“Employee”** means any eligible, Active State Employee, Teacher, or Public School Employee.

(26) **“Employing Entity”** means any department, school system, Local Employer, Contract Employer, agency, authority, board, commission, county department of family and children services, county department of health, community service board or retirement system that employs or issues an annuity check to an Employee, Contract Employee or Retiree as defined in these regulations.

(27) **“Enrolled Member”** means the contract holder who may be the Employee, Retiree, Contract Employee, or Extended Beneficiary who is currently enrolled in Coverage and who has paid the necessary Deduction or Premium for such Coverage.

(28) **“Extended Beneficiary”** means the individual who was covered as an Active or Retired Employee, Employee on Approved Leave of Absence Without Pay or person who was covered as a Spouse or eligible Dependent of an Active or Retired Employee or Employee on Approved Leave of Absence Without Pay on the day SHBP Coverage was lost as a result of a Qualifying Event under the requirements of federal law and regulation known as the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended.

(29) **“Full-time Attendance”** means that the full-time student is registered for the minimum number of hours required to meet that Accredited School’s full-time status. A withdrawal from some coursework that reduces the number of hours to less than full-time during the school’s summer break will not affect Full-Time Attendance provided the student will be registered to return to full-time status during the Fall or semester. Full-Time Attendance ends at the end of the month in which coursework is completed or if the student ceases attendance.

(30) **“Fund”** or **“Health Benefit Fund”** or **“Health Insurance Fund”** means the State Employees Health Insurance Fund, the Teachers Health Insurance Fund, and the Public School Employees Health Insurance Fund.

(31) **“Georgia Retiree Health Benefit Fund”** or **“GRHBF”** means the fund which provides for costs of retiree post employment health insurance benefits. The fund shall be a trust fund of public funds; the Board in its official capacity shall be the fund’s trustee; and the Commissioner in his or her official capacity shall be its administrator.

(32) **“Group”** means all eligible Employees authorized under a specific chapter, article or part of the Official Code of Georgia Annotated for Coverage under the SHBP.

(33) **“Health Maintenance Organization”** or **“HMO”** means an organization authorized and certified to provide services under Chapter 21 of Title 33 of the Official Code of Georgia Annotated.

(34) **“Local Employer”** means a county or independent board of education, regional or county libraries of Georgia, the governing authority of the Georgia Military College, or Regional Educational Service Areas.

(35) **“Managed Care Plan”** means plans that provide health Coverage through a specified network of providers with benefit differentials in cost sharing between in-network and out-of-network providers.

(36) **“Medicare Advantage”** means ~~an the managed care Option that is offered to Retirees through an HMO or other legally licensed organization and that and is approved through the Centers for Medicare and Medicaid Services (CMS) as a Medicare Advantage plan under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and federal regulations thereunder for Medicare enrolled Retirees.~~

(37) **“Member”** means a benefit eligible or ineligible Employee, former Employee, Retiree, or Extended Beneficiary.

(38) **“Option”** means ~~a the type of benefit schedule or premium rating category that is offered to an eligible Member through Regular Insurance, an HMO, supplement, or other health benefit offering of the SHBP.~~

(39) **“Other Post Employment Benefits”** or **“OPEB”** means retiree post-employment health insurance benefits.

(40) **“Partial Disability”** means the Employee is unable to perform the normal, full-time duties of the individual’s occupation or employment due to disability, but is certified by his/her physician to return to work on a part-time basis following a period of disability for a fixed period of time in that individual’s occupation or in a modified work capacity.

(41) **“Payor, Primary”** means the entity which is required by contract or law to reimburse or pay for covered health services without regard to any other benefit entitlement or contractual provision.

(42) **“Payor, Secondary”** means the entity which does not have the primary liability for providing benefit reimbursement for covered health services.

(43) **“Plan”** or **“Health Insurance Plan”** means the insurance Options formed by the combination of Health Insurance Plans for State Employees, Teachers, and Public School Employees.

(44) **“Plan Year”** means the twelve-month period beginning on January 1, and ending on the following December 31. The Commissioner shall have the flexibility to modify the SHBP Plan Year.

(45) **“Pre-existing Condition”** is a term defined by the Health Insurance Portability and Accountability Act of 1996 and regulations thereunder. In general, it means a sickness, injury, or other condition (except for pregnancy) for which medical advice,

diagnosis, care or treatment was recommended or received within the six (6) months immediately before Coverage began under the Plan. ~~Genetic status is not a Pre-existing Condition unless diagnosis, care or treatment was rendered within the six-month period. (Health Insurance Portability and Accountability Act of 1996).~~

(46) **“Premium”** means the Enrolled Member’s cost as set by the Board of Community Health for the elected Coverage

(47) **“Public School Employee”** means a person who is employed by the local school system, meets the eligibility requirements under these regulations and is receiving a salary for services.

(48) **“Qualifying Event”** means an event as defined by federal law or regulation that authorizes: (a) eligibility for Extended Coverage or (b) change in coverage election under a health benefit plan. Qualifying Events include changes in employment or family status as outlined in Sections 111-4-1-.06, 111-4-1-.07, and 111-4-1-.08 of these regulations.

(49) **“Rate”** means an amount set by the Board for the Enrolled Member Premium or an amount or percentage of salary set by the Board as the Employer’s Contribution.

(50) **“Regular Insurance”** means the self-insured Options that are not Medicare Advantage Options. ~~“PPO”, “PPO Choice, and “Indemnity”~~.

(51) **“Retired Employee”** or **“Retiree”** or **“Annuitant”** means a former State Employee, former Teacher, or former Public School Employee who met the eligibility criteria when Active or was included by specific legislation and who receives a monthly benefit from the Employees’ Retirement System, Georgia Legislative Retirement System, Teachers Retirement System, Public School Employees Retirement System, Superior Court Judges Retirement System, District Attorneys’ Retirement System, or local school system retirement system and an eligible and former Employee of a county department of family and children services or county department of health who receives a monthly benefit from the Fulton County Retirement System. In the case of a county health department Employee, the Employee must have been covered as an Active Enrolled Member and continued Coverage upon receiving an annuity from the Fulton County Retirement System. Retiree shall also include Enrolled Members who remit payment directly to the SHBP and who are eligible for Coverage as a Surviving Spouse of the eligible Employee or Retiree, and Extended Beneficiary who is eligible by virtue of State law, or an Annuitant whose monthly benefit from a retirement system is insufficient to pay the Premium for the Coverage in which enrolled.

(52) **“Retiring Employee”** means a Enrolled Member who is eligible to receive an immediate retirement benefit payment from the Employees’ Retirement System, Georgia Legislative Retirement System, Teachers Retirement System, Public School Employees Retirement System, Superior Court Judges Retirement System, District Attorneys’ Retirement System or local school system retirement system or an Enrolled Member of a county department of family and children services or county department of health who is eligible to receive an immediate retirement benefit payment from the Fulton County Retirement System.

(53) **“Spouse”** means an individual who is not legally separated, who is of the opposite sex to the Enrolled Member and who is legally married or who submits satisfactory evidence to the Administrator of common law marriage to the Employee or Retired Employee entered into prior to January 1, 1997 and is not legally separated.

(54) **“State Employee”** means a person employed by the State or a community service board and who meets the eligibility definitions of these regulations and who is receiving a salary or wage for services rendered.

(55) **“State Health Benefit Plan”** or **“SHBP”** means the health benefit plan administered by the Department of Community Health covering State Employees, Public School Teachers, Public School Employees, Retirees and their eligible Dependents, and other entities under The Acts for health insurance.

(56) **“Summary Plan Description”** is a booklet that describes the health benefits and other provisions of the State Health Benefit Plan (SHBP) specific to the Coverage elected by the Enrolled Member.

(57) **“Surviving Spouse”** means the living Spouse of a deceased Enrolled Member.

(58) **“Teacher”** or **“Public School Teacher”** means a person employed by a local school system in a Certificated Position and who meets the eligibility definitions of these regulations and who is receiving a salary or wage for services rendered.

(59) **“Tier”** means the number and relationship to the Enrolled Member of the persons enrolled under the Member’s Coverage.

(60) **“Total Disability”** means that the Enrolled Member is not able to perform any and every duty of the individual’s occupation or employment or that the Dependent is not able to perform the normal activities of a person of like age or sex.

(61) **“TPA”** or **“Third-party Administrator”** means an approved contractor for adjudicating paying Claims, and performing other administrative processes.

Authority: O.C.G.A. §§ 20-2-881, 20-2-892, 20-2-911, 45-18-2, Health Insurance Portability and Accountability Act of 1996 (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA).

**Rule 111-4-1-.02
Organizations**

SYNOPSIS

The purpose of the rule change is to revise descriptions of employer contributions to better reflect the direct billing process, to clarify that the SHBP shall be administered in accordance with federal law, to eliminate references to specific plan design terms, to clarify certain obligations of Employing Entities, and to clarify that any penalties or expenses arising from an Employing Entity's failure to meet those obligations may be assessed against the Employing Entity.

EXPLANATION OF CHANGES

Rule 111-4-1-.02(1)(d) has been modified to revise the description of how Employer Contribution rates are expressed in order to comply with current law and expected direct billing implementation.

Rule 111-4-1-.02(1)(e) has been modified to eliminate references to specific plan design terms that may have several different meanings in the industry.

Rule 111-4-1-.02(1)(e)(3) has been modified to correct a typographical error.

Rule 111-4-1-.01(1)(j) has been modified to refer to federal law and eliminate language that may conflict with that law.

Rule 111-4-1-.02(2)(a) has been modified to clarify that the Commissioner shall administer the SHBP in accordance with all applicable law, not just Board regulation and policy.

Rule 111-4-1-.02(2)(e) has been modified to clarify that the Board sets several Employer Contribution Rates, not one "average" Employer Contribution Rate. In addition, it has been modified to provide additional flexibility for the calculation of contributions while still ensuring that the Commissioner is able to notify Employing Entities of Employer Contribution rates by the deadline set forth in O.C.G.A. Section 45-18-16.

Rule 111-4-1-.02(2)(h) has been modified to comply with the change to the deadline in O.C.G.A. Section 45-18-16 that was enacted in 2006.

Rule 111-4-1-.02(3)(a) has been modified to clarify that Employing Entities are responsible for determining whether their employees are eligible for coverage. It has also been modified to clarify that the SHBP may assess relevant penalties and claims expenses against an Employing Entity that fails to properly enroll or disenroll its employees. This modification is timely due to recent changes in reporting obligations and enforcement procedures related to the Medicare Secondary Payer Act. The accuracy of information provided by Employing Entities is essential to the proper coordination of benefits with Medicare.

Rule 111-4-1-.02(3)(d) has been modified for clarity.

Rule 111-4-1-.02(3)(f) has been modified to add Military Leave as a type of approved leave of absence, to clarify that Employing Entities are responsible for complying with all applicable laws relating to leaves of absence, and to clarify that an Enrolled Member's failure to pay premiums during a leave of absence results in termination of coverage unless federal law provides otherwise. This modification is timely due to changes in federal law under the National Defense Authorization Act of 2010.

Rule 111-4-1-.02(3)(g) has been modified to clarify that Employing Entities must notify the SHBP when a member loses eligibility for coverage by failing to pay a required Premium while on leave without pay

Rule 111-4-1-.02(3)(h) has been added. This new section clarifies that the SHBP provides enrollment information only to designated employees of the Employing Entities, and clarifies the Employing Entities' responsibility to protect this information. This clarification is timely due to new obligations arising under the expansion of privacy and security obligations under the American Recovery and Reinvestment Act of 2009.

111-4-1-.02 Organizations.

(1) Functions, Duties and Responsibilities of the Board of Community Health.

The Board shall provide policy direction for the operation of the State Health Benefit Plan. Other responsibilities as defined by law are:

(a) **Establish and Design Plan.** The Board is authorized to establish a Health Insurance Plan for group medical insurance against the financial costs of hospitalizations and medical care. The Plan may also include, but is not required to include, prescription drugs, prosthetic appliances, hospital inpatient and outpatient Benefits, dental Benefits, vision care Benefits, and other types of medical Benefits. The Plan shall be designed to:

1. Provide reasonable hospital, surgical, and medical benefits with cost sharing of expenses for each such type to be incurred by the Enrolled Members, Dependents and the Plan;

2. Include reasonable controls, which may include deductible and reinsurance provisions applicable to some or all of the benefits, to reduce unnecessary utilization of the various hospital, surgical and medical services to be provided and to provide reasonable assurance of financial stability in future years of the Plan; and

(b) **Promulgate Regulations.** The Board is authorized to adopt and promulgate rules and regulations for the effective administration of the SHBP; to adopt and promulgate regulations for defining the contract(s) for Retiring Employees and their Spouses and Dependent children; to adopt and promulgate regulations for prescribing the conditions under which an Employee or Retiring Employee may elect to participate in or withdraw from the SHBP; to adopt and promulgate regulations defining the conditions for covering the eligible Member's Spouse and Dependent children and for discontinuance and resumption by eligible Members of Coverage for the Spouse, Surviving Spouse, and Dependents; to adopt and promulgate regulations to establish and define terms and conditions for former and terminated eligible Member participation; adopt and promulgate rules and regulations which define the conditions under which eligible Members who originally rejected Coverage may acquire Coverage at a later date; and adopt and promulgate rules and regulations for withdrawing from the SHBP upon eligibility for the aged program of the Social Security Administration. Additionally, the Plan shall be required to establish the same eligibility requirements, unless either State or federal law, or regulations promulgated by the State of Georgia's Insurance Commissioner requires a modification.

(c) **Establish Member Premium Rates.** The Board shall establish Member Premium Rates for each Coverage Option. The Board shall consider the actuarial estimate of the SHBP costs and the funds appropriated to the various departments, boards, agencies, and school systems in establishing the Employee Deduction amount. Other Member Premium amounts shall be established in accordance with these regulations. All Enrolled Member Premium Rates shall be established by resolution and shall remain in effect until changed by resolution.

1. **Tobacco Surcharge.** An Enrolled Member may be charged a tobacco surcharge in an amount approved by the Board if either the Enrolled Member or any of his or her Covered Dependents have used tobacco products in the previous twelve (12) months. The surcharge amount will be added to the Enrolled Member's base monthly Premium. Any Enrolled Member who fails to answer any designated question(s) relating to the surcharge during Open Enrollment will automatically be charged a surcharge for the

remainder of the Plan Year, unless the tobacco user successfully completes a tobacco cessation program, or other similar program, specifically designated by the SHBP.

2. Spousal Surcharge. An Enrolled Member may be charged a spousal surcharge in an amount approved by the Board if the Enrolled Member elects to cover his or her Spouse and the Spouse is eligible for health benefits through his or her employer but opts not to take those benefits. Notwithstanding the foregoing, if the Spouse is already eligible for Coverage with the SHBP through his or her employment, and the Spouse answered the surcharge question(s) on-line, the SHBP will not add the surcharge to the Premium amount. Any Enrolled Member who fails to answer any designated question(s) relating to the surcharge during Open Enrollment will automatically be charged the surcharge for the remainder of the Plan Year.

(d) Establish Employer Rates. The Board shall establish by Resolution, subject to the Governor's approval, Employer Contribution Rates. These rates may be a dollar amount for each Member, a dollar amount for each Enrolled Member, a percentage of Member salary or any other method permitted by law. If the rates are expressed as a percentage of Member salary, the requirements of (3) and (4) below apply. The Commissioner is authorized to establish necessary procedures to facilitate the receipt of Employer Contributions on a timely and accurate basis.

1. The Employer Contribution Rate for Teachers who retired prior to January 1, 1979 shall ~~may~~ be a dollar amount as identified in the Appropriations Act.

2. The State Department of Education Employer Contribution Rate for the Public School Employee Health Insurance Fund shall ~~may~~ be a dollar amount as identified in the Appropriations Act.

3. The local school system Employer Contribution Rate for the Public School Employee Health Insurance Fund shall ~~may~~ be a dollar amount per Enrolled Member and shall be remitted to the Administrator on a monthly basis. The Employer's Contribution amount shall be due to the Administrator on the first of the month coincident with the Employees' monthly Premium amounts. ~~The Commissioner is authorized to establish necessary procedures to implement the receipt of the Employer Contribution on a timely and accurate basis.~~

4. The Employer Contribution Rate for the Teachers Health Insurance Fund ~~may~~ shall be a percentage of the salary approved by the State Board of Education under the Quality Basic Education Act for persons holding "Certificated Positions" or in a "Certificated Capacity". If it is expressed as a percentage of salary, the monthly Employer Contribution shall be a percentage of state based salaries. County or district libraries shall pay as the Employer Contribution the Board approved percentage of total salaries, exclusive of per diem and casual labor, which is defined as part-time Employees who work less than seventeen and a half (17 ½) hours per week. The Employer's contribution amount shall be due to the Administrator on the date coincident with the Employees' monthly Premium amounts. ~~The Commissioner is authorized to establish necessary procedures to implement the receipt of the Employer Contribution on a timely and accurate basis.~~

5. The Employer Contribution Rate for the State Employees Health Insurance Fund shall ~~may~~ be a percentage of the total salaries of all Members. Total salaries include temporary salaries, overtime pay, terminal leave pay, and all types of supplemental pay. If it is expressed as a percentage of salary, the monthly Employer Contribution shall

be based on salaries for the previous month and shall be due on the date coincident with the Employees' monthly Premium amounts. ~~The Commissioner is authorized to establish necessary procedures to facilitate the receipt of the Employer Contribution on a timely and accurate basis.~~

(e) **Approve Contracts.** The Board is authorized to approve contracts for insurance, reinsurance, health services, and administrative services for the operation of the Plan. ~~The Board shall also approve contracts to include HMOs and Consumer Driven Health Plans ("CDHP") as an alternative to Regular Insurance and~~ The Board is authorized to approve contracts as authorized by law with governments, authorities, or other organizations for inclusion in the Plan.

1. **Insurance.** The Board may execute a contract or contracts to provide the Benefits under the Plan. Such contract or contracts may be executed with one or more corporations licensed to transact accident and health insurance business in Georgia. The Board shall invite proposals from qualified insurers who, in the opinion of the Board, would desire to accept any part of the health benefit Coverage. Any contracts that the Board executes with insurers shall require compliance with O.C.G.A. § 10-1-393 (b)(30.1) relating to certain unfair practices in consumer transactions. The Board may reinsure portions of a contract for the Plan. At the end of any contract year, the Board may discontinue any contract or contracts it has executed with any corporation or corporations and substitute a contract or contracts with any other corporation or corporations licensed to transact accident and health insurance business in Georgia.

2. **Self Insurance.** The Board in its discretion may establish a self-insured Plan in whole or in part. The contract for Administrative Services in connection with a self-insured health benefit plan may be executed with an insurer authorized to transact accident and sickness insurance in Georgia; with a hospital service nonprofit corporation, nonprofit medical service corporation, or health care corporation; with a professional claim Administrator authorized or licensed to transact business in Georgia; or with an independent adjusting firm with Employees who are licensed as independent adjusters pursuant to Article 2 of Chapter 23 of Title 33.

3. **Local Governments.** The Board is authorized to contract with the various counties of Georgia, the County Officers Association of Georgia, the Georgia Cooperative Services for the Blind, public and private nonprofit sheltered employment centers which contract with or employ persons within the Division of Rehabilitation Services and the Division of Mental Health and Mental Retardation of the Department of Human Resources; and to contract with the Georgia Development Authority, the Georgia Agrirama Development Authority, the Peace Officer's Annuity and Benefit Fund, the Georgia Firefighters' Pension Fund, the Sheriffs' Retirement Fund of Georgia, the Georgia Housing and Financing Authority, the Georgia-Federal State Inspection Service for the inclusion of eligible Members, retiring Enrolled Members and Dependents in the SHBP. The Board is further authorized to include the Georgia-Federal State Inspection Service Employees who retired under the Employees' Retirement System of Georgia on or before July 1, 2000. Each Contract Employer shall deduct from the Enrolled Members salary the Member's cost of Coverage. In the case of the Georgia Development Authority, the Peace Officers' Annuity and Benefit Fund, the Georgia Firefighters' Pension Fund, the Sheriffs' Retirement Fund of Georgia, the Georgia Housing Authority, and the Georgia Agrirama Development Authority, the Retiree's cost of Coverage shall be deducted from the Retired Enrolled Member's annuity payment. In addition, each Contract Employer shall make the Employer Contribution required for

inclusion in the Plan and remit such payments in accordance with procedures as the Administrator may require.

4. Consumer Driven Health Plans (CDHPs). The Board may contract with any CDHP qualified and licensed to conduct business in Georgia pursuant to Chapter 21 of Title 33 of the Official Code of Georgia Annotated.

5. Other Organizations. The Board is authorized to contract with other organizations, including any public or nonprofit critical access hospital, and any federally qualified health center as defined in 42 U.S.C.A. 1395x(aa)(4), that meets such requirements as the Administrator may establish for the inclusion of eligible Members and Dependents in the SHBP. Each Contract Employer shall deduct from the Enrolled Member's salary the Member's share of the cost of Coverage. Each Employer shall remit the total Premium amount as established by the Administrator for inclusion of its Members in the Plan and in accordance with such procedures as the Administrator may require.

(i) **Coverage Termination for Failure to Remit Premiums.** Upon providing written notice, the Commissioner may terminate Coverage for any Group that either contracts for SHBP Coverage or is designated by applicable state law as eligible for such Coverage for failure to remit either Employee or Employer Contributions.

(ii) **Reinstatement of Coverage.** Upon remittance of the required contributions from any Group that either contracts for SHBP Coverage or is designated by applicable state law as eligible for such Coverage, the SHBP may reinstate Coverage that has been terminated previously for failure to remit Premiums.

(iii) **Bond.** The Board may require that specified Groups provide a bond to ensure payment performance before allowing SHBP Coverage.

6. Health Maintenance Organizations (HMOs). The Board may contract with any HMO qualified and licensed to conduct business in Georgia pursuant to Chapter 21 of Title 33, relating to Health Maintenance Organizations.

7. Local School Systems. When a school system has elected not to participate in the SHBP for Public School Employees, the Employees may petition the local school system to contract with the Board for an Employee-Pay-Group. The local system may contract with the Board after agreeing to:

(i) Collect the Enrolled Member Premium amounts for the Rates established by the Board; and

(ii) Enroll and maintain enrollment at 75% of the eligible Public School Employees as defined in these regulations.

(2) Functions, Duties and Responsibilities of the Commissioner. The Commissioner is the chief administrative officer of the Department of Community Health. The Commissioner and Administrator as used in these regulations are synonymous. The Commissioner shall employ such personnel as may be needed to administer the SHBP, to appoint and prescribe the duties of positions, all positions of which shall be included in the classified service except as otherwise provided in the law, and may delegate administrative functions and duties at the Commissioner's discretion.

(a) Administer Regulations and Policies. The Commissioner shall administer the SHBP consistent with applicable law, Board regulation and policy.

(b) **Custodian of Funds.** The Commissioner shall be the custodian of the health benefit Funds and shall be responsible under a properly approved bond for all monies coming into said Funds and paid out of said Funds.

1. All amounts contributed to the Funds by the Member and the Employers and all other income from any source shall be credited to and constitute a part of such trust Funds. Any amounts remaining in such Fund(s) after all expenses have been paid shall be retained in such Fund(s) as a special reserve for adverse fluctuation.

2. The Commissioner shall establish accounting procedures for maintaining trust Funds for the Premium income, interest earned on the income and expenses and benefits paid. Any amounts remaining in each trust Fund after all expenses have been paid shall be retained wholly for the benefit of the members who are eligible and who continue to participate in each health insurance trust.

3. The Commissioner shall submit to the Director of the Office of Treasury and Fiscal Services any amounts available for investment, an estimate of the date such Funds shall no longer be available for investment, and when Funds are to be withdrawn. The director of the Office of Treasury and Fiscal Services shall deposit the Funds in a trust account for credit only to the Plan and shall invest the Funds subject only to the terms, conditions, limitations and restrictions imposed by the laws of Georgia upon domestic life insurance companies.

4. The Commissioner may administratively discharge a debt or obligation not greater than \$400.00 due the Health Insurance Fund or Funds.

(c) **Regulations.** The Commissioner shall recommend to the Board amendments to the regulations, submit the approved regulations to appropriate filing entities, cause all regulations to be published and provide a copy to the Employing Entities.

(d) **Elicit and Evaluate Proposals from Health Care Contractors and/or Administrators.** As required for the appropriate administration of the Plan, the Commissioner shall cause to be prepared requests for proposals for selection of health care contractors, vendors, or administrators. Upon receipt of the proposals, the Commissioner shall secure an evaluation of the proposals and submit recommendations for the selection of health care contractors, vendors, or administrators to the Board for approval.

(e) **Calculate Employer Contribution Rates.** The Commissioner shall cause to be calculated ~~an average Employer Contribution Rates for each Tier non-Medicare Advantage Enrolled Members based on the method expressed in the manner specified in Section 111-4-1-.02(d)(1)-(5) of these regulations. These Employer Contribution Rates shall be calculated and presented to the board by such time as is required for the Commissioner to meet the notification deadline set forth in (h) below. The Commissioner shall present the Employer HMO Contribution Rates at least sixty (60) days before the beginning of the State of Georgia's Fiscal Year and the Enrolled Member Deduction/Reduction amounts for each Option and Tier to the Board for adoption at least ninety (90) days before the beginning of the SHBP plan year.~~

(f) **Premium Payments to a Contractor.** The Commissioner shall cause to be calculated the Premium amounts due to each HMO and to any underwriter of insurance or re-insurance and remit payments from the appropriate trust Funds for Member Coverage.

(g) **Develop and Publish Plan Document.** The Commissioner shall cause to be developed a Summary Plan Description (SPD) or Certificate of Coverage which incorporates the approved schedule of Benefits, eligibility requirements, Termination of Coverage provisions, Extended Coverage provisions, to whom benefits will be payable, to whom claims should be submitted, and other administrative requirements. The Commissioner or designee shall cause a pre-determined percentage of the SPD's to be printed and distributed to each local and state Employer for distribution to Enrolled Members. The Commissioner or designee shall cause to distribute the SPD to Retired Enrolled Members and Extended Beneficiaries at their last known address.

(h) **Provide Notice of Employer Contribution.** The Commissioner shall provide notice and certification of the required Employer Contribution Rate to each of the Employing Entities and the Department of Education no less than thirty (30) days prior to the commencement of the plan year on or before June 1 of each year, if the Rate for the ensuing fiscal year is to be modified. The Commissioner shall notify the Employing Entities before the Rate is effective of any Rate change which may be required at times other than the beginning of a fiscal year.

(i) **Provide Notice of Eligibility.** The Commissioner shall develop procedures for notifying Extended Beneficiaries of the Extended Coverage provisions of Section 111-4-1-.08 of these regulations upon notification by the Employing Entity of the Enrolled Member's employment termination, death, or reduced hours or upon notification by the Member of divorce, legal separation, or child no longer meeting the definition of Dependent.

(j) **Provide Certification of Creditable Coverage.** The Administrator shall establish procedures for providing a Certificate of Creditable Coverage to each Enrolled Member in compliance with federal law. In general, this Certificate of Creditable Coverage must be provided at the time Coverage cancels or upon request of the Member or Covered Dependent and for a period of twenty-four (24) months after coverage cancellation. The Member may use the certification to limit a subsequent plan's imposition of a Pre-existing Condition limitation or exclusion period. ~~Coverage cancellation may be the result of termination of Coverage through Employee Deduction/Reduction, termination of Coverage at the end of an Approved Leave of Absence Without Pay, or termination of Coverage at the end of the COBRA Extended Coverage period.~~

(k) **Correction for Administrative Error.** An administrative error is defined as any clerical error in submitting pertinent records or a delay in making any changes by the Employing Entity or Administrator that affects the Coverage for a Member or Dependent who has followed all established procedures and met the time deadlines regarding enrollment or maintenance of Coverage. If the error has placed the Member or Dependent at a substantial financial risk or risk of loss of Coverage, the facts shall be reviewed and corrective action taken. If the Administrator concludes that the Member or Dependent was substantially harmed, the Member or Dependent shall be restored to the former position or shall be granted the request in whole or in part. Any determination of an administrative error shall be left to the discretion of the Administrator and is not subject to challenge.

(3) **Duties and Responsibilities of Employing Entity.** Each Employing Entity is responsible for complying with these regulations. Statements made by the staff of the Employing Entities or any third party representing the Employing Entity, that are in conflict with these regulations, the Schedule of Benefits, Decision Guide, or the

Summary Plan Description (SPD) shall not be binding on the Administrator. Failure of the Employing Entities to fulfill the duties and responsibilities listed in these regulations does not negate the time requirements specified throughout these regulations.

(a) **Enroll Eligible Employees.** Each Employing Entity shall determine which of its employees meet the eligibility requirements of the SHBP. Each Employing Entity shall instruct and assist all persons who become eligible to become Enrolled Members under these regulations how to complete the SHBP enrollment or declination process. The Employing Entity shall require each eligible new Member to complete, within thirty-one (31) calendar days of reporting to work, a form for enrolling or declining SHBP Coverage. The Employing Entity shall be responsible for collecting any Premiums due for the selected Coverage. Any penalties or claim expenses resulting from the Employing Entity's enrollment of an ineligible Member, or from the Employing Entity's failure to provide enrollment information to an eligible Member, shall be assessed against the Employing Entity.

(b) **Deduct Enrolled Member Premium Amounts.** The Employing Entity shall withhold the Enrolled Member Premium amount as approved by the Board, or the Premium amount authorized by the applicable Georgia Code sections, from earned compensation as the Enrolled Member's share of the cost of Coverage under the Plan. Any retirement system under which retired or retiring Enrolled Members may continue Coverage under the SHBP as an Annuitant shall withhold the Premium amount as approved by the Board from the annuity as the Enrolled Member's share of the cost of Coverage under the Plan.

(c) **Remit Employee and Employer Amounts.** The Employing Entity or retirement system shall reconcile their Enrolled Member's SHBP Coverage records to their payroll records in the manner prescribed by the Administrator. Each Employing Entity and retirement system shall remit within five (5) working days following the effective date of Coverage, an amount equal to the full, face amount of the Premium due for the period coincident with the Enrolled Member's SHBP Coverage, as reflected on the SHBP monthly billing statement. Each Employer is responsible for reconciling the Premium payments and the monthly billing invoice to make any and all corrections to the records prior to the Coverage effective date. This reconciliation is to be done within thirty (30) days of issue of the billing invoice. Each Employing Entity, except for a retirement system, shall remit the Employer Contribution amount to the Administrator for the period coincident with the Enrolled Member's Coverage month within five (5) working days of the due date.

1. The Employing Entity shall calculate and remit the appropriate Employer Contribution including administrative fees, for those Members who elect to enroll or continue Coverage during an approved family medical or Approved Leave of Absence Without Pay.

(d) **Provide ~~Employee Enrollment Information to~~ Eligible Members the Administrator.** Each Employing Entity shall make available to eligible Members all educational and benefit enrollment information necessary for the eligible Members to make an informed health benefit plan decisions.

(e) **Provide Plan Materials to Each Eligible Member.** Each Employing Entity shall distribute the Summary Plan Description and enrollment information to each eligible Member. Each Employing Entity shall make every effort to distribute other SHBP

materials, including Open or Special Enrollment information, and information about the web site, to Members at the request of the Administrator. When appropriate, each Employing Entity shall hold group meetings to explain a specific aspect of the SHBP to Members.

(f) **Administer Leave Without Pay Provisions.** Each Employing Entity shall administer Approved Leave of Absence Without Pay, Military Leave, and and-Family and Medical Leave Act Programs in compliance with the federal laws and shall provide information regarding the conditions for continuing Coverage under the SHBP to eligible Enrolled Members. Each Employing Entity shall also provide continuation of Coverage enrollment information to Members. Each Employing Entity shall insure Members on Approved Leave of Absence Without Pay are properly notified of the annual Open Enrollment period and afforded the opportunity to enroll or change Coverage. Each Employing Entity shall maintain procedures to ensure that Member Premiums are collected during these leave periods. If a Member fails to timely pay a Premium during the leave period, that failure causes a loss of eligibility for coverage unless federal law requires otherwise.

(g) **Provide Member Loss of Eligibility Information to the Administrator.** Each Employing Entity shall report to the Administrator the last date employed/eligible and the reason for the loss of employment/eligibility no later than thirty (30) days following the event leading to loss of eligibility to participate in the Plan, ~~through payroll Deduction/Reduction.~~ The reasons for loss of eligibility shall be limited to: failure of a Member to pay a required Premium during an approved leave of absence (unless federal law requires continuing coverage), resignation, transfer, retirement, termination of employment for gross misconduct, separation from employment for reasons other than gross misconduct, reduced employment hours that affect Coverage eligibility, lay-off, leave of absence without pay, discontinuation, and death. Any claim expenses borne by the SHBP, and any penalties assessed upon the Administrator as a result of the Employing Entity's failure to timely notify the Administrator of a Member's loss of eligibility for failure to comply with notification requirements of COBRA as a result of the Employing Entity's failure to notify the Administrator shall be billed to the respective Employing Entity. The Employing Entity shall reimburse the Administrator in full for claim liability and expenditures incurred by the Plan as a result of the Employing Entity's failure to comply with notification requirements.

(h) **Protect the Privacy of Enrollment Information.** The SHBP only shares enrollment information with designated employees of the Employing Entity who help with Plan enrollment. Each Employing Entity shall ensure that the SHBP is promptly notified whenever such an employee is no longer permitted to review and share enrollment information about Members with the SHBP. The Employing Entity shall ensure that designated employees are properly trained to protect the privacy and security of the enrollment information. The Employing Entity shall never use enrollment information for any purpose other than helping with enrollment in the Plan.

Authority: O.C.G.A. §§ 20-2-55, 20-2-881, 20-2-883 to 20-2-885, 20-2-891 to 20-2-896, 20-2-911 to 20-2-916, 20-2-918 to 20-2-922, 20-2-924, 31-5A, 45-18-1 et seq., Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Family Medical Leave Act(FMLA).

**Rule 111-4-1-.10
Plan Benefits**

SYNOPSIS

The purposes of the rule change are to 1) state that the SHBP shall be designed to comply with applicable law and further the specific plan design goals set forth in O.C.G.A. Sections 45-18-3; 20-2-883; 20-2-913, 2) describe the process by which the board establishes the plan design and records the related contribution rates in board minutes, and 3) eliminate specific plan provisions and descriptions that are not required and may conflict with applicable law.

EXPLANATION OF CHANGES

Rule 111-4-1-.10 (1) has been modified to state that the plan design must comply with applicable law and further the plan design goals set forth in O.C.G.A. Sections 45-18-3; 20-2-883; and 20-2-913. It has also been modified to describe the process of establishing the plan design each year. This modification eliminates the practice of recording changes to plan designs in this rule, since this practice is not required by law and gives rise to incomplete descriptions. The history of past Board actions related to specific plan design changes between 1998 and 2004 that was formerly contained in subsection a) has been deleted. This history shall remain in official Board minutes.

Rule 111-4-1-.10 (1)(a)(i) has been eliminated because it is stated elsewhere.

Rule 111-4-1-.10 (1)(a) (ii) has been renumbered as Rule 111-4-1-.10 (1)(a), and has been modified to conform with the requirement that medical necessity decisions are delegated entirely to the TPA.

Rule 111-4-1-.10 (2) "Pre-Existing Conditions" has been deleted to avoid conflict with federal law.

Rule 111-4-1-.10 (3) "Coordination of Benefits" has been deleted in order to avoid conflicts with coordination of benefits provisions and practices that are properly described in summary plan descriptions.

Rule 111-4-1-.10 (4) "Medicare Coordination and Medicare Subrogation" has been deleted to avoid conflict with federal law.

Rule 111-4-1-.10 (5) "Exclusions" has been renumbered as Rule 111-4-1-.10 (2) and modified to clarify that the Pre-Existing Condition Exclusion must be administered in accordance with federal law. It has also been modified to clarify that requirements for the summary plan description do not apply to Medicare Advantage summary plan descriptions, which are regulated by the Centers for Medicare and Medicaid Services.

Rule 111-4-1-.10 (6) "Actions" has been renumbered as Rule 111-4-1-.10 (3).

Rule 111-4-1-.10 (7) "Nonduplication of Benefits and Subrogation" has been renumbered as Rule 111-4-1-.10 (4).

Rule 111-4-.10 (8) "Extended Disability Benefits" has been deleted because this benefit was eliminated at the same time conversion policies were eliminated.

Rule 111-4-.10 (9) has been modified for clarity and renumbered as Rule 111-4-.10 (5).
Rule 111-4-10 (10) "Consumer Choice Option" has been deleted as a historical reference.

111-4-1-.10 Plan Benefits.

(1) **Creation of Benefit Schedule.** The Board is authorized to establish benefit schedules for Options to be included in a health benefit plan for eligible persons as defined in Georgia law. Benefit schedules shall comply with applicable state and federal law. Benefit schedules shall further the plan design goals set forth by O.C.G.A. Sections 45-18-3; 20-2-883; 20-2-913: "to (1) Provide a reasonable relationship between the hospital, surgical and medical benefits to be included and the expected distribution of expenses of each such type to be incurred by the covered employees and dependents; and (2) Include reasonable controls, which may include deductible and reinsurance provisions applicable to some or all of the benefits, to reduce unnecessary utilization of the various hospital, surgical, and medical services to be provided and to provide reasonable assurance of stability in the future years of the plan." Benefit schedules for HMO-Options may include a different schedule for Medicare enrolled Retirees and non-Medicare enrolled Retirees. Benefit schedules of Options shall be considered in the calculation of Employer and Employee Contribution Rates. The Regular Insurance Option benefit schedules shall be established upon approval of the Employer and Employee Contribution Rates for such Options. The Medicare Advantage Option benefit schedules shall be established upon approval of the Employer and Employee Contribution Rates for such Options. benefit schedule(s). The dates of approval of Employer and Employee Contribution Rates modification, addition or deletion of the schedules of the Regular Insurance Options shall be recorded in official minutes of Board meetings these regulations. Medicare Advantage Options must be developed and administered in the manner approved by the Centers for Medicare and Medicaid Services. Accordingly, the following subsections apply only to Regular Insurance Options.

(a) **Benefit Schedule Approvals.** ~~The benefit schedule for a comprehensive, self-insured, Regular Insurance Standard Option under the State Health Benefit Plan was approved on September 15, 1982 to become effective on January 1, 1983. Amendments to the benefit schedules are recorded on:~~

~~1. **December 18, 1996.** Approval was given to adopt the portability requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); to adopt the requirements of the Newborns' and Mother's Health Protection Act of 1996; and to implement the NurseCall 24 program for an effective date of July 1, 1997;~~

~~2. **September 25, 1997.** Approval was given to modify the utilization review program to require participating hospitals to pre-certify of inpatient stays for an effective date of January 1, 1998;~~

~~3. **April 23, 1998.** Approval was given to implement a change in the Plan Year from calendar to the State's Fiscal Year; and to adopt the Women's Health and Cancer Rights Act of 1998 for an effective date of July 1, 1999;~~

~~4. **July 22, 1999.** Approval was given to implement a Disease State Management pilot program for an effective date of January 1, 2000;~~

~~5. **November 10, 1999.** Approval was given to add the hospital DRG pricing contractual provision for an effective date of July 1, 2000;~~

~~6. **February 9, 2000.** Approval was given to increase the Maximum Lifetime Benefit to \$2 million; adopt the Standard Preferred Provider Organization (Standard PPO) Option in lieu of the Standard Indemnity Option; and to implement the Consumer Choice Options (CCO) for all managed care plans for an effective date of July 1, 2000;~~

~~7. **September 13, 2000.** Approval was given to amend the pharmacy benefit to include a card program with three Tier co-payments; to enhance Wellness/Preventive Services benefits for High Option, Standard PPO and PPO Choice Options; and to add a national network to the PPO provider network for an effective date of July 1, 2001;~~

~~8. **December 12, 2001.** Approval was given for the regular insurance, High Option, to be known as the Indemnity Option for an effective date of July 1, 2002;~~

~~9. **January 9, 2002.** Approval was given to amend coverage for cancer clinical trials that meet guidelines established by the Georgia Cancer Coalition for an effective date of June 1, 2002;~~

~~10. **January 17, 2003.** Approval was given to amend coverage for specific osseous surgeries for the treatment of periodontal disease for an effective date of July 1, 2003;~~

~~11. **March 10, 2004.** Approval was given for the following:~~

~~(i) The Administrator shall interpret the general schedules into specific benefit language for inclusion in the Summary Plan Description and for use by the TPA in adjudicating claim payments;~~

~~(ii) The Administrator shall authorize the use of established procedures by the TPA to terminate benefit payments if continuation of treatment in the mode being billed is not medically necessary. The TPA's procedures must ensure that the Member shall have the right to ask for a record review by medical consultants.~~

~~12. The Indemnity Option shall be eliminated as an available Option under SHBP.~~

(b) The Administrator shall interpret the general schedules into specific benefit language for inclusion in the Summary Plan Description and for use by the TPA in adjudicating claim payments.

(c) The Administrator shall incorporate specific benefit language to be used by the TPA for review of utilization patterns and to implement claim cost containment features, including but not limited to, medical review of excessive utilization and audits of hospital or other claims.

(d) The Administrator shall be authorized to require pre-authorization by the TPA of any new medical service before approval for benefit payment. Generally, the service will not be considered for coverage unless medical consultants/advisors substantiate through literature research that clinical trials demonstrate the medical effectiveness of the service. Other guidelines, such as those of the Federal Drug Administration of the Centers for Medicare & Medicaid Services may also be used, at the discretion of the Administrator, in the determination of coverage.

(e) The Administrator shall authorize the use of established procedures by the TPA for obtaining additional medical information from members and from providers of medical services and supplies, in order to determine the amount and appropriateness of benefit payments.

(f) The Administrator shall establish procedures for permitting the Member to appeal an adverse determination of eligibility for Coverage or of a benefit, service, or Claim. These procedures shall be outlined in the Summary Plan Description to advise the Member of the process to initiate an appeal. However, the Administrator has delegated the final authority to the TPA for approval in accordance with the schedule of Benefits and the interpretation thereof. The Administrator shall have final authority for approval of all eligibility appeals.

(g) The Administrator may contract for or employ professionals from any medical discipline to advise the Administrator on continuing medical necessity, quality of medical care, or the level of fees charged by the providers of medical care.

(h) The Administrator is authorized to develop appropriate medical policy in conformity with the schedule of benefits and these regulations so that new procedures will be included for coverage when the new procedures are adopted as accepted medical practice and that medical procedures which are excessively used without significantly improving the treatment of an illness or injury are reviewed.

~~(2) **Pre-existing Conditions.** Benefits will be limited to one thousand dollars (\$1,000.00) for the treatment of a Pre-existing Condition until the person has been covered under the Plan for twelve (12) consecutive months.~~

~~-(a) The twelve (12) calendar month pre-existing condition waiting period will be reduced by the length of time that Creditable Coverage existed under the following conditions:~~

- ~~1. The Creditable Coverage must not have time periods of non-coverage that lasted for more than sixty-three (63) calendar days;~~
- ~~2. The Member provides certification of the Creditable Coverage and the time beginning and ending time periods;~~
- ~~3. The Creditable Coverage ending period occurred within sixty-three (63) calendar days of the Member's employment date or waiting period for SHBP Coverage when Coverage begins at a time other than upon employment;~~
- ~~4. When the most recent Creditable Coverage terminated less than sixty-three (63) calendar days prior to the waiting period for SHBP Coverage, the pre-existing period shall be reduced by the same period(s) of prior Creditable Coverage (periods without a break of coverage of more than sixty-three (63) calendar days, but not for the SHBP waiting period (i.e., first full month before the effective date); and~~

~~-(b) If the Member or dependent provides satisfactory documentation to the Administrator that the covered person has been free of treatment for the Pre-existing Condition for six (6) consecutive months, the limitation will be waived upon approval by the Administrator. If the Administrator requests additional documentation regarding the~~

~~Pre-existing Condition, the Member or Dependent will not receive benefits until satisfactory documentation has been presented for the Administrator's approval.~~

~~(c) A new Pre-existing Condition requirement will not be applicable if an individual's SHBP coverage is interrupted for any reason by an unpaid Coverage period equal to or less than four (4) calendar months. A new Pre-existing Condition requirement will not be applicable when Coverage for all Members of the family are transferred from one Spouse to the other Spouse or an enrolled Dependent becomes covered as an Employee.~~

~~(d) A Pre-existing Condition limitation will not be applied to newborns covered within thirty-one (31) calendar days of birth or to adoptees, under the age of 18, covered within thirty-one (31) calendar days of adoption.~~

~~(3) **Coordination of Benefits.** Coordination of Benefits provisions are intended to establish uniformity in the permissive use of other insurance provisions among health insurance carriers and self-insured group plans. Coordination of benefits within the Plan~~

~~shall conform generally to the Uniform Guidelines as adopted by the National Association of Insurance Commissioners.~~

~~(a) "Group Policy or Group Type Contract" means that the policy or contract is not available to the general public and can be obtained and maintained only because of the covered person's Membership in or connection with a particular organization or group. Franchise policies, even though provided on a group basis, are considered individual rather than group policies. Group policies or contracts usually, but not exclusively, mean that the Employee's cost of the policy or contract is employer sponsored with the cost paid by the employer or deducted from the Employee's compensation.~~

~~(b) When it is determined that this Plan is not the primary plan, the plan which pays benefits first, benefits are limited to the difference between the benefits paid by the primary plan and total eligible charges under this Plan, but no more than this Plan would have paid had the Plan been the primary plan for those eligible charges.~~

~~(c) Primary payor determination shall be in accordance with the following guidelines.~~

~~1. If another plan is involved and does not contain a provision for coordinating its benefits, that plan will be the primary plan; or~~

~~2. If there is federal or Georgia law requiring another plan to be the secondary plan, this Plan will be the primary plan; or~~

~~3. In other cases, the order of primary plan determination shall be:~~

~~(i) When the patient is covered as an Employee; or~~

~~(ii) When the patient is covered as the eligible and unmarried Dependent child of the parent whose birthday occurs first in the calendar year; or~~

~~(iii) When the patient is covered as the eligible and unmarried Dependent child of a divorced or legally separated Employee who has custody of that child, unless:~~

~~(I) the divorce or legal separation decree assigns financial responsibility for the child's health care expenses to the other divorced or legally separated parent, or~~

~~(II) the other divorced or legally separated parent's group health care plan establishes itself as the primary plan.~~

~~(iv) When the patient is covered as the eligible and unmarried dependent of a divorced or legally separated parents who have joint (50% - 50%) custody, determination is as if the parents were not divorced or separated.~~

~~4. When the active Member was covered under another group plan prior to the effective date of coverage in this Health Benefit Plan, that plan will be primary. A change in the amount or scope of benefits provided by a plan, a change in the carrier insuring the plan or a change from one type of plan to another does not constitute a new plan for the purposes of this guideline.~~

~~5. When the Member or eligible Dependents are covered by another plan as an Employee and under this Health Benefit Plan as a Retired Employee or Extended Beneficiary, or Dependent of the Retired Employee or Surviving Spouse of an Employee, the other plan will be primary.~~

~~(d) When payment has been made by this Plan in excess of the maximum amount of payment necessary at that time to satisfy the intent of the Coordination of Benefit provision, the Plan shall have the right to recover the excess payments, payments greater than one hundred percent (100%) of eligible and covered charges, from among the other insurers, the Member or the person (entity) to whom payment was made.~~

~~**(4) Medicare Coordination of Benefits and Medicare Subrogation.** By federal law, Medicare is primary for persons who are retired or who are disabled, subject to the Medicare Secondary provisions. By federal law, effective May 1, 1986, Medicare is secondary for active Employees and their eligible spouses who are age sixty five (65) or older. The Administrator is authorized to modify the procedures if future federal law requires such change.~~

~~(a) Prior to the Member reaching age sixty five (65), the Administrator shall notify the Member that an election for determining the primary payor must be made. The Administrator shall also inform the Employee that electing Medicare as primary will eliminate his eligibility to continue coverage under the SHBP.~~

~~(b) For those Members who are active and elect the SHBP as the primary payor, notification will be transmitted to the TPA and other vendors to facilitate processing future claims as the primary payor. The Administrator shall assume that the Spouse, who is age sixty five (65) or older, of a Member who continues to work has chosen the SHBP as the primary payor, unless the Member or his Spouse otherwise notifies the Administrator.~~

~~(c) When retired Members or their eligible Dependents are enrolled in Medicare, the Regular Option's liability will be limited to the secondary reimbursement amount. When it is determined that this Plan is secondary to Medicare, benefits are coordinated according to the Plan Options elected. When a provider has accepted the Medicare~~

~~assignment, any charges greater than the Medicare approved amount shall not be considered eligible charges under this Plan.~~

~~(d) When it is determined that a Member is covered under the SHBP as the Member and as a Dependent, the payment order shall be as follows:~~

~~1. If one Spouse is working and one Spouse is non-working and is age sixty-five (65) or older, the SHBP is primary under the working Spouse's coverage, Medicare is secondary, and the Plan is tertiary payor under the non-working Spouse's coverage.~~

~~2. If both Spouses are non-working, Medicare is primary payor, the coverage of the patient Spouse is secondary, and the coverage of the Dependent Spouse is tertiary payor.~~

(52) Exclusions. Plan benefits shall eExclude expenses incurred by or on account of an individual prior to the effective date of coverage; expenses for services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan; expenses for which the individual is not required to make payment; expenses to the extent of benefits provided under any employer group plan other than this plan of benefits in which the state participates in the cost thereof. In addition, for all Regular Insurance Options, the Administrator shall publish in the Summary Plan Description interpretative language showing the exclusions for the following types of charges:

(a) Charges for treatment for Pre-existing Conditions in excess of one thousand dollars (\$1,000), to the extent this exclusion is permitted by federal law;

(b) Charges for treatment or supplies which are determined to be not medically necessary;

(c) Charges for treatment before the effective date of coverage or after coverage termination, except for Extended Coverage benefits;

(d) Charges other than Wellness/Preventive benefits, that are not specifically related to the care and treatment of a sickness or an injury;

(e) Charges for treatment specifically for dental or vision care;

(f) Charges for treatment for experimental or investigative services or supplies;

(g) Charges that are considered educational or treatment to restore learning capacity;

(h) Charges in connection with custodial care, extended care facilities or a nursing home;

(i) Charges in connection with rehabilitation, rehabilitation therapy, or restorative therapy when the condition is no longer expected to improve significantly in a reasonable and generally predictable period of time;

(j) Charges in connection with therapy for learning disabilities;

(k) Charges for prosthesis or equipment which are determined to be not medically necessary.

(63) Actions. In creating the SHBP, neither the Georgia General Assembly nor the Board of Community Health has waived its sovereign immunity. Thus no action either in law or in equity, can be brought or maintained against the State of Georgia, the Board of Community Health, or any other department or political subdivision of the State of Georgia to recover any money under this Plan. In like fashion, no suit may be maintained against any officials or Employees of these bodies if the ultimate financial responsibility would have to be borne by public Funds from the General Treasury, the health benefit Funds or elsewhere.

(a) The Board of Community Health, however, does reserve the right to maintain any suits, either in its own name, or through its officials, Employees, or agents, which it deems necessary to the administration of the SHBP, including actions to recover money from participants, beneficiaries, agents, Employees, officials, or any other person.

(b) The Board of Community Health reserves the right to modify its Benefits, Coverages, and eligibility requirements at any time, subject only to reasonable advance notice to its Members. When such a change is made, it will apply as of the effective date of the modification to any and all charges which are incurred by Members from that date forward, unless otherwise specified by the Board of Community Health.

(c) The Administrator is authorized to act as interpreter of the terms and conditions of the Plan.

(74) Non-duplication of Benefits and Subrogation. The Plan will not duplicate payments for medical expenses made under third-party personal-injury-protection contracts nor will it duplicate payments made as the result of any litigation. The Plan will be subrogated to any right of recovery that a Member has against a person or organization where medical expenses were incurred as a result of injuries suffered because of alleged negligence or misconduct. In any case where the primary plan provides for subrogation for third-party liability and this Plan would be determined to be secondary, benefits under this Plan shall be reduced to the amount that would have been paid under the secondary provisions of this Plan.

~~(8) **Extended Disability Benefits.** If coverage terminates under this Plan at a time when the Member or eligible Dependent is totally disabled, reimbursement for that individual's treatments for the condition that caused the disability shall continue for up to four (4) additional calendar months after coverage termination.~~

~~(a) The Administrator shall require satisfactory documentation from the physician for approval of the Extended Coverages. At minimum the documentation from the physician shall include a statement of the diagnosing disability and of the duration of the condition.~~

~~(b) Eligibility for Extended Coverages under any of the provisions in these regulations or conversion to a private pay policy is predicated on the application being filed in accordance with the specified time from coverage termination rather than the extended benefit period.~~

(95) Recovery of Benefit Overpayments. The Administrator shall seek repayment for any benefits paid to any individual, corporation, firm, or other entity who or which is not qualified, in the opinion of the Administrator, to receive benefits from the Plan.

~~—(a) The Administrator shall establish procedures for collecting the overpayments, duplicate payments, or wrong payee payments. The procedures may include, but are not limited to, establishing installment payments, withholding future benefit payment, or filing suit or garnishment.~~

~~—(b) The Administrator shall establish procedures to collect the amounts in excess of the payments allowed in the Coordination of Benefits or Medicare Coordination of Benefits regulations.~~

~~—(10) **Consumer Choice Option.** The Commissioner shall have the authority to eliminate the Consumer Choice Option.~~

Authority: O.C.G.A. §§ 20-2-881 to 20-2-885, 20-2-887, 20-2-911 to 20-2-915, 45-18-1 et seq., Health Insurance Portability and Accountability Act of 1996 (HIPAA), Social Security Act.

**Rule 111-4-1-.11
Claims**

SYNOPSIS

The purpose of this rule change is to clarify that the two year time period for filing claims is a maximum liability period. Specifically, it has been modified to clarify that the time period and procedures coordinated between the Administrator and the Third Party Claims Administrator must be followed, as long as they do not permit payment of claims after the maximum liability period.

EXPLANATION OF CHANGES

Rule 111-4-1-.11 (1) "Filing Claims" has been modified to clarify that the Administrator and the Third Party Claims Administrator may not establish a liability period greater than the maximum liability period.

Rule 111-4-1-.11 (2) "Liability Period" has been modified to add "Maximum" to the title, and to clarify that the claim procedures established by the Administrator and the Third Party Claims Administrator must be followed, subject to the maximum liability period.

111-4-1-11 Claims.

(1) **Filing Claims.** The Administrator shall coordinate the procedures for filing claims with the TPA. Such procedures may not establish a liability period greater than the maximum liability period set forth below. Claim forms shall be designed and printed for the Member's and providers' use when appropriate.

(2) **Maximum Liability Period.** All Claims of Benefits must be presented in writing to the Administrator or TPA in accordance with the procedures established by the Administrator and the TPA, which procedures may not permit payment of claims submitted after ~~within~~ twenty-four (24) calendar months following the month of service in which the service was rendered. If any Claim for Benefits is presented to the Administrator or TPA after two (2) years from the date the service was rendered, benefits will not be owed or paid.

(3) **Unclaimed or Uncashed Claim Checks.** All drafts issued on behalf of the Plan shall be void if not presented and accepted by the drawer's bank within six (6) calendar months of the date the draft was drawn. If the payee or Subscriber does not present the draft or request a reissue of the draft for a period of seven (7) years from the date the draft was drawn, the draft will be void and funds retained in the appropriate trust Fund.

Authority: O.C.G.A. §§ 20-2-881, 20-2-884, 20-2-890, 20-2-911, 20-2-917, 45-18-2, 45-18-6, 45-18-11.