

## **Georgia Affordable HSA Eligible High Deductible Health Plan**

### **120-2-96-.01 Authority and Purpose**

O.C.G.A. Section 33-51-2 (1) Authorizes the Commissioner of Insurance to “establish flexible guidelines” for HSA- High Deductible Health Plan filings submitted in connection with products that incorporate health promotion and wellness principles. Within the provisions of Chapter 33-51-4, it is stated that to the extent wellness principles are applied within approved policy contracts, that discounts, refunds, credits or other incentives shall not be considered to be illegal inducements or rebating under applicable provisions of the Georgia Insurance Code, including Unfair Trade Practice provisions. Other provisions of the Act make changes to PPO allowable differentials between classes of providers and product design potential changes. This Rule is intended to amplify and promulgate practical guidelines to carry out the Georgia Affordable HSA Eligible High Deductible Health Plan Act.

Authority – O.C.G.A. §§33-2-9, 33-51-3.

### **120-2-96 -.02 Categories of Products Allowed as High Deductible Health Plan in Wellness Program**

(1) Under this Rule, a health insurance policy, which satisfies Internal Revenue Code requirements for a High Deductible Health Plan, may be used by an insurer in connection with a Wellness Program and with a Health Savings Account program.

This means that compliant health insurance products could include, but not be limited to:

- (a) Comprehensive or major medical health insurance products offered by Life, Accident and Sickness Insurers or Property and Casualty Insurers;
- (b) Comprehensive or major medical health coverage products styled and appropriately disclosed as health maintenance organization coverage when offered by a licensed HMO;
- (c) Preferred Provider Organization comprehensive or major medical health coverage products offered by insurers of any applicable licensure type;
- (d) Point of Service comprehensive or major medical health insurance coverage products (when offered by licensed insurers in connection with approved HMO products); or
- (e) Other comprehensive or major medical health insurance products which do not violate IRS Rules for High Deductible Health Plans under Section 223 of the Internal Revenue Code or related IRS Rules and Regulations.

Such product types as described in (1)(a) through (1)(e) above may be reviewed and considered for approval by the Commissioner under O.C.G.A. Section 33-51-2 and corresponding favorable treatment under Georgia provisions relating to taxation and relief from unfair trade practice provisions regarding rebating or illegal inducements with respect to wellness program benefits.

Authority – O.C.G.A. §§33-2-9, 33-51-3.

**120-2-96-.03 Special Provisions for Preferred Provider Organization Products under O.C.G.A. Section 33-51-5, O.C.G.A. Section 33-51-6 and this Rule**

(1) Preferred Provider Organization (“PPO”) products offered under O.C.G.A. Section 33-51-5 Rule may contain greater percentage differentials between preferred and non-preferred providers than the 30% percentage differential limitations under Rule 120-2-44-.04(5).

(a) Notwithstanding O.C.G.A. Section 33-51-5 and Rule 120-2-96-.03(1), plans may not have a coinsurance percentage applicable to benefit levels for services provided by non-preferred providers that is less than 60% of the benefit levels under the policy for such services. This means the maximum coinsurance percentage which may be required by insurers for the enrollee’s responsibility for non-preferred provider benefits under PPO products remains at a maximum of 40%.

(2) O.C.G.A. Section 33-51-6 confirms the continuation of the historical requirement under Georgia Law that within PPO coverage, non-preferred dental and/or non-preferred pharmaceutical providers be reimbursed by insurers at the same level as preferred dental or pharmaceutical providers as stated in O.C.G.A. Section 33-30-23 and O.C.G.A. Section 33-51-6.

Authority – O.C.G.A. §§33-2-9, 33-51-3.

**120-2-96-.04 Categories of Products Not Qualified for favorable treatment in Wellness Program**

(1) Examples of plans that will not be allowable or approved under O.C.G.A. Section 33-51-2 would include, but not be limited to:

(a) limited benefit insurance products, as defined in O.C.G.A. Section 33-30-12, where the term "limited benefit insurance" means accident and sickness insurance designed, advertised, and marketed to supplement major medical insurance. The term "limited benefit insurance" includes accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long term care, Medicare supplement, specified disease, vision, and any other accident and sickness insurance other than

basic hospital expense, basic medical-surgical expense, or major medical insurance.

(b) limited duration health insurance products of terms of less than 12 months, regardless of the scope or limitations of benefits within the health insurance coverage.

Authority – O.C.G.A. §§33-2-9, 33-51-3.

### **120-2-96-.05 Product Filing Standards and Procedures**

(1) Insurers proposing products for consideration and potential approval under O.C.G.A. Chapter 33-51 and this Rule shall, in cover letters or their equivalent if filed electronically under SERFF, indicate their intent and shall describe:

(a) the type of comprehensive or major medical health insurance coverage being proposed,

(b) shall make a clear disclosure on the face page of the Master Policy, if group, and on face pages of Certificates, or on the face page of individual policies to this effect.

(c) There shall also be a clear and conspicuous disclosure that states, in effect, that the health insurer has designed and constructed the evidence of coverage with the intent of satisfying and qualifying the health insurance coverage as a High Deductible Health Plan under applicable provisions of Section 223 of the Internal Revenue Service laws and rules, but that neither the insurer nor the Office of Commissioner of Insurance of the State of Georgia provides federal tax advice, and that consumers should seek their own private tax advice with respect to federal tax treatment beyond the insurance coverage.

(2) High Deductible Health Plan Policies which contain the appropriate disclosures should receive an expedited review with respect to those coverage issues and the overall filing. All otherwise applicable requirements regarding mandated benefits, limitations, disclosures, notices and other requirements remain in effect to the extent they do not violate IRS Rules for High Deductible Health Plans under Section 223 of the Internal Revenue Code or related IRS Rules and Regulations.

(3) The Commissioner will consider and may accept a statement from the insurer in a cover letter or its electronic equivalent in the case of SERFF or other electronic filing submission modes accompanying a filing for High Deductible Health Plan coverage, signed by an officer of the company, that indicates the insurer has sought and obtained appropriate advice of counsel familiar with Internal Revenue Service Laws and Rules and that to the best of the company's knowledge and belief, the proposed product qualifies as High Deductible Health Plan coverage under all applicable IRS laws and rules.

(4) The Commissioner may accept, but is not required to accept, a statement from an officer of the Insurer that the product is similar to a previously approved health insurance product, if so identified by exact form number, date of original or most recent approval, and if accompanied by documentation of differences from any such prior approved form. Such documentation may take the form of a redline version, markup, summary of differences or other clearly designed instrument which helps the reviewer isolate and identify substantive differences from previously approved versions of similar coverage.

(5)(a) Wellness or Health Promotion Programs should be adequately disclosed by an insurer, either as an integral component of the health insurance product itself, or by attachment of such wellness or health promotion product as a rider to be sold or offered in connection with allowable high deductible health insurance products under Rule 120-2-96-.02(1). Insurers shall be required to clearly disclose the relationship between any proposed health promotion or wellness program and the high deductible health product within application materials, within any advertisement or other solicitation materials and within the evidence of coverage, if applicable. Health Promotion or Wellness Programs shall disclose any and all applicable costs in terms of premium, contribution or other costs, as well as clearly and accurately disclose potential incentives, rewards, discounts or other benefits and how enrollees may claim or otherwise earn and receive any such incentives, rewards or discounts. Such disclosures must be provided by the insurer to any interested party on request.

(b) Health Promotion or Wellness programs that are not designed, controlled, operated by and offered by insurers within their health insurance policies must be filed by insurers wishing to use them in connection with High Deductible Health Plan products seeking protection from rebates, illegal inducements or other unfair trade practices under O.C.G.A. Section 33-51-4.

(6) The Commissioner may post enhanced instructions for insurers to use in making formalized SERFF or other electronic or other expedited filings under O.C.G.A. Section 33-51-2 on Office of Commissioner of Insurance website materials. The Commissioner will continue to apply applicable policy form filing fees on any such expedited filing methods, but insurers are encouraged to utilize such methods of filing and any such methods of Electronic Funds Transfer to pay applicable policy form and rate filing fees whenever possible or as required in the future for all other SERFF filings.

Authority – O.C.G.A. §§33-2-9, 33-51-3.

## **120-2-10-.12 Small Group Health Insurance Access and Pooling.**

(3) Prohibitions. The following practices by an insurer are prohibited with regard to small groups and the small group health insurance pool:

(a) Durational rating which increases premiums for any small group based solely on the length of time the small group has been insured;

(b) Except as permitted under O.C.G.A. § 33-30-12(d) and paragraph (5)(e), tier rating which increases rates directly related to the tier within which any one small group's claims experience falls;

(c) Cancellation or termination of any small group or any insured individual in a small group, provided that insurers may refuse to re-new coverage only for those reasons permitted by the Rules and Regulations of the Office of Commissioner of Insurance Chapter 120-2-67;

(d) Waivers for one or more preexisting conditions, except that insurers may use preexisting condition exclusions pursuant to O.C.G.A. § 33-30-15;

(e) Declination of any small employer for coverage, or refusal to offer to insure, make insurance available or make a quote or offer of coverage to any small employer, or engagement in practices directly or through agents or representatives which prevent, discourage, delay or impede the availability or marketing of group health insurance to any small employer, under all policies or contracts offered or actively made available by an insurer to small employers in the state or service area, except that an insurer may decline a small employer for coverage if any of the following applies:

1. minimum participation or contribution rules are not satisfied by the small employer;

2. with regard to policies offered only through a true association of employers, a small employer is not a member of the association;

3. none of the eligible employees, members, or enrollees live, work, or reside in the service area of the network if the policy or contract is offered by a health maintenance organization or a provider-sponsored health care corporation;

4. a health maintenance organization or provider-sponsored health care corporation has demonstrated, to the satisfaction of the Commissioner, and based on current documentary evidence, that it does not have the service capacity to adequately provide medical services to new small employers through network providers in a particular service area because of its obligations to existing groups in the service area, provided that:

(i) all declinations apply uniformly to all small employers in the service area without regard to claims experience or any health status-related factors; and

(ii) the health maintenance organization or provider-sponsored health care corporation includes in such filing a certification from the President, Executive Director, or Chief Financial Officer which purports to claim such service capacity limits; and

(iii) the Commissioner has not determined that such a claim is not warranted within 90 days of filing documentary evidence.

5. an insurer has demonstrated, to the satisfaction of the Commissioner, and based on its most recent quarterly financial report, examination, or any other

more current documentary evidence, that it does not have sufficient financial capacity to underwrite additional coverage under any and all policy forms available to small employers in the state, provided that:

(i) all declinations apply uniformly to all small employers in the state without regard to claims experience or any health status-related factors; and

(ii) the insurer includes in such filing a certification from the President, Executive Director, or Chief Financial Officer which purports to claim such financial capacity limits; and

(iii) the Commissioner has not determined that such a claim is unwarranted within 90 days of filing documentary evidence.

(f) Issuing coverage under any and all policies or contracts in the small employer market in the state (or a particular service area if applicable) after satisfactorily demonstrating to the Commissioner the conditions described in subparagraphs (e)4. or (e)5., unless at least 180 days have elapsed since the date coverage was declined and the Commissioner has approved such resumption of issue based on documentary evidence that conditions have changed.

(g) Discriminatory rating practices which result in premium rate differentials for an individual employee, member, enrollee, or dependent of such employee, member, or enrollee, within a small group based solely on any health status-related factor or claims experience in relation to that individual in the small group, or premium rate differentials for classes of employees, members, or enrollees within a small group subdivided solely on the basis of any health status-related factor or claims experience. Rate adjustments for demographic underwriting factors, differences in benefit designs or network arrangements, premium differentials based on family or dependent coverage, or other rate differentials permitted by this Rule do not constitute discriminatory rating practices.