



**NOTICE OF PUBLIC HEARING**

PLEASE TAKE NOTICE THAT on December 1, 2010, at 10:00 a.m., in the Board Room at the Department of Community Health, #2 Peachtree Street, 5<sup>th</sup> 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:

**(Amend) Ga. Admin. Comp. Ch. 111-4-1, State Health Benefit Plan**

- 111-4-1-.01      *Definitions.*
- 111-4-1-.02      *Organizations.*
- 111-4-1-.04      *Eligibility for Coverage.*
- 111-4-1-.05      *Effective Date of Coverage.*
- 111-4-1-.09      *Termination of Coverage.*

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 no later than the close of business at 5:00 p.m. on December 2, 2010. Comments may be faxed to (404) 656-0663, emailed to [pjohnson@dch.ga.gov](mailto: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 December 9, 2010.

This 18<sup>th</sup> day of October, 2010.

Clyde L. Reese, III, Esq.

CLR:pmj

Attachments

**SYNOPSIS OF PROPOSED RULE CHANGES**

**RULES OF  
DEPARTMENT OF COMMUNITY HEALTH  
STATE HEALTH BENEFIT PLAN**

**RULE 111-4-1-.01  
DEFINITIONS**

**STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE**

**Synopsis**

Definitions related to student status and financial dependency and residence have been removed in order to comply with the Patient Protection and Affordable Care Act of 2010.

**Explanation of Changes**

The Patient Protection and Affordable Care Act of 2010 ("PPACA") prohibits group health plans from considering the employment or student status of dependent children under age twenty-six. The following definitions have been removed:

- 111-4-1-.01(1) "Accredited School"
- 111-4-1-.01(24) "Disabled Student"
- 111-4-1-.01(29) "Full-Time Attendance"

PPACA prohibits group health plans from considering the residency or financial dependency of dependent natural children, adopted children, foster children or step-children under age twenty-six. The definition 111-4-1-.01(22) "Dependent" has been revised to eliminate references to these requirements.

## 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).~~

(21) “**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.

(32) “**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.

(43) “**Administrator**” means the Department of Community Health or the Commissioner of the Department of Community Health.

(54) “**Administrative Services**” means the services that are provided by contract for a self-insured Health Benefit Plan.

(65) “**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.

(76) “**Annual Required Contribution**” means an actuarially determined amount to pay for future OPEB liability over a period of years.

(87) “**Beneficiary**” means an Employee, Surviving Spouse, divorced or legally separated Spouse, or eligible Dependent child who loses Coverage under these regulations.

(98) “**Benefits**” mean the schedule of Benefits of health care services eligible for approval of payments under the Options approved by the Board.

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

(1044) **“Cafeteria Plan”** means a plan which meets the requirements of the regulations of the Internal Revenue Service under Internal Revenue Code (IRC) 125.

(1142) **“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.

(1243) **“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.

(1344) **“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.

(1445) **“Commissioner”** means the Commissioner of the Department of Community Health as created by O.C.G.A. § 31-2-6.

(1546) **“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.

(1647) **“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.

(1748) **“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.

(1849) **“Coverage”** means the type, Tier, and Option of contract offered to an Enrolled Member.

(1920) **“Covered Dependent”** means any individual eligible under these regulations and for whom the Premium has been paid by the Employee, Retiree, or Extended Beneficiary.

(2024) **“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.

(2122) **“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.

~~(2223) “Dependent” means any eligible Spouse, Dependent child, or Totally Disabled 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.~~

(2325) “Employee” means any eligible, Active State Employee, Teacher, or Public School Employee.

(2426) “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.

(2527) “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.

(2628) “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.~~

(2730) “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.

(2834) “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.

(2932) “**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.

(3033) “**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.

(3134) “**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.

(3235) “**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.

(3336) “**Medicare Advantage**” means an Option that is offered to Retirees 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.

(3437) “**Member**” means a benefit eligible or ineligible Employee, former Employee, Retiree, or Extended Beneficiary.

(3538) “**Option**” means a type of benefit schedule or premium rating category that is offered to an eligible Member through the SHBP.

(3639) “**Other Post Employment Benefits**” or “**OPEB**” means retiree post-employment health insurance benefits.

(3740) “**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.

(3841) “**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.

(3942) “**Payor, Secondary**” means the entity which does not have the primary liability for providing benefit reimbursement for covered health services.

(4043) “**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.

(4144) “**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.

(4245) “**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.

(4346) “**Premium**” means the Enrolled Member’s cost as set by the Board of Community Health for the elected Coverage

(4447) “**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.

(4548) “**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.

(4649) “**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.

(4750) “**Regular Insurance**” means Options that are not Medicare Advantage Options.

(4851) “**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.

(4952) “**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.

(5053) “**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.

(5154) **“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.

(5255) **“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.

(5356) **“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.

(5457) **“Surviving Spouse”** means the living Spouse of a deceased Enrolled Member.

(5558) **“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.

(5659) **“Tier”** means the number and relationship to the Enrolled Member of the persons enrolled under the Member’s Coverage.

(5760) **“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.

(5864) **“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); Patient Protection and Affordable Care Act (PPACA).

## **SYNOPSIS OF PROPOSED RULE CHANGES**

### **RULES OF DEPARTMENT OF COMMUNITY HEALTH STATE HEALTH BENEFIT PLAN**

#### **RULE 111-4-1-.02 ORGANIZATIONS**

#### **STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE**

##### **Synopsis**

Changes have been made in order to clarify Employing Entities' obligations regarding payment of contributions to the SHBP. These changes also describe the legally mandated consequences when certain Employing Entities fail to timely and promptly pay contributions to the SHBP. These changes restate existing law and support the Department's efforts to confirm the accuracy of contributions and ensure that contributions are timely received.

Changes have been made in order to restate the requirements in existing law about how contribution rates must be calculated for counties and school boards that elect to include county employees and school board members in the SHBP.

Changes have been made to clarify that groups included in the SHBP through a contractual relationship with the Board must pay the entire cost of coverage in the SHBP plus an administration fee. Changes have been made to clarify that the Department may terminate such coverage for failure to promptly and accurately pay required contributions.

Changes have been made in order to comply with the Patient Protection and Affordable Care Act of 2010.

##### **Explanation of Changes**

111-4-1-.02(1)(a) has been edited for grammatical correctness.

111-4-1-.02(1)(d)(6) has been added to restate the following requirement in O.C.G.A. Section 45-18-5(d): "In administering this Code section, it shall be the responsibility of the board to develop rates for coverage based on the actual claims experience of the individuals covered by this Code section."

111-4-1-.02(1)(d)(7) has been added to clarify that groups included in the SHBP through a contractual relationship with the Board that is authorized by law must pay the full cost of coverage in the SHBP plus an administrative fee.

111-4-1-.02(1)(e)(3) lists groups whom the Board may include in SHBP coverage pursuant to a contractual relationship. This subsection has been changed so that all groups designated by law are mentioned. This subsection has been changed to clarify which groups will be required to maintain contracts with the Department, and to clarify that the terms of those contracts are to be established by the Department in accordance with the regulations and Board resolutions.

This subsection has been changed to clarify that the terms of the contract for inclusion of school board members are established by the regulations after an election for inclusion has been filed by the local board of education with the Department.

111-4-1-.02(1)(e)(5) has been changed to remove responsibilities and powers of the Commissioner regarding the termination and reinstatement of coverage, since those have been relocated to 111-4-1-.02(2)(b)(5).

111-4-1-.02(2)(b)(5) has been added to restate existing law related to the Commissioner's obligations as custodian of the SHBP and to describe requirements necessary for the Commissioner to meet those obligations.

- 111-4-1-.02(b)(5)(ii) restates the following requirement, which is set forth in O.C.G.A. Sections 45-18-5(c.1), 20-2-892(b), and 20-2-920(b) "In the event that the commissioner shall determine that a local employer has failed to contribute the full amount of such portion, as calculated by the commissioner, it shall be the duty of the commissioner to notify the State Board of Education of such failure and it shall be the duty of the State Board of Education to withhold from the employer which has failed to comply all appropriations allotted to such employer until such employer has fully complied with the provisions of this Code section by making remittance of the sums required."
- 111-4-1-.02(b)(5)(i) requires Employing Entities to provide additional documentation that the Department may use to verify the accuracy of the payments.
- The obligations and powers of the Commissioner regarding termination and reinstatement of coverage for failure to pay contributions that were removed from 111-4-1-.02(1)(e)(5) are now set forth in 111-4-1-.02(2)(b)(5)(iii), because these are obligations related to the Commissioner's role as custodian of the SHBP.

111-4-1-.02(2)(g) has been changed to more accurately reflect current enrollment materials, which include legal notices, and to clarify that the Commissioner prepares electronic versions of these materials and delivers the electronic versions to Employing Entities, but does not provide Employing Entities with paper versions of these materials.

111-4-1-.02(3)(a) has been changed to clarify that the Employing Entities bear full responsibility for ensuring that only eligible employees are enrolled in the SHBP. This subsection has also been changed to clarify that the Employing Entities bear full responsibility for delivering enrollment materials, including legal notices, to their employees.

111-4-1-.02(3)(d) and (e) have been deleted because their requirements are already set forth in 111-4-1-.02(3)(a), and the following provisions have been renumbered accordingly.

## 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; 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 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 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 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 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.

4. The Employer Contribution Rate for the Teachers Health Insurance Fund may 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.

5. The Employer Contribution Rate for the State Employees Health Insurance Fund 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.

6. The Employer Contribution Rate required for coverage of local school board members shall be based on the actual claims experience of all county officers, employees, and local school board members enrolled in the SHBP.

7. The Contributions required from Contract Employers shall be calculated in a manner designed to ensure that Contract Employers pay the full cost of coverage for Enrolled Members, plus an administration fee.

(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 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. The term of these contracts shall be established by the Department in accordance with these regulations and Board resolutions. The Board is authorized to contract with local boards of education for inclusion of current board members and their Dependents in the SHBP. The terms of such contracts are established by these regulations once an election for inclusion has been submitted to the Department by the local board of education. 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 Contract 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. The Board may require that specified Groups provide a bond to ensure payment performance before allowing SHBP Coverage.

~~(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.

**5. Accurate and Timely Payment of Employer or Employee Contributions.**

**(i) Payroll System and Other Supporting Documentation Required.** Employing Entities that pay Employer Contributions calculated based on salaries or state based salaries must submit the documentation set forth below.

(I) Annually and upon request of the Administrator, the Employing Entity must submit documentation showing that the Employing Entity's payroll software is set up to correctly reflect the salary or state-based salary used to determine the required Employer Contribution for each month. This requirement may be satisfied by the State Accounting Office on behalf of all Employing Entities that use payroll software managed by the State Accounting Office.

(II) At the time of each payment of Contributions, the Employing Entity must submit the summary page from the payroll software that displays the total salary or state-based salary used to determine the required Employer Contribution for that month, documentation showing that Employee Contributions were properly calculated and remitted, and documentation showing that Employer and Employee Contributions required for employees on unpaid leave of absence were properly calculated and remitted.

**(ii) Local Employers.** When a required payment from a local Board of Education, RESA, library or charter school is not received by the deadline, the Administrator shall notify the appropriate superintendent or official and the State Board of Education of the delinquency. The

State Board of Education is required by law to withhold all allotments to the local Board of Education, RESA, library or charter school until the full required payment is received.

(iii) **Entities Included in the SHBP Pursuant to Contract.** 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. 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.

(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 Employer Contribution Rates 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.

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

(g) **Develop and Publish Enrollment Materials, Legal Notices, and Plan Documents.** The Commissioner shall cause to be developed enrollment materials, legal notices, and plan documents. Plan documents shall include, for each option, 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 publish enrollment materials, legal notices, and plan documents on the portion of the Department Website dedicated to the State Health Benefit Plan, and shall provide electronic versions of the enrollment materials, legal notices and plan documents to cause a pre-determined percentage of the SPDs to be printed and distributed to each local and state Employer for distribution to eligible Members and Enrolled Members. The Commissioner or designee shall cause to distribute the enrollment materials, legal notices and plan documents 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. 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.

(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 SHBP eligibility requirements of the SHBP, which are set forth in the regulations. Each Employing Entity shall provide enrollment materials, legal notices and plan documents to eligible Members and Enrolled Members, and 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 timely obtain the completed enrollment or declination form, or from the Employing Entity's failure to provide Plan Documents, legal notices or 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 Enrollment Information to Eligible Members.** Each Employing Entity shall make available to eligible Members all educational and benefit enrollment information necessary for the eligible Members to make 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.~~

**(fd) Administer Leave Without Pay Provisions.** Each Employing Entity shall administer Approved Leave of Absence Without Pay, Military Leave, 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.

**(ge) 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. 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 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.

**(hf) 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).

## **SYNOPSIS OF PROPOSED RULE CHANGES**

### **RULES OF DEPARTMENT OF COMMUNITY HEALTH STATE HEALTH BENEFIT PLAN**

#### **RULE 111-4-1-.04 ELIGIBILITY FOR COVERAGE**

#### **STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE**

##### **Synopsis**

Changes have been made in order to clarify the eligibility of individuals employed by a group with which the Department is authorized to contract for inclusion in the SHBP.

Changes have been made in order to comply with the Patient Protection and Affordable Care Act of 2010.

##### **Explanation of Changes**

111-4-1-.04(1)(a) has been changed to clarify that an individual employed by a group with which the Department is authorized to contract for inclusion in the SHBP is only eligible if the Department is in fact providing coverage to the group through such a contractual relationship.

111-4-1-.04(2)(b)(3) has been changed to clarify that the coordination of benefits provisions are contained in the Summary Plan Descriptions and not in the regulations.

111-4-1-.04(6) has been changed to reflect the fact that the Employing Entity, and not the Administrator, is responsible for administering Leave Without Pay provisions and collecting required documentation.

The Patient Protection and Affordable Care Act of 2010 ("PPACA") prohibits group health plans from considering the marital, employment or student status, or the residency or financial dependence of natural children, adopted children, foster children and step-children under age twenty-six. PPACA also requires group health plans to provide coverage for these dependent children until age twenty-six. PPACA permits group health plans to impose financial dependency requirements on other children, such as legal wards. 111-4-1-.01(8) "Dependent Child" and 111-4-1-.01(9) "Totally Disabled Child" have been revised to comply with PPACA.

#### **111-4-1-.04 Eligibility for Coverage.**

(1) Active Employees. Employees who are actively at work or on approved leave of absence and have not terminated their employment may participate in the SHBP if classified as the following:

##### **(a) Full-Time.**

1. State Employees who work a minimum of thirty (30) hours per weeks are considered full-time.
2. A regular full-time Employee who receives a salary or wage payment from a state department, board, agency, commission, the general assembly, a community service board, or a local government or other organization with to which the Department of Community Health provides SHBP coverage through a contract authorized by the Board of Community Health is authorized to contract; except contingent workers of the Labor Department, specially classified Employees of the Jekyll Island State Park Authority, Employees working as an independent contractor or on a temporary, seasonal, or intermittent basis and Employees whose duties are expected to require less than nine (9) months of service.
3. A regular full-time Employee who receives a salary or wage payment from a state authority that participates in the Employees' Retirement System;
4. Part-time Employees of the General Assembly who had coverage prior to January 1981, and Administrative and clerical personnel of the General Assembly;
5. A full-time district attorney, assistant district attorney who was appointed pursuant to O.C.G.A. § 15-18-14, or district attorneys' investigators appointed pursuant to O.C.G.A. § 15-18-14.1 of the superior courts of this state;
6. A full-time Employee who receives a salary or wage payment from a county board of health or a county board of family and children services that receives financial assistance from the Department of Human Resources; except for sheltered workshop Employees;
7. Full-time secretaries and law clerks who are employed by district attorneys and judges and are employed under O.C.G.A. §§ 15-6-25 through 15-6-28 and O.C.G.A. §§15-18-17 through 15-18-19.

(b) Teachers who are employed not less than half time, which must be at least seventeen and a half (17½) hours per week, in the public school systems of Georgia are eligible to participate under these regulations. An eligible teacher shall not include any independent contractor, emergency or temporary person and is further defined as:

1. A person employed in a professionally Certificated Capacity or Position in the public school systems of Georgia;
2. A person employed by a regional or county library of Georgia;
3. A person employed in a professionally Certificated Capacity or Position in the public vocational and technical schools operated by a local school system;

4. A person employed in a professionally Certificated Capacity or Position in the Regional Educational Service Areas of Georgia;

5. A person employed in a professionally Certificated Capacity or Position in the high school program of the Georgia Military College.

(c) Public School Employees who are employed by a local school system that have elected to participate in the Plan, and are not considered independent contractors, are eligible to enroll under the conditions of these regulations.

1. An Employee who is eligible to participate in the Public School Employees Retirement System as defined by Paragraph (20) of O.C.G.A. § 47-4-2 may enroll, provided the Employee works the greater of at least 60 percent of the time required to carry out the duties of such position or a minimum of fifteen (15) hours per week and is not employed on an emergency or temporary basis.

2. An Employee who holds a non-certificated public school position and who is eligible to participate in the Teachers Retirement System (or other independent local school retirement system), provided the Employee is not employed on an emergency or temporary basis and the Employee works at least 60 percent of the time required to carry out the duties of such position or a minimum of twenty (20) hours per week, whichever is greater may enroll.

(d) **Local Boards of Education** that elect to provide group medical insurance for members of the local board of education, their spouses, and dependents in accordance with O.C.G.A. § 45-18-5 are eligible to enroll under the conditions of these regulations. Collection and remittance of Enrolled Member premium and employer contribution amounts shall be in accordance with O.C.G.A. § 20-2-55 and these regulations.

(2) **Retired Employees.** Any Employee who was eligible to participate under 111-4-1-.04(1)(a), 111-4-1-.04(1)(b), or 111-4-1-.04(1)(c) and who was enrolled in the Plan at the time of retirement shall be eligible to continue coverage if:

(a) The Retired Employee is eligible to immediately receive an annuity from the Employees' Retirement System, Georgia Legislative Retirement System, Judicial Retirement System, Superior Court Judges or District Attorneys' Retirement System, Teachers Retirement System, Public School Employees Retirement System, any local school system teachers retirement system, or other retirement system with which the Board is authorized to contract; or

(b) The Retired Employee as an Employee of a county department of family and children services or a county department of health is eligible to receive an annuity from the Fulton County Retirement System.

(3) **Eligibility for Coverage as an Enrolled Member and a Dependent.** In the situation where both husband and wife are eligible to be covered under the SHBP as an Enrolled Member, each may enroll as a Member and enroll the eligible dependents, ~~so that~~ the benefits provided under the SHBP will be coordinated in accordance with the Coordination of Benefits or the Medicare Coordination of Benefits provisions of ~~these~~ regulations the Summary Plan Description. In no case shall the sum of the total benefits provided by the SHBP exceed the reasonable charges for covered services.

**(4) Eligibility for Coverage as an Enrolled Member Limited.** In the situation where the Enrolled Member is entitled to Coverage under the SHBP as an Active Employee under a health insurance act and Retired Employee under a different health insurance act, or any combination of provisions, the Member may choose among the Active Employee provisions under which the Member will be covered, but may not choose Coverage as a Retiree or Beneficiary of a Retiree as long as the Member is eligible for Coverage under one of the Active Employee provisions. In no circumstance shall the individual be an Enrolled Member under more than one provision of these regulations.

**(5) Eligibility for Coverage as an Active Employee with Two (2) Employing Entities.** Dual eligibility and overlapping Coverage shall be handled as follows:

**(a) Dual Eligibility.** In the situation where the Enrolled Member is eligible for Coverage under the SHBP as an Active Employee of two (2) separate Employing Entities, the Employee may, during the annual Open Enrollment period, elect which Employing Entity shall deduct the Employee Premium in the upcoming Plan Year. Each Employing Entity is responsible for remitting Employer Contribution amounts in accordance with 111-4-1-.02(3)(d) of these regulations.

**(b) Overlapping Coverage.** In the situation where the Enrolled Member experiences a period of overlapping Coverage as a result of transferring employment between two (2) separate Employing Entities, the Coverage effective date with the second Employer shall determine the Coverage termination date with the first Employer. The Employing Entities shall be responsible under this provision for deducting or refunding Employee Premiums as appropriate.

**(6) Employees on Leave Without Pay.** Active Employees who are Enrolled Members of the SHBP may continue the Coverage in which enrolled during a period of "Approved Leave of Absence Without Pay", subject to the conditions in these regulations. Enrolled Employees who are on suspension or Approved Leave of Absence Without Pay who did not continue Coverage shall not be eligible to enroll or re-enroll for Coverage while on Approved Leave of Absence Without Pay under any provision of these regulations except during the annual Open Enrollment period. Except for military leave Coverage shall not be extended for an Employee who is self employed or gainfully employed by another party during a period of Approved Leave of Absence Without Pay. A request to continue Coverage while on Approved Leave Without Pay must be received by the ~~Administrator~~ Employing Entity within thirty-one (31) calendar days of the termination of paid Coverage through payroll Deductions. Employees who qualify for continued Coverage under multiple leave types may continue Coverage under a combination of leave types; however, the total period of Coverage on Approved Leave of Absence Without Pay shall not exceed twelve (12) calendar months, unless otherwise noted in these provisions. Premium payments must be in an amount sufficient to provide continuous Coverage between termination of paid Coverage through payroll Deductions and the beginning of Approved Leave of Absence Without Pay Coverage. When an Employee on Approved Leave of Absence Without Pay enrolls during the annual Open Enrollment, Period the twelve (12) calendar month Coverage period shall be reduced by the number of prior months of Approved Leave of Absence Without Pay during which the Employee did not elect to participate in the SHBP.

**(a) Disability Leave.** A disability leave is the period of time an Approved Leave of Absence Without Pay has been granted to the Employee due to personal illness, accident or disability. Coverage may be continued under this paragraph for the period of disability, but not longer than twelve (12) consecutive calendar months. Certification of the disability period by a licensed physician shall be required to continue coverage under this provision.

(b) **Reduced Working Hours Due to Partial Disability.** A Partial Disability leave is the period of time during which an Employer approves an Employee's return to work on a part-time basis from a period of disability leave or paid leave if the part-time work is part of a process to gradually return the Employee to full-time work. Coverage may be continued under this provision for the period of disability approved by a licensed physician, but not longer than twelve (12) consecutive calendar months, inclusive of any time from a period of disability leave without pay. Certification of the Partial Disability period shall be required to continue coverage under this provision.

(c) **Leave of Absence for the Employer's Convenience.** Employer's convenience leave is a period of time during which an Approved Leave of Absence Without Pay has been granted by the appropriate organizational official due to a regular programmatic plan for Employee absence and pursuant to appropriate regulation. The Employee may continue the Coverage such leave of absence, but not longer than twelve (12) consecutive calendar months.

(d) **Educational Leave.** Educational leave is the period of time during which an Approved Leave of Absence Without Pay has been granted by the appropriate organizational official for educational or training purposes. The Employee may continue the Coverage under such leave for the period of absence, but not longer than twelve (12) consecutive calendar months.

(e) **Family Medical Leave.** Family medical leave is the period of time during which an Approved Leave of Absence Without Pay has been granted to the Employee by the appropriate organizational official for personal illness, the care of the Employee's child after birth or placement for adoption or the care of an Employee's seriously ill Spouse, child, or parent. An Employee's personal illness, if properly certified and approved may be granted under the disability leave provisions. Coverage while on Approved Leave of Absence Without Pay for family medical leave may be continued for the period of approved leave, but not longer than twelve (12) weeks in any twelve (12) consecutive month period.

(f) **Military Leave.** Military leave is the period of time during which an Approved Leave of Absence Without Pay has been granted by the appropriate organization official when an Employee is ordered to military duty or the period, as provided by law, during which an Employee is attending military training. Military leave also applies to an Employee who qualifies for an exigency leave or service member care leave, as defined under Federal law. The Employee may continue the Coverage under such leave for the period of absence.

(g) **Suspension or Other Leave of Absence.** Suspension or other leave of absence is the period of time during which suspension is in effect or an Approved Leave of Absence Without Pay has been granted by the appropriate organization official for the Employee's convenience. The Employee may continue the Coverage for the period of suspension or approved leave, but not to exceed twelve (12) calendar consecutive months, provided the Employee is not self employed or gainfully employed by another party during such leave of absence.

(h) **Extensions of Leave of Absence.** If the Employee is unable to return to work at the expiration of the approved leave and the maximum period has not been exhausted, a request to extend the leave of absence may be filed. The Administrator must receive the Employee's request for extension no later than thirty-one (31) calendar days following expiration of Coverage under the leave of absence. The Employing Entity must certify approval of the

extension. The attending physician must complete a new disability certification for an extension of a disability leave.

(i) **Sequential Periods of Leave.** Health benefits may be continued during sequential types of leave, provided that continuation of health benefits during continuous, sequential periods of time shall not exceed the time limitation of the most recently approved type of leave.

(j) **Premiums.** Premiums for continued Coverage during a period of Approved Leave of Absence Without Pay shall be paid monthly. When establishing the monthly Premium amount to be paid by the Employee, the Board may add a processing fee. The Premium Rate, excluding the processing fee, shall be based on the type of approved leave. The Premium Rate for disability, family leave or military leave of absence shall be the same as the Employee Deduction; the Premium Rate for all other types of leave shall be the total amount, which consists of the Employee Deduction and average Employer Contribution. Failure to pay the full Premium as billed within the allotted time shall result in termination of Coverage until the first of the month following a payroll deduction for coverage after the Employee returns to work or until all premiums are paid in full if the Employee remains out on leave.

(7) **Spouse.** An Active Employee shall be entitled to enroll the Employee's Spouse upon employment, during Open Enrollment, or under conditions specified in Section 111-4-1-.06 of these regulations. A Retiree shall be entitled to continue Coverage for the Spouse upon retirement or may enroll the Spouse in accordance with Section 111-4-1-.06 (5) or 111-4-1-.06 (6). The Administrator shall require appropriate documentation from an Enrolled Member in order to verify a Spouse's eligibility for Coverage.

(8) **Dependent Child.** An Active Employee shall be entitled to enroll eligible Dependent children upon employment, during Open Enrollment, or under conditions specified in Section 111-4-1-.06 of these regulations. A Retiree shall be entitled to continue Coverage for eligible Dependent children upon retirement or may enroll eligible Dependent children in accordance with Section 111-4-1-.06 (5). The Administrator shall require appropriate documentation from an Enrolled Member in order to verify a Dependent child's eligibility for Coverage. An eligible Dependent child must meet one of the following definitions; is one who is not married nor has been married, except for a legally accepted annulment, and is:

(a) A natural child, for which the natural guardian has not relinquished all guardianship rights through a judicial decree, for the period from birth to the Eligibility begins at birth and ends at the end of the month in which the child reaches age nineteen (19); twenty-six (26).

(b) An adopted child. Eligibility begins on the date of legal placement for adoption and for the period from the date of adoption contract. Coverage may be granted from the date of legal physical custody and placement in the home. Coverage ends at the end of the month in which the child reaches age twenty-six (26). nineteen (19);

(c) A stepchild, who resides in the Enrolled Member's home one hundred eighty (180) days or more per year in a parent-child relationship. Eligibility begins on the later of the date of marriage to the natural parent, or the effective date of a custody order resulting in residential custody greater than one hundred eighty (180) days per year. Eligibility and ends at the earlier end of: the month in which the child turns reaches age nineteen (19), if not a full-time student, the date of the Enrolled Member's divorce from the natural parent, or the effective date of a change in the joint custody order that results in residential custody of less than one hundred

eighty (180) days per year; twenty-six (26), or at the end of the month in which he or she loses status as the stepchild of the Enrolled Member, whichever date is earlier, or

~~(d) Guardianship. A resident in the Enrolled Member's home in a parent-child relationship and is legally certified as a Dependent of the Enrolled Member for financial support until the earlier of the end of the month in which the child reaches age nineteen (19) or the expiration date specified in the court order; provided, however, certification of legal dependency is submitted to and approved by the Administrator. child for whom the Enrolled Member is the legal guardian. Eligibility begins on the date the legal guardianship is established and ends at the end of the month in which the child reaches ages in which the child reaches age twenty-six (26), or at the end of the month in which the legal guardianship terminates, whichever is earlier. Certification documentation requirements are at the discretion of the Administrator. However, a judicial decree from a court of competent jurisdiction is required unless the Administrator concludes that documentation is satisfactory to meet the test of legal dependency establish legal guardianship and financial dependence and that other legal papers present undue hardship on the Member or living natural parent(s).~~

~~—(9) **Full-time Student.** An eligible Dependent child may be included under the Enrolled Member's Coverage while a full-time student in Full-Time Attendance at an Accredited School after age nineteen (19) and until the end of the month in which the child reaches age twenty-six (26), or age twenty-three (23) for TriCare Supplement, provided the child, if employed, is not eligible for a substantially comparable medical benefit plan at the place of employment. Failure to document eligibility and Full-Time Attendance or registration prior to loss of Coverage as an eligible Dependent child or as an eligible student under this Plan shall result in loss of the Dependent's eligibility for Coverage until the next Open Enrollment period or subsequent Qualifying Event.~~

~~—(a) If a full-time student's attendance is interrupted by a period of disability, the Administrator may, upon receipt of appropriate medical information, extend Coverage as a temporarily Disabled Student for the lesser of twelve (12) consecutive months or the period of temporary disability. Documentation of temporary disability must be received by the Administrator no later than thirty-one (31) calendar days following the date of temporary disability.~~

~~(b) The Administrator shall require appropriate documentation to demonstrate Full-Time Attendance or registration and eligibility for a student between the ages of nineteen (19) and twenty-six (26) for re-enrollment after a period of non-Coverage.~~

~~-(10) **Failure to Document Eligibility for Coverage.** For subsections 111-4-1-.04(7) through 111-4-1-.04(9) immediately above, a failure to fully document eligibility of a Dependent shall result in loss of the Dependent's eligibility for Coverage until such documentation is received by SHBP.~~

~~(449) **Totally Disabled Child.** An Enrolled Member shall be entitled to apply for Coverage of a natural child, legally adopted child or stepchild after age nineteen (19) twenty-six (26) or older if the child is was physically or mentally disabled before age twenty-six (26), continues to be physically or mentally disabled, lives with the Enrolled Member or is institutionalized and depends primarily on the Enrolled Member for support and maintenance.~~

~~(a) **Application Period.** The Enrolled Member may apply for Coverage during Open Enrollment, as a New Hire, or as the result of a Qualifying Event. At all other times, an Enrolled Members whose Totally Disabled Child was a covered dependent on the Member's Family Plan~~

prior to turning age ~~nineteen (19)~~ twenty-six (26) must apply for continuation of Coverage and include all supporting documentation no later than thirty-one (31) calendar days following the ~~new hire date or prior to the end of the month in which the child reaches age nineteen (19)~~ twenty-six (26) or ~~loses continuous Coverage as a full-time student under this Plan.~~ If the Enrolled Member fails to complete the request within the allotted time, eligibility for Coverage until the next Open Enrollment is limited to the conditions outlined for ~~full-time students or~~ Extended Beneficiaries. ~~If, however, the Dependent child was eligible for Coverage under the SHBP as a disabled Dependent upon reaching age nineteen (19), an Enrolled Member shall be entitled to apply to enroll the disabled Dependent upon loss of other group plan Coverage, provided the Administrator receives the complete application no later than thirty-one (31) calendar days following the loss of another group health plan Coverage or prior to the loss of continuous Coverage as a full-time student under this Plan.~~

(b) **Documentation and Approval.** The Administrator shall require documentation as necessary to provide certification that the child was physically or mentally incapable of sustaining, self-supporting employment because of the physical or mental disability before age twenty-six (26), continues to be is physically or mentally incapable of sustaining, self-supporting employment because of the physical or mental disability, and ~~that the child lives at the Enrolled Member's home, unless or is~~ institutionalized. The documentation may include but is not limited to certification from a qualified medical practitioner that outlines the physical and psychological history, diagnosis, and provides an estimate of length of time for disability, and an estimate of the child's earning capacity. If the documentation is satisfactory to substantiate the physical or mental disability as required in these regulations, the Administrator may approve ~~the continuation for Coverage for~~ the period of incapacitation. The Administrator may require periodic recertification of the disabling condition and circumstances, provided the recertification is not more frequent than each twelve (12) calendar months or at the end of the projected disability period if that date is less than twelve (12) calendar months.

(4210) **Surviving Beneficiary.** An Enrolled Member's Surviving Spouse and eligible Dependent children, who were included in the Coverage by the Enrolled Member may continue Coverage provided an application for continuing Coverage is received by the Administrator within thirty-one (31) calendar days following Coverage termination as a result of the death of the Enrolled Member and one or more of the following conditions are met:

(a) The Surviving Spouse of an Active Employee may continue Coverage provided the Spouse is eligible to immediately receive a monthly benefit payment from a state supported retirement system in an amount sufficient to pay the Premium. The Spouse must elect Coverage or as an Employee as a result of the Spouse's own employment, and cannot elect double or dual Coverage under separate provisions of the SHBP. The Surviving Spouse may elect to continue Coverage for surviving eligible Dependent children. Eligibility of Dependent children shall terminate in accordance with provisions for Dependent children of these regulations. An election to take a lump sum distribution rather than the monthly Annuity negates eligibility to continue Coverage as a Surviving Spouse. Surviving Spouses of Active Employees are also eligible for Coverage under the Extended Beneficiary provisions of Section 111-4-1-.08 of these regulations.

(b) The Surviving Spouse of an Annuitant may continue Coverage provided the Spouse is eligible to immediately receive a monthly benefit payment from a state supported retirement system in amount sufficient to pay the Premium. The Spouse must elect Coverage or as an Employee as a result of the Spouse's own employment, and cannot elect double or dual Coverage under separate provisions of the SHBP. The Surviving Spouse may elect to continue

Coverage for surviving eligible Dependent children. Eligibility to continue Dependent children shall terminate in accordance with provisions for Dependent children.

(c) Upon the death of an Active Employee, an eligible Dependent child who is the principal Beneficiary under one of the state supported retirement systems may continue Coverage, provided the Dependent child is not covered as a Dependent child under another contract under the SHBP, and provided the monthly benefit payment from a state supported retirement system is in an amount sufficient to pay the Premium. Eligibility to continue Coverage shall terminate in accordance with Dependent child regulations unless continued as an Extended Beneficiary. Surviving Covered Dependents of Active Employees are also eligible for Coverage under Extended Beneficiary provisions in Section 111-4-1-.08 of these regulations.

(d) Upon the death of a Retired Employee, an eligible Dependent child who is the principal beneficiary under one of the state supported retirement systems may continue coverage, provided the dependent child is not covered as a dependent child under another contract under the SHBP, and provided the monthly benefit payment from a state supported retirement system is in an amount sufficient to pay the premium. Eligibility to continue coverage shall terminate in accordance with provisions for Dependent children.

(e) The Surviving Spouse of Retired Employee who is included in Coverage at the time of death of the enrolled Retiree and who will not receive a monthly annuity payment from one of the state supported retirement systems shall be eligible to enroll oneself and any of the Retiree's Dependent children at the time of the Retiree's death under the following conditions:

1. The Surviving Spouse must make written application no later than thirty-one (31) calendar days following Coverage termination as a result of the death of the Retired Employee; and
2. The parties must have been married at least one full year prior to the death of the Retired Employee; and
3. The Surviving Spouse agrees to pay the monthly premium payment established by the Board in accordance with the established requirements; and
4. Coverage under this provision shall terminate for the Surviving Spouse and any enrolled Dependent children in the event the Surviving Spouse remarries.

(f) The eligible Covered Dependents of an Active State Employee who is killed or receives injury that results in death while acting in the scope of his or her employment may continue Coverage provided the deceased Enrolled Member's Coverage was continuous during the period between injury and death. The eligible Covered Dependents may elect Coverage as a surviving Dependent or as an Employee as a result of the person's own employment, but cannot elect double or dual Coverage under separate provisions of the SHBP. A surviving Covered Dependents must agree to pay the monthly Premium payment established by the Board in accordance with the established requirements. The Surviving Spouse may elect to continue Coverage for eligible Dependent children. Eligibility of Dependent children shall terminate in accordance with provisions for Dependent children.

(g) The Surviving Spouse shall be required to list all eligible Dependents with the Administrator at the time of such election to continue Coverage and shall not be allowed to add another Spouse or other Dependent children acquired in future marriage(s).

**(4311) Dependent Eligibility Unverified.** The Administrator shall define the supporting documentation requirements for verifying Dependent eligibility. Coverage for Dependents whose eligibility is unverified will pend awaiting receipt and review of the documentation. When the Administrator has verified eligibility of the Dependent, the Coverage will be activated in accordance with the provisions of this Section. If the Administrator cannot verify Dependent eligibility within the allotted time, the Dependent will be ineligible for Coverage. The next opportunity to enroll the Dependent and verify the Dependent's eligibility will be the annual Open Enrollment period or subsequent Qualifying Event. Changes to a different coverage tier will not be allowed based on unverified dependent eligibility.

**(4412) Retired Employees Having Intermittent Periods of Active Employment.** Retired Employees who are eligible to continue Coverage under these regulations may elect to return to or continue Active employment with any of the Employing Entities. In such case, the retirement benefit may be suspended or continued; however, the federal Social Security Act requires the health benefit Coverage must be purchased as an Active Employee whenever the eligibility requirements of Section 111-4-1-.04 of these regulations are met. At the point the Employee discontinues Active employment, continuous health benefit Coverage shall be reinstated with the state supported retirement system which previously collected the Premium. In no case, however is an individual who retired prior to the initial legislated funding for that Group of Employees to be entitled to enroll as a Retiree, unless the final Active service period qualifies the Employee for a retirement benefit by one of the state supported retirement systems.

**(4513) Judicial Reinstatement of State Employees.** State Employees who are reinstated to employment by the State Personnel Board or the judiciary shall have Coverage reinstated for themselves and any eligible Dependents. If employment reinstatement occurs within twelve (12) calendar months of discharge and back-pay for continuous employment is awarded, all retroactive Premiums must be collected and remitted to the Plan before and Claims incurred during the period may be filed for reimbursement. If back-pay to provide for continuous employment is not awarded, Coverage may be reinstated with the Employee's return to work. If reinstatement occurs following a period longer than twelve (12) calendar months after the discharge, Coverage for the Employee and previously Covered Dependents will be reinstated when the Employee returns to work or in accordance with the judicial review. In any case where the reinstatement overlaps an Open Enrollment period, the Employee will be given fifteen (15) calendar days after reinstatement to modify Coverage in compliance with Open Enrollment guidelines. Pre-existing condition limitations will be waived for the reinstated Employee and all previously enrolled Dependents. Employing Entities shall be responsible for collecting and remitting any Premiums due for the selected Coverage.

**(4614) Contract Employees.** Employees who are on approved leave of absence and/or have not terminated their employment may participate in the Plan if their Employer has contracted with the Board to provide inclusion in the SHBP. The Employee will be eligible to participate in accordance with the provisions of the contract.

Authority O.C.G.A. §§ 20-2-55, 20-2-880, 20-2-881, 20-2-885 to 20-2-887, 20-2-895, 20-2-910 to 20-2-912, 20-2-915, 20-2-916, 20-2-923, 31-3-2.1, 45-18-1 et seq., 45-20-2, 47-2-313, 47-6-41, Family and Medical Leave Act of 1993 (FMLA), Social Security Act, Uniformed Services Employment & Reemployment Act, Americans With Disabilities Act (ADA); Patient Protection and Affordable Care Act (PPACA).

**SYNOPSIS OF PROPOSED RULE CHANGES**

**RULES OF  
DEPARTMENT OF COMMUNITY HEALTH  
STATE HEALTH BENEFIT PLAN**

**RULE 111-4-1-.05  
EFFECTIVE DATE OF COVERAGE**

**STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE**

**Synopsis**

Changes have been made in order to comply with the Patient Protection and Affordable Care Act of 2010.

**Explanation of Changes**

The Patient Protection and Affordable Care Act of 2010 ("PPACA") prohibits group health plans from considering the marital, employment or student status, or the residency or financial dependence of natural children, adopted children, foster children and step-children under age twenty-six. PPACA also requires group health plans to provide coverage for these dependent children until age twenty-six. PPACA permits group health plans to impose financial dependency requirements on other children, such as legal wards.

111-4-1-.05(5)(c) "Stepchildren," (d) "Adopted Children," and (e) "Other Children" have been revised to comply with PPACA.

#### 111-4-1-.05 Effective Date of Coverage.

(1) **Upon Employment.** The Employee's Coverage under the SHBP shall become effective on the first of the month following employment for the full preceding calendar month if the Employee has not terminated employment on or before that date. Coverage for a transferring Employee shall be effective the first of the month following the end of Coverage under a previous Employing Entity. Coverage for eligible Dependents will become effective on the date the Employee's Coverage is effective.

(2) **Upon Change in Coverage.** If the Member changes Coverage to include eligible Dependents based upon acquisition of Dependent(s), Coverage for the Dependents shall become effective on the later of the first of the month following the request for Coverage, or subject to guidelines for acquisition of Dependent(s).

(3) **Upon Open Enrollment Change or Enrollment.** The effective date for enrollments or changes in Coverage election to add eligible dependents shall be January 1<sup>st</sup> unless the Member no longer meets the definition of an Active Employee on or before that date. The termination date for Open Enrollment discontinuation of Coverage shall be December 31<sup>st</sup>. Subject to the provisions of Section 111-4-1-.06 of these regulations, Coverage elections shall be binding upon the Member for the duration of the Plan Year.

(4) **Upon Return from Leave Without Pay.** The effective date for re-enrollments following an Approved Leave of Absence Without Pay shall be the first of the month following the return to work. The effective date for re-enrollments following a military leave without pay shall be the first of the month following the return to work or the date employment is reinstated. In all instances, the appropriate Premiums must be deducted and remitted by the Employing Entity.

(5) **Upon Acquisition of a Dependent.** The effective date of Coverage for acquired Dependents is subject to the requirements as outlined for the Member and shall be the later of the first of the month following the request for Coverage or:

(a) **Legally Married Spouse.** The effective date of Coverage shall be no earlier than the first of the month of marriage to the Member. The Plan is not responsible for payment of the Spouse's medical services incurred prior to the actual date of the marriage.

(b) **Natural Children.** The effective date of Coverage shall be the date of birth.

(c) **Stepchildren.** The effective date of Coverage shall be no earlier than the date of marriage of the Member and the natural parent of the children, ~~or the date that the stepchildren began living in the home of the Member, if later than the date of parental marriage.~~

(d) **Adopted Children.** The effective date of Coverage shall be no earlier than the date of legal placement for adoption, ~~specified in the adoption contract. Coverage may be granted based on the date of legal placement and physical custody.~~

(e) **Other Children.** The effective date of Coverage shall be no earlier than the date that sole legal guardianship is established, ~~the first of the month in which the court approves legal guardianship.~~

(f) **Full-time Student Children.** The effective date of Coverage shall be no earlier than the first of the month of documented Full-time Attendance at an Accredited School.

(6) **Premium.** The Administrator shall terminate Coverage of Enrolled Members and Covered Dependents for which the Plan has not received full payment of the required Premium prior to the first day of the Coverage month. Terminated Coverage will be reactivated upon receipt of full payment of the required monthly Premium.

Authority O.C.G.A. §§ 20-2-881, 20-2-911, 45-18-2, Health Insurance Portability and Accountability Act (HIPAA), Internal Revenue Code Section 125, Uniformed Services Employment and Reemployment Act 5; Patient Protection and Affordable Care Act (PPACA).

**SYNOPSIS OF PROPOSED RULE CHANGES**

**RULES OF  
DEPARTMENT OF COMMUNITY HEALTH  
STATE HEALTH BENEFIT PLAN**

**RULE 111-4-1-.09  
TERMINATION OF COVERAGE**

**STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE**

**Synopsis**

Changes have been made in order to comply with the Patient Protection and Affordable Care Act of 2010.

**Explanation of Changes:**

The Patient Protection and Affordable Care Act of 2010 ("PPACA") prohibits group health plans from considering the marital, employment or student status, or the residency or financial dependence of natural children, adopted children, foster children and step-children under age twenty-six. PPACA also requires group health plans to provide coverage for these dependent children until age twenty-six. PPACA permits group health plans to impose financial dependency requirements on other children, such as legal wards. 111-4-1-.09(6) "Dependent Child" has been revised to comply with PPACA.

## **111-4-1-.09 Termination of Coverage.**

(1) **Termination from Employment.** Termination from employment includes resignation, abandonment of job, release from job, forfeiture of job, and all other types of termination. Health benefit Coverage shall terminate at the end of the month following the month of the last date of employment that was transmitted to the Administrator unless continued under the provision of Extended Coverage. This date will normally be the end of the month following the month in which separation or termination of employment occurred.

(2) **Employment Layoff.** Employment layoff means that the Employer has formalized a reduction in staff plan and the Employee will no longer be employed by one of the Employing Entities. Health Benefit Coverage shall terminate at the end of the month following the month of the last date of employment that was transmitted to the Administrator, unless continued under the provisions of Extended Coverage. The Coverage termination date will normally be the end of the month following the month in which the layoff occurred.

(3) **Reduction of Hours.** A reduction in hours worked may result in loss of eligibility to continue health benefit Coverage.

(a) If for any reason the number of worked hours is reduced for a covered State Employee to less than thirty (30) hours per week, Coverage shall terminate at the end of the month following the month in which the reduced hours took effect; unless continued under the provisions of Extended Coverage.

(b) If for any reason the number of worked hours is reduced for a covered Teacher to less than half-time or a minimum of seventeen and one-half (17 ½) hours per week, Coverage shall terminate at the end of the month following the month in which the reduced hours took effect; unless continued under the provisions of Extended Coverage.

(c) If for any reason the number of worked hours is reduced for a covered Public School Employee to less than sixty (60) percent of that required to perform the position duties, Coverage shall terminate at the end of the month following the month in which the reduced hours took effect; unless continued under the provisions of Extended Coverage. However, the sixty (60) percent cannot be less than twenty (20) hours if the Member is a participant in the Teachers Retirement System and less than fifteen (15) hours if the member is a participant in the Public School Employees Retirement System.

(4) **Failure to Return from an Approved Leave of Absence Without Pay.** If an Employee on an Approved Leave of Absence Without Pay fails to return to Active employment, Coverage will terminate at the earlier of the end of the month for which the Leave Without Pay was approved or the end of the month for which a valid Premium payment has been received. Failure to return to Active employment from an Approved Leave of Absence Without Pay will be considered termination of employment for the purposes of Extended Coverage eligibility.

(5) **Legal Separation or Divorce.** Coverage for a legally separated or divorced Spouse will terminate at the end of the month in which the separation papers were

approved by a court of competent jurisdiction or in which the divorce decree is approved by the court of competent jurisdiction unless continued as an Extended Beneficiary.

(6) **Dependent Child.** Coverage for an eligible Dependent child shall terminate at the end of the month in which the child marries, enters into full-time military service, reaches age nineteen ~~(19)~~ twenty-six (26) unless a Qualified Medical Child Support Order (QMCSO) or other court order bears an earlier expiration date or Coverage is continued under the provisions for a Totally Disabled Child, or an Extended Beneficiary, ~~or as a Full-time Student.~~

~~(7) **Full-time Student.** Coverage as a Full-time Student shall terminate at the earlier of the end of the month in which the Administrator has determined the Dependent does not meet the criteria for Coverage, or~~

~~(a) At the end of the month in which the Dependent child graduates, or~~

~~(b) At the end of the month in which academic requirements for graduation are completed if graduation is delayed more than one month, or~~

~~(c) At the end of the month in which the child ceases to be in Full-time Attendance at an accredited school. The Administrator may cancel any certified period of coverage on a prospective basis when information becomes available that the child no longer fulfills the requirements of a Full-time Student.~~

(87) **Failure to Remit Premium.** Failure to remit the billed Premium amount in full within thirty (30) calendar days following the end of the month for which Coverage has been paid will result in suspension of benefit payments and will constitute forfeiture of eligibility to continue Coverage while on Approved Leave of Absence Without Pay or Extended Coverages of any kind. Coverage will not be reinstated for payments received thirty (30) calendar days following termination of Coverage for insufficient payment, unless an administrative error has been made. Failure to remit Premium will constitute a declination of eligibility to continue coverage as an Extended Beneficiary without further notice by the Administrator.

(98) **Expiration of Approval Leave of Absence Without Pay.** Coverage will terminate at the end of the month following expiration of the Approved Leave of Absence Without Pay period unless the leave is extended by the appropriate organizational official and such extension is approved by the Administrator or the Employee returns to work, or the Employee extends coverage under the provisions of Extended Coverage. Coverage may be terminated earlier than the expiration of such leave when the Failure to Remit Premium provisions of these regulations apply.

(409) **Expiration of Coverage as a Pending Retiree.** Health benefit Coverage will terminate at the end of the month following determination that the Retiree is not immediately eligible to receive an annuity under a state supported participating retirement system operated for Employees, unless the Retiree is eligible to continue Coverage under the Extended Coverage provisions of these regulations. Pending Retirees appealing a denial of retirement benefits may continue up to the maximum period outlined in Section 111-4-1-.07.

(4410) **Expiration of Extended Beneficiary Coverage Privileges.** Health benefit Coverage for Extended Beneficiaries will terminate at the end of the month in which the earliest of the following conditions occur:

(a) The full Premium amount is not paid within the time allowed under these regulations;

- (b) The maximum Coverage period permitted under these regulations is exhausted;
- (c) The Extended Beneficiary becomes enrolled in Medicare benefits;
- (d) The Extended Beneficiary becomes covered under another group health care plan by reason of employment or marriage, and pre-existing condition exclusions are not applied under the new coverage;
- (e) Cancellation of contract with an organization with whom the Board of Community Health is authorized to contract;
- (f) The State Health Benefit Plan is terminated.

**(1211) Deceased Enrolled Member.** Coverage shall terminate no later than the end of the month of death of a Member enrolled in employee only Coverage. Coverage shall terminate no later than the end of the month following the month of death of a Member when the Coverage includes Dependents. The Employing Entity, retirement system or deceased's estate shall remit the appropriate Premium. A surviving Beneficiary may continue coverage as outlined in 111-4-1-.04, the Extended Coverage provisions of these regulations.

**(1312) Discontinuation of Coverage Outside Open Enrollment.** Coverage shall terminate no earlier than the end of the month following receipt of the request to discontinue Coverage outside the annual Open Enrollment period. Requests to discontinue Coverage must be approved by the Administrator. The Administrator may require documentation of other Coverage.

**(1413) Suspension of Benefits Due to Nonpayment.** If an Employing Entity fails to remit Premiums or documentation or fails to reconcile bills in the manner required by the Plan, the Plan may suspend benefit payments for Enrolled Members of the Employing Entity.

Authority O.C.G.A. §§ 20-2-881, 20-2-911, 45-18-1 et seq., IRS Code Section 125; Patient Protection and Affordable Care Act (PPACA).