MISSISSIPPI LEGISLATURE REGULAR SESSION 2009

By: Senator(s) Clarke To: Insurance

SENATE BILL NO. 2842
(As Passed the Senate)

AN ACT TO AMEND SECTION 83-9-203, MISSISSIPPI CODE OF 1972, TO REVISE THE PURPOSE OF THE COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION; TO AMEND SECTION 83-9-205, MISSISSIPPI CODE OF 1972, TO REVISE DEFINITIONS; TO AMEND SECTION 83-9-209, MISSISSIPPI CODE OF 1972, TO INCREASE THE LIFETIME MAXIMUM BENEFITS; TO AMEND SECTION 83-9-211, MISSISSIPPI CODE OF 1972, TO REVISE THE MEMBERSHIP OF THE BOARD OF DIRECTORS; TO AMEND SECTION 83-9-213, MISSISSIPPI CODE OF 1972, TO REVISE THE POWERS OF THE ASSOCIATION; TO AMEND SECTION 83-9-215, MISSISSIPPI CODE OF 1972, TO CLARIFY THE POWERS AND DUTIES OF THE ADMINISTERING INSURER; TO AMEND SECTION 83-9-217, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR FILING OF REPORTS NECESSARY FOR ASSESSMENTS; TO AMEND SECTION 83-9-221, MISSISSIPPI CODE OF 1972, TO REVISE THE PRIMARY SOURCES OF BENEFITS; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. Section 83-9-203, Mississippi Code of 1972, is amended as follows:

83-9-203. It is the purpose of the Legislature to establish a mechanism to allow the availability of a health insurance program and to allow the availability of health and accident insurance coverage to those citizens of this state who (a) because of health conditions cannot secure such coverage, or (b) desire to obtain or continue health insurance coverage under any state or federal program designed to enable persons to obtain or maintain health insurance coverage.

SECTION 2. Section 83-9-205, Mississippi Code of 1972, is amended as follows:

83-9-205. As used in Sections 83-9-201 through 83-9-222, the following words shall have the meaning ascribed herein unless the context clearly requires otherwise:

(a) "Association" means the Comprehensive Health Insurance Risk Pool Association.

(b) "Board" means the board of directors of the association.

(c) "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

(d) "Commissioner" means the Commissioner of Insurance of this state.

(e) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 USCS Section 9801(c)(1)). A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under the plan, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(f) "Dependent" means a resident spouse or resident unmarried child under the age of nineteen (19) years, a child who is a student under the age of twenty-three (23) years and who is financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

(g) "Excess or stoploss coverage" means an arrangement whereby an insurer insures against the risk that any one (1) claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount.

(h) "Federally defined eligible individual" means an individual:

(i) For whom, as of the date on which the individual seeks coverage under the plan, the aggregate of the periods of creditable coverage is eighteen (18) or more months;

(ii) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with such a plan;

(iii) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social

Security Act (Medicare), or a state plan under Title XIX of the act (Medicaid) or any successor program, and who does not have other health insurance coverage;

(iv) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(v) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and

(vi) Who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in subparagraph (v).

(i) "Governmental plan" has the meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

(j) "Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

(k) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care services plan contract, health maintenance organization subscriber contract or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise *** * ***.

(i) "Health insurance coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident, or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(ii) "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

3. Other similar, limited benefits specified in federal regulations issued pursuant to Public Law 104-191.

(iii) "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

1. Coverage only for a specified disease or illness; or

2. Hospital indemnity or other fixed indemnity insurance.

(iv) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

2. Coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

3. Similar supplemental coverage provided to coverage under a group health plan.

(l) "Health maintenance organization" means any organization authorized under the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act, Section 83-41-301 et seq., to operate a health maintenance organization in this state.

(m) "Insurer" means any entity that is authorized in this state to write health insurance coverage or that provides health insurance coverage in this state or any third-party administrator. For the purposes of Sections 83-9-201 through 83-9-222, insurer includes an insurance company, nonprofit health care services plan, fraternal benefit society, health maintenance organization, to the extent consistent with federal law any self-insurance arrangement covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state, any other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation and any reinsurer reinsuring health insurance coverage in this state.

(n) "Medicare" means coverage under both Parts A or B of Title XVIII of the Social Security Act, 42 USC, Section 1395 et seq., as amended.

(o) "Plan" means the health insurance plan adopted by the board under Sections 83-9-201 through 83-9-222.

(p) "Resident" means an individual who is legally located in the United States and has been legally domiciled in this state for a period to be established by the board and subject to the approval of the commissioner but in no event shall such residency requirement be greater than one (1) year, except that for a federally defined eligible individual, there shall not be a prior residency requirement.

(q) "Agent" means a person who is licensed to sell health insurance in this state or a third-party administrator.

(r) "Covered person" means any individual resident of this state (excluding dependents) who is eligible to receive benefits from any insurer.

(s) "Third-party administrator" means any entity who is paying or processing health insurance claims for any Mississippi resident.

(t) "Reinsurer" means any insurer from whom any person providing health insurance coverage for any Mississippi resident procures insurance for itself in the insurer, with respect to all or part of the health insurance coverage risk of the person.

(u) "Significant break in coverage" means a period of sixty-three (63) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

SECTION 3. Section 83-9-209, Mississippi Code of 1972, is amended as follows:

83-9-209. (1) Any individual who is and continues to be a resident shall be eligible for coverage under this plan if evidence is provided of:

(a) A notice of rejection or refusal to issue substantially similar insurance for health reasons by one (1) insurer;

(b) A refusal by an insurer to issue insurance except with material underwriting restriction; or

(c) A refusal by an insurer to issue insurance except at a rate exceeding the plan rate.

(2) A federally defined eligible individual who has not experienced a significant break in coverage and who is and continues to be a resident shall be eligible for plan coverage.

(3) The board shall develop a procedure for eligibility for coverage by the association for any natural person who changes his domicile to this state and who at the time domicile is established in this state is insured by an organization similar to the association. The eligible maximum lifetime benefits for such covered person shall not exceed the lifetime benefits available through the association, less any benefits received from a similar organization in the former domiciliary state.

(4) The board shall promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance coverage under subsection (1) of this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in subsection (1) of this section. The list may be amended by the board from time to time as may be appropriate.

(5) A person shall not be eligible for coverage under this plan if:

(a) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it; except that:

(i) A person may maintain other coverage for the period of time the person is satisfying a preexisting condition waiting period under a plan policy; and

(ii) A person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy.

(b) The person is determined to be eligible for health care benefits under the Mississippi Medicaid Law, Section 43-13-101 et seq. or Medicare.

(c) The person previously terminated plan coverage unless twelve (12) months have elapsed since the person's latest termination, except that this paragraph (c) shall not apply with respect to an applicant who is a federally defined eligible individual.

(d) The plan has paid out One Million Dollars ($1,000,000.00) in benefits on behalf of the person. The lifetime maximum shall be One Million Dollars ($1,000,000.00).

(e) The person is an inmate or resident of a public institution.

(f) The person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

(6) The coverage of any person shall cease:

(a) On the date a person is no longer a resident of this state;

(b) Upon the death of the covered person;

(c) On the date state law requires cancellation of the policy; or

(d) At the option of the association, thirty (30) days after the association makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

(7) The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated immediately.

(8) It shall constitute an unfair trade practice for any insurer, insurance agent or broker, employer or third-party administrator to refer an individual employee or a dependent of an individual employee to the association, or to arrange for an individual employee or a dependent of an individual employee to apply to the program, for the purpose of separating such employee or dependent from a group health benefits plan provided in connection with the employee's employment.

SECTION 4. Section 83-9-211, Mississippi Code of 1972, is amended as follows:

83-9-211. (1) There is created a nonprofit legal entity to be known as the "Comprehensive Health Insurance Risk Pool Association." All insurers, as a condition of doing business, shall be members of the association.

(2) (a) The association shall operate subject to the supervision and approval of a nine-member board of directors consisting of:

(i) Four (4) members appointed by the Insurance Commissioner. Two (2) of the commissioner's appointees shall be chosen from the general public and shall not be associated with the medical profession, a hospital or an insurer. One (1) appointee shall be representative of medical providers. One (1) appointee shall be representative of health insurance agents. Any

board member appointed by the commissioner may be removed and replaced by him at any time without cause.

(ii) Three (3) members appointed by the participating insurers, at least one (1) of whom is a domestic insurer.

(iii) The Chair of the Senate Insurance Committee and the Chair of the House Insurance Committee, or their designees, who shall be nonvoting, ex officio members of the board.

(iv) Of those members appointed by the Insurance Commissioner, one (1) shall serve for a term of one (1) year, two (2) for a term of two (2) years, and one (1) for a term of three (3) years. Of those members appointed by the participating insurers, one (1) shall serve for a term of one (1) year, one (1) shall serve for a term of two (2) years, and one (1) shall serve for a term of three (3) years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

(v) All terms after the initial term shall be for a period of three (3) years.

(b) The board of directors shall elect one (1) of its members as chairman.

(c) Board members may be reimbursed from monies of the association for actual and necessary expenses incurred by them as members in the manner and amount provided in Section 25-3-41, Mississippi Code of 1972, but shall not otherwise be compensated for their services.

(3) The association shall adopt a plan in accordance with Sections 83-9-201 through 83-9-222 and submit its articles, bylaws and operating rules to the State Department of Insurance for approval. If the association fails to adopt such plan and suitable articles, bylaws and operating rules within ninety (90) days after the appointment of the board, the State Department of

Insurance shall adopt rules to effectuate the provisions of Sections 83-9-201 through 83-9-222; and such rules shall remain in effect until superseded by a plan and articles, bylaws and operating rules submitted by the association and approved by the State Department of Insurance.

(4) Individual board members shall not be liable and shall be immune from suit at law or equity for any conduct performed in good faith and which is within the subject matter over which they have been given jurisdiction.

SECTION 5. Section 83-9-213, Mississippi Code of 1972, is amended as follows:

83-9-213. (1) The association shall:

(a) Establish administrative and accounting procedures for the operation of the association.

(b) Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board.

(c) Select an administering insurer in accordance with Section 83-9-215.

(d) Collect the assessments provided in Section 83-9-217 from insurers and third-party administrators for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board. Assessments shall be collected pursuant to the plan of operation approved by the board. In addition to the collection of such assessments, the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses which have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessments. Organizational assessments shall be equal in amount for all insurers, but shall not exceed One Hundred Dollars ($100.00) per insurer for all such assessments. Assessments are

due and payable within thirty (30) days of receipt of the assessment notice by the insurer.

(e) Require that all policy forms issued by the association conform to standard forms developed by the association. The forms shall be approved by the State Department of Insurance.

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

(2) The association may:

(a) Exercise powers granted to insurers under the laws of this state.

(b) Take any legal actions necessary or proper for the recovery of any monies due the association under Sections 83-9-201 through 83-9-222. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner of Insurance or any of his staff, the administrator, the board or its directors, agents or employees, or against any participating insurer for any actions performed in accordance with Sections 83-9-201 through 83-9-222.

(c) Enter into contracts as are necessary or proper to carry out the provisions and purposes of Sections 83-9-201 through 83-9-222, including the authority, with the approval of the commissioner, to enter into contracts with similar organizations of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(d) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the association.

(e) Take any legal actions necessary to:

(i) Avoid the payment of improper claims against the association or the coverage provided by or through the association.

(ii) Recover any amounts erroneously or improperly paid by the association.

(iii) Recover any amounts paid by the association as a result of mistake of fact or law.

(iv) Recover other amounts due the association.

(f) Establish, and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the association. Rates and rate schedules may be adjusted for appropriate factors such as age, sex and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(g) Issue policies of insurance in accordance with the requirements of Sections 83-9-201 through 83-9-222.

(h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the association.

(i) Borrow money to effect the purposes of the association. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for insurers and may be carried as admitted assets.

(j) Establish rules, conditions and procedures for reinsuring risks of member insurers desiring to issue plan coverages to individuals otherwise eligible for plan coverages in their own name. Provision of reinsurance shall not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(k) Prepare and distribute application forms and enrollment instruction forms to insurance producers and to the general public.

(l) Provide for reinsurance of risks incurred by the association.

(m) Issue additional types of health insurance policies to provide optional coverages, including Medicare supplemental health insurance.

(n) Provide for and employ cost containment measures and requirements including, but not limited to, disease management programs and incentives for participation therein, preadmission screening, second surgical opinion, concurrent utilization review and individual case management for the purpose of making the benefit plan more cost effective.

(o) Design, utilize, contract or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements.

(p) Serve as a mechanism to provide health and accident insurance coverage to citizens of this state under any state or federal program designed to enable persons to obtain or maintain health insurance coverage.

(3) The commissioner may, by rule, establish additional powers and duties of the board and may adopt such rules as are necessary and proper to implement Sections 83-9-201 through 83-9-222.

(4) The State Department of Insurance shall examine and investigate the association and make an annual report to the Legislature thereon. Upon such investigation, the Commissioner of Insurance, if he deems necessary, shall require the board: (a) to contract with an outside independent actuarial firm to assess the solvency of the association and for consultation as to the

sufficiency and means of the funding of the association, and the enrollment in and the eligibility, benefits and rate structure of the benefits plan to ensure the solvency of the association; and (b) to close enrollment in the benefits plan at any time upon a determination by the outside independent actuarial firm that funds of the association are insufficient to support the enrollment of additional persons. In no case shall the commissioner require such actuarial study any less than once every two (2) years.

SECTION 6. Section 83-9-215, Mississippi Code of 1972, is amended as follows:

83-9-215. (1) The board shall select an insurer, through a competitive bidding process, to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board, which criteria shall include:

(a) The insurer's proven ability to handle large group accident and health insurance.

(b) The efficiency of the insurer's claims-paying procedures.

(c) An estimate of total charges for administering the plan.

(2) The administering insurer shall serve for a period of three (3) years. At least one (1) year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. The selection of the administering insurer for the succeeding period shall be made at least six (6) months prior to the end of the current three-year period.

(3) The administering insurer shall:

(a) Perform all eligibility and administrative claims-payment functions relating to the plan.

(b) Pay an agent's referral fee as established by the board to each insurance agent who refers an applicant to the plan, if the applicant's application is accepted. The selling or marketing of plans shall not be limited to the administering insurer or its agents. The referral fees shall be paid by the administering insurer from monies received as premiums for the plan.

(c) Establish a premium-billing procedure for collection of premiums from insured persons. Billings shall be made periodically as determined by the board.

(d) Perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including:

(i) Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made.

(ii) Evaluating the eligibility of each claim for payment under the plan.

(iii) Notifying each claimant within forty-five (45) days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected or compromised.

(iv) The board shall establish reasonable reimbursement amounts for any services covered under the benefit plans.

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

(f) Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association, and the incurred losses of the year and report this information to the association and the State Department of Insurance.

(g) Pay claims expenses *** * ***. If the payments by the administering insurer for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide the administering insurer with additional funds for payment of claims expenses.

(4) (a) The administering insurer shall be paid, as provided in the contract of the association, for its direct and indirect expenses incurred in the performance of its services.

(b) As used in this subsection, the term "direct and indirect expenses" includes that portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the administering insurer which are approved by the board as allocable to the administration of the plan and included in the bid specifications.

SECTION 7. Section 83-9-217, Mississippi Code of 1972, is amended as follows:

83-9-217. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(2) Each insurer shall be assessed an amount not to exceed Three Dollars ($3.00) per covered person insured or reinsured by each insurer per month. There shall not be such assessment on any insurer on policies or contracts insuring federal or state employees.

(3) The board shall make reasonable efforts designed to ensure that each covered person is counted only once with respect

to any assessment. For that purpose, the board shall require each insurer that obtains excess or stoploss insurance to include in its count of covered persons all individuals whose coverage is insured (including by way of excess or stoploss coverage) in whole or part. The board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stoploss insurer for the purpose of determining its assessment under this subsection.

(4) Each insurer's assessment may be verified by the board based on annual statements and other reports deemed to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.

(5) If assessments and other receipts by the association, board or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums.

As used in this subsection, the term "future losses" includes reserves for claims incurred but not reported.

(6) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment or otherwise file any report or furnish information required to be filed with the board pursuant to the board's direction that the board determines is necessary in order for the board to perform its duties under this section. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than One Hundred Dollars ($100.00) per month.

SECTION 8. Section 83-9-221, Mississippi Code of 1972, is amended as follows:

83-9-221. (1) **Coverage offered.**

(a) The plan shall offer in an annually renewable policy the coverage specified in this section for each eligible person.

(b) If an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.

(c) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within sixty-three (63) days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

(2) **Major medical expense coverage.** The plan shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the plan, its schedule of benefits, exclusions and other limitations shall be established by the board and may be amended from time to time subject to the approval of the commissioner.

(3) In establishing the plan coverage, the board shall take into consideration the levels of health insurance <u>coverage</u> provided in the state and medical economic factors as may be deemed appropriate; and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance <u>coverage</u> provided through a representative number of large employers in the state.

(4) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

(a) Separate schedules of premium rates based on age may apply for individual risks.

(b) Rates are subject to approval by the State Department of Insurance.

(c) Standard risk rates for coverages issued by the association shall be established by the association, subject to approval by the department, using reasonable actuarial techniques, and shall reflect anticipated experiences and expenses of such coverages for standard risks.

(d) The rating plan established by the association shall initially provide for rates equal to one hundred fifty percent (150%) of the average standard risk rates. Any changes in the initial rates shall be based on experience of the plan and shall reflect reasonably anticipated losses and expenses.

(e) No rate shall exceed one hundred seventy-five percent (175%) of the standard risk rate.

(5) **Preexisting conditions.** (a) An association policy may contain provisions under which coverage is excluded during a period of twelve (12) months following the effective date of coverage with respect to a given covered individual for any preexisting condition, as long as:

(i) The condition manifested itself within a period of six (6) months before the effective date of coverage;

(ii) Medical advice or treatment was recommended or received within a period of six (6) months before the effective date of coverage.

(b) No preexisting condition exclusion shall be applied to a federally defined eligible individual.

(6) **Other sources primary.**

(a) The association shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. The coverage provided by the association shall be considered excess coverage, and benefits otherwise

payable under association coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any * * * workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable by any insurer or insurance arrangement or any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(b) No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums or to reduce the limits of benefits available.

(c) The association shall have a cause of action against a participant for the recovery of the amount of any benefits paid to the participant which should not have been claimed or recognized as claims because of the provisions of this subsection or because otherwise not covered. Benefits due from the association may be reduced or refused as a setoff against any amount recoverable under this paragraph.

SECTION 9. This act shall take effect and be in force from and after July 1, 2009.