MISSISSIPPI LEGISLATURE REGULAR SESSION 2016

By: Representatives Chism, Dixon To: Insurance

HOUSE BILL NO. 111

AN ACT TO AMEND SECTION 83-9-209, MISSISSIPPI CODE OF 1972, TO REVISE THE ELIGIBILITY FOR COVERAGE PROVIDED UNDER THE COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION ACT; TO AMEND SECTION 83-9-219, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE ASSOCIATION MAY UNDER CERTAIN CIRCUMSTANCES AND UPON DETERMINATION BY THE BOARD CLOSE ENROLLMENT IN THE COVERAGE PROVIDED BY THE PLAN; TO AMEND SECTION 83-9-221, MISSISSIPPI CODE OF 1972, TO CLARIFY THE COVERAGE OFFERED BY THE PLAN; AND FOR RELATED PURPOSES.

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

SECTION 1. 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 *** * *** health insurance coverage for health reasons by one (1) insurer;

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

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

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(*** * ***2) 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.

(*** * ***3) The board *** * *** may 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 *** * *** such list promulgated by the board *** * *** may not be required to provide the evidence specified in subsection (1) of this section. *** * *** Any such list previously promulgated by the board may be amended or repealed by the board from time to time as may be appropriate.

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

(a) The person has or obtains health insurance coverage *** * ***, 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.<u>,</u> or Medicare.

(c) The person previously terminated plan coverage unless twelve (12) months have elapsed since the person's latest termination *** * ***.

(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.

(*** * ***<u>5</u>) 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.

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

(* * *7) 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 2. Section 83-9-219, Mississippi Code of 1972, is amended as follows:

83-9-219. The coverage provided by the plan shall be directly insured by the association, and the policies shall be issued through the administering insurer. Subject to the approval

of the commissioner, the association may close enrollment in, and/or cease to offer the coverage provided by, the plan at any time upon a determination by the board that the availability of such coverage is no longer necessary.

SECTION 3. Section 83-9-221, Mississippi Code of 1972, is amended as follows:

83-9-221. (1) **Coverage offered.** (a) The plan shall offer *** * *** the coverage specified in this section for each eligible person subject to the association's discretion to close enrollment and/or cease offering coverage as authorized in Section 83-9-219.

(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 *** * *** coverage *** * *** 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 coverage 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 coverage 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. * * *** 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.

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(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 4. This act shall take effect and be in force from and after its passage.