

ALEC EXPOSED

"ALEC" has long been a secretive collaboration between Big Business and "conservative" politicians. Behind closed doors, they ghostwrite "model" bills to be introduced in state capitols across the country. This agenda—underwritten by global corporations—includes major tax loopholes for big industries and the super rich, proposals to offshore U.S. jobs and gut minimum wage, and efforts to weaken public health, safety, and environmental protections. Although many of these bills have become law, until now, their origin has been largely unknown. With **ALEC EXPOSED**, the Center for Media and Democracy hopes more Americans will study the bills to understand the depth and breadth of how big corporations are changing the legal rules and undermining democracy across the nation.

ALEC's Corporate Board —in recent past or present

- AT&T Services, Inc.
- centerpoint360
- UPS
- Bayer Corporation
- GlaxoSmithKline
- Energy Future Holdings
- Johnson & Johnson
- Coca-Cola Company
- PhRMA
- Kraft Foods, Inc.
- Coca-Cola Co.
- Pfizer Inc.
- Reed Elsevier, Inc.
- DIAGEO
- Peabody Energy
- Intuit, Inc.
- Koch Industries, Inc.
- ExxonMobil
- Verizon
- Reynolds American Inc.
- Wal-Mart Stores, Inc.
- Salt River Project
- Altria Client Services, Inc.
- American Bail Coalition
- State Farm Insurance

For more on these corporations, search at www.SourceWatch.org.

DID YOU KNOW? Corporations VOTED to adopt this. Through ALEC, global companies work as "equals" in "unison" with politicians to write laws to govern your life. Big Business has "a VOICE and a VOTE," according to newly exposed documents. **DO YOU?**

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High-Risk Health Insurance Pool Model Act

Did you know that global pharmaceutical company Bayer Healthcare was the corporate co-chair in 2011?

Summary

The purpose of this Act is to provide insurance for individuals with high-risk health conditions such as AIDS, diabetes, and cancer. Approximately 1 percent of the uninsured population is denied access to individual market health insurance because of pre-existing conditions. This bill establishes a state run high-risk pool and allows individuals who have been denied traditional insurance because of health problems to buy into the pool. This program is effective because it spreads the cost of coverage among all insurance carriers doing business in a state. Two critical goals that ALEC's high-risk pool accomplishes are guaranteed access to health care at reasonable rates to all of a state's uninsurable citizens, and that the costs of this guarantee are spread equitably among all of the state's citizens.

The pool is funded through the premiums charged to the individuals and through an assessment against insurers participating in the health insurance market. Any state resident would be eligible to participate in the pool, provided that certain conditions were met, and the pool would also serve as the state's guaranteed mechanism of providing group-to-individual health insurance portability, as required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The pool would operate under the supervision and approval of a Board of Directors appointed by the Commissioner of Insurance. (Drafting Note: or the appropriate regulator of insurance in your state.)

Model Legislation

{Title, enacting clause, etc.}

Section 1. This Act may be cited as the High-Risk Health Insurance Pool Act.

Section 2. For the purposes of this Act the following definitions apply:

(A) "Producer" means any person who is licensed to sell health insurance in this state.

(B) "Board" means the Board of Directors of the State Comprehensive Health Insurance Pool.

(C) "Health insurance" means any hospital or 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, when sold to an individual or as a group policy. This term does not include short-term, accident, dental-only, fixed indemnity, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(D) "Insured" means a person who is a resident of this state and a citizen of the United States who is eligible to receive benefits from the pool. The term "insured" may include dependents and family members.

(E) "Insurer" means any entity that is authorized in this state to write health insurance or that provides health insurance in this state. For the purposes of this act, the insurer includes an insurance company, nonprofit health care services plan, fraternal benefits society, health maintenance organization, third party administrator, state or local governmental unit, to the extent permitted by federal law any self insured arrangement covered by Section 3, Employment Retirement Income Security Act of 1974 (29 U.S.C. Section 1002), as amended, that provides health care benefits in this state, any other entity providing a plan of health insurance or health benefits subject to state insurance regulation, and any reinsurer or stop-loss plan providing reinsurance or stop-loss coverage to a health insurer in this state.

(F) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 USC, Section 1395, et seq., as amended).

(G) "Pool" means the State High-Risk Health Insurance Pool.

(H) "Physician" means an individual licensed to practice medicine, as defined by this state.

(I) "Plan" means the Comprehensive Health Insurance Plan as adopted by the Board of Directors of the State Comprehensive Health Insurance Pool, or by rule.

(J) "Preexisting Condition" means a condition for which medical advice, care or treatment was recommended or received during the X months prior to effective date of coverage under the pool. Except as otherwise provided in this Act, preexisting conditions shall not be covered during the X months following the person's effective date of coverage under the plan.

(J) "Resident" means: (1) an individual who has been legally domiciled in (Insert State) for a minimum of 30 days for persons eligible for enrollment in the pool; or (2) an individual who is legally domiciled in (Insert State) and is eligible for enrollment in the pool as a result of the federal Health Insurance Portability and Accountability Act of 1996; or (3) an individual who is legally domiciled in the pool and is eligible for enrollment as a result of the federal Trade Adjustment Assistance Act of 2002. (Drafting note: The third criterion should only be used in states that wish to make their risk pools a purchasing option for individuals who are eligible for the health insurance tax credit established in the federal Trade Adjustment Assistance Act of 2002.)

Section 3.

(A) There is hereby created a nonprofit legal entity to be known as the "(Insert State Name) High-Risk Health Insurance Pool." All insurers, as a condition of doing business in this state, shall be members of the pool.

(B) Health insurance policies available in accordance with this Act shall be available for sale within one year from the date of enactment of this Act.

Section 4.

(A) Any individual person who is and continues to be a resident of (Insert State) and a citizen of the United States shall be eligible for coverage from the pool if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by two insurers, provided that at least two insurers offer individual health insurance coverage in the state. If only one insurer offers individual market health insurance coverage in the state, then one rejection shall be sufficient. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection;

(2) a refusal by two insurers to issue insurance except at a rate exceeding the pool rate, provided that at least two insurers offer individual health insurance coverage in the state. If only one insurer offers individual market health insurance coverage in the state, then one quote that exceeds the pool rate shall be sufficient;

(3) a diagnosis of the individual with one of the medical or health conditions listed by the board in accordance with Section 6 (G) of this act. A person diagnosed with one or more of these conditions shall be eligible for a pool coverage without applying for health insurance coverage;

(4) for persons eligible due to eligibility under federal HIPAA law, the maintenance of health insurance coverage for the previous 18 months with no gap in coverage greater than 63 days of which the most recent coverage was through an employer sponsored plan; or

(5) for persons eligible as a result of certification for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002, coverage with no pre-existing conditions limitation for individuals with three months of prior creditable coverage with a break in coverage of no more than 63 days. (Drafting Note: Optional section for states that wish to use their pool as a means of providing coverage to individuals eligible for the federal health insurance tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002.)

(B) Each dependant of a person who is eligible for coverage from the pool shall also be eligible for coverage from the pool. In the instance of a child who is the primary insured, resident family members shall also be eligible for coverage.

(C) A person may maintain pool coverage for the period of time the person is satisfying a preexisting waiting period under another health insurance policy or insurance arrangement intended to replace the pool policy.

(D) A person is not eligible for coverage from the pool if the person;

(1) has in effect on the date pool coverage takes effect health insurance coverage from an insurer or insurance arrangement;

(2) is eligible for other health care benefits at the time application is made to the pool, including COBRA continuation except;

(a) coverage, including COBRA continuation, other continuation or conversion coverage, maintained for the period of time the person is satisfying any pre-existing condition waiting period under a pool policy; or

(b) employer group coverage conditioned by the limitations described by Subsections (A)(4) and (5) of this section; or

(c) individual coverage conditioned by the limitation described by Subsections (A)(1) -

(3) of this section;

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(3) has terminated coverage in the pool within 12 months of the date that application is made to the pool, unless the person demonstrates a good faith reason for the termination;

(4) is confined in a county jail or imprisoned in a state prison;

(5) has premiums that are paid for or reimbursed by any third party payer or 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; or if the individual receives premium payment assistance through the federal health insurance tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002. (Drafting Note: This section is optional and is for states that wish to use their pool as a means of providing coverage to individuals eligible for the federal health insurance tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002.)

(6) has not had prior coverage with the pool terminated for nonpayment of premiums or fraud.

(E) Pool preexisting condition requirements are waived for the following individuals:

(1) Individuals for whom, as of the date on which the individual seeks Plan coverage, the aggregate of the periods of creditable coverage is 18 or more months, and whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

(2) Individuals who are eligible for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002, provided that as of the date on which the individual was certified as eligible for federal Trade Adjustment Assistance, the individual had at least three months of prior creditable coverage with no longer than a 63 day break in coverage as established by the federal Trade Adjustment Assistance Reform Act of 2002, as it may be amended, or the regulations under that Act. (Drafting Note: Optional section for states that wish to use their pool as a means of providing coverage to individuals eligible for the federal health insurance tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002.)

(F) Pool coverage shall cease:

(1) on the date a person is no longer a resident of his state, except for a child who is a student under the age of 23 years and who is financially dependent upon the parent, a child for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent;

(2) on the date a person requests coverage to end;

(3) upon the death of the covered person;

(4) on the date state law requires cancellation of the policy;

(5) at the option of the pool, 30 days after the pool sends to the person any inquiry concerning the person's eligibility, including an inquiry concerning the person's residence, to which the person does not reply;

(6) on the 31st day after the day on which a premium payment

for pool coverage becomes due if the payment is not made before that date;

(7) a person has reached the maximum lifetime limit, as provided in Section 12 of this act; or

(8) at such time as the person ceases to meet the eligibility requirements of this section.

(G) A person who ceases to meet the eligibility requirements of this section may have his coverage terminated at the end of the policy period.

Section 5.

(A) The pool shall operate under the supervision and approval of a seven member Board of Directors appointed by the Commissioner of Insurance, and shall consist of:

(1) two representatives of domestic insurance companies licensed to do business in this state;

(2) one representative of a nonprofit health care service plan;

(3) one representative of a health maintenance organization;

(4) one member representing the medical provider community, such as a physician licensed to practice medicine in this state or a hospital administrator;

(5) one member of the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the pool. Representatives of the general public includes persons whose only affiliation with an insurance company or plan, group hospital service corporation, or health maintenance organization are as an insured or person who has coverage through a plan provided by the corporation or organization.

(6) one member to represent resident licensed health insurance producers.

(C) In making appointments to the Board of Directors, the Commissioner shall strive to ensure that at least one person serving on the Board of Directors is at least 60 years of age.

(D) The original Board of Directors shall be appointed for the following terms:

(1) three members for a term of one year;

(2) two members for a term of two years; and

(3) two members for a term of three years.

(4) All terms after the initial term shall be for three years.

(E) The Board of Directors shall elect one of its members as Chairman.

(F) Members of the Board of Directors may be reimbursed from monies of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the Board of Directors, but shall not otherwise be compensated for their services.

(G) Members of the Board of Directors are not liable for an action or omission performed in good faith in the performance of powers and duties under this Act, and cause of action does not arise against a member for the action or omission.

The Board shall adopt a plan pursuant to this Act and submit its articles, bylaws, and operating rules to the State Commissioner of Insurance for approval. If the Board fails to adopt such a plan and suitable articles, bylaws, and operating rules within 180 days after the appointment of the Board, the State Commissioner of Insurance shall promulgate rules to effectuate the provisions of this Act; and such rules shall remain in effect until superseded by a plan and articles, bylaws, and operating procedures submitted by the Board and approved by the State Commissioner of Insurance.

Section 6. The Board shall:

(A) establish administrative and accounting procedures for the operation of the pool;

(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 8 of this Act;

(D) collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made, in accordance with Section 9 of this act;

(E) require that all policy forms issued by the Board conform to standard forms developed by the Board. The forms shall be approved by the State Commissioner of Insurance;

(F) develop a program to publicize the existence of the plan, the eligibility requirements of the plan, and the procedures for enrollment in the plan, and to maintain public awareness of the plan;

(G) promulgate a list of medical or health conditions for which a person shall be eligible for pool coverage without applying for health insurance. The list shall be effective on the first day of the operation of the pool and may be amended from time to time as may be appropriate; and

(H) no later than June 1 of each year, make an annual report to the governor, the state legislature, and the commissioner. The report shall summarize the activities of the pool in the preceding calendar year, including information regarding net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses.

Section 7.

(A) The pool may exercise any of the authority that an insurance company authorized to write health insurance in this state may exercise under the law of this state.

(B) As part of its authority, the pool may:

(1) provide health benefits coverage to persons who are eligible for that coverage under this article;

(2) enter into contracts that are necessary to carry out this article including, with the approval of the commissioner, entering into contracts with similar pools in other states for the joint performance of common administrative functions or with other organizations for the performance of administrative functions;

(3) sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the pool;

(4) institute any legal action necessary to avoid payment of improper claims against the pool or the coverage provided by or through the pool, to recover any amounts erroneously or improperly paid by the pool, to recover any amount paid by the pool as a mistake of fact or law, and to recover other amounts due the pool;

(5) establish appropriate rates, rate schedules, rate adjustments, expense allowance, agents' referral fees, and claim reserve formulas and perform any actuarial function

- appropriate to the operation of the pool;
- (6) adopt policy forms, endorsements, and riders and applications for coverage;
 - (7) issue insurance policies subject to this article and the plan of operation;
 - (8) appoint appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in operating the pool and performing any of the functions of the pool;
 - (9) employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions;
 - (10) contract for stop-loss insurance for risks incurred by the pool;
 - (11) borrow money as necessary to implement the purposes of the pool;
 - (12) issue addition types of health insurance policies to provide optional coverage which comply with applicable provisions of state and federal law, including Medicare supplemental health insurance;
 - (13) provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization case management for the purpose of making the benefit plans more cost effective;
 - (14) design, utilize, contract, or otherwise arrange for delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations; and
 - (15) provide for reinsurance on either a facultative or treaty basis or both.

Section 8.

(A) The Board shall select an insurer, through a competitive bidding process, to administer the plan. The Board shall evaluate the bids submitted under this Subsection based on criteria established by the Board, which criteria shall include, but not be limited to, the following:

- (1) the insurer's proven ability to handle large group accident and health policies insurance;
- (2) the efficiency of the insurers claims-paying procedures;
- (3) an estimate of total charges for administering the plan.

(B) The administering insurer shall serve for a period of three years. At least one 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 three-year period shall be made at least six months prior to the end of the current three-year period.

(C) The administering insurer shall:

- (1) Perform all eligibility and administrative claims-payment functions relating to the plan;
- (2) pay an agent's referral fee as established by the Board to each agent who refers an applicant to the plan, if the applicant 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 moneys received as premiums for the plan;
- (3) establish a premium billing procedure for collection of premiums from persons insured under the plan; and
- (4) perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including, but not limited to, the following:
 - (a) 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;
 - (b) evaluating the eligibility of each claim for payment under the plan;
 - (c) notifying each claimant within thirty (30) days after receiving a properly completed and executed proof of loss, whether the claim is accepted, rejected, or compromised.
- (5) submit regular reports to the Board regarding the operation of the plan. The frequency, content, and form of the reports shall be determined by the Board.
- (6) following the close of each calendar year, determine net premiums, re-insurance premiums less administrative expenses allowance, the expense of administration pertaining to the re-insurance operations of the pool, and the incurred losses for the year, and report this information to the Board and to the Commissioner of Insurance; and
- (7) pay claims expenses from the premium payments received from, or on behalf of, covered persons under the plan. If the payments by the administering insurer for claims expenses exceeds the portion of premiums allocated by the Board for the payment of claims expenses, the Board shall assess the additional funds necessary for payment of claims expenses.

Section 9.

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OPTION ONE

(A) For the purposes of providing the funds necessary to carry out the powers and duties of the pool, the board of directors shall assess member insurers at such time and for such amounts as the board finds necessary. Assessments shall be due in not less than 30 days after prior written notice to the member insurers and shall accrue interest at twelve percent per annum on and after the due date.

(B) Each insurer shall be assessed in an amount not to exceed Two Dollars (\$2.00) per covered person insured or reinsured by each insurer per month.

(C) 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 in 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 purposes of determining its assessment under this section.

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

(E) If assessments and other receipts by the pool, 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. Future losses include reserves for claims incurred but not reported.

(F) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment. As an alternative, the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. Such forfeiture may not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than One Hundred Dollars (\$100.00) per month.

OPTION TWO

(A) Each insurer shall be assessed by the Board a portion of the operating losses of the plan; such portion being determined by multiplying such operating losses by a fraction, the numerator of which equals the insurer's premium and subscriber contract charges pertaining to the direct writing of health insurance written in this state during the preceding calendar year and the denominator of which equal's the total of all such premiums and subscriber contract charges written by participating insurers in this state during the previous calendar year. The computation of assessments shall be made with a reasonable degree of accuracy, with the recognition that exact determinations may not always be possible.

(B)(1) If assessments and other receipts by the pool 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 premiums.

(2) As used in this Subsection, the term "future losses" includes reserves for claims incurred but not reported.

(C)(1) Each insurer's proportion of participation in the plan shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed with it by the insurer.

(2) Any deficit incurred under the plan shall be recouped by assessment apportioned among participating insurers by the Board in the manner set forth in Subsection (A) of this Section; and the insurers may recover the net loss, if any, after the tax offset provided in Section 10 of this Act in the normal course of their respective businesses without time limitation.

Section 10. The coverage provided by the plan shall be directly insured by the pool, and the policies administered through the administering insurer.

Section 11.

(A) The plan shall offer in an annually renewable policy the coverage specified in this Section for each eligible person. In approving any of the benefit plans to be offered by the Plan, the Board shall establish such benefit levels, deductibles, coinsurance factors, exclusions, and limitations as it may deem appropriate and that it believes to be generally reflective of and commensurate with individual market health insurance that is provided in the individual health insurance market in the state.

(B)(1) The plan shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under Subsection (E) of this Section up to a lifetime limit of \$1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarially equivalent benefit may be substituted by the Board.

(2) The plan shall provide that any policy issued to a person eligible for Medicare shall be separately rated to reflect differences in experiences reasonably expected to occur as a result of Medicare payments.

(C)(1) The usual customary charges or negotiable reimbursement for the following services and articles, when prescribed by a physician and medically necessary, shall be

covered expenses:

- (a) hospital services;
 - (b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are rendered by a physician or by others at his direction;
 - (c) drugs requiring a physician's prescription;
 - (d) services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than one hundred (100) calendar days during a policy year, if the services and reimbursements are the type which would qualify as reimbursable services under Medicare;
 - (e) services of a home health agency, of which the services are of a type which would qualify reimbursable services under Medicare;
 - (f) use of radium or other radioactive materials;
 - (g) oxygen;
 - (h) anesthetics;
 - (i) prosthesis, other than dental prosthesis;
 - (j) rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;
 - (k) diagnostic x-rays and laboratory tests;
 - (l) oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;
 - (m) services of a physical therapist;
 - (n) transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;
 - (o) processing of blood, including, but not limited to, collecting, testing, fractioning, and distributing blood; and
 - (p) services for the treatment of alcohol and drug abuse, but the insured shall be required to make a 50 percent co-payment and the payment of the plan shall not exceed \$4,000.
- (2) as an option, the plan shall make available, at an additional premium, coverage for services provided by a duly licensed chiropractor.
- (D) Covered expenses shall not include the following:
- (1) any charge for treatment for cosmetic purposes, other than for repair or treatment of any injury or congenital bodily defect to restore normal bodily functions;
 - (2) any charge for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid;
 - (3) any charge for confinement in a private room to the extent that such charge is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician;
 - (4) that part of any charge for services or articles rendered or provided by a physician or other health care personnel which exceeds the prevailing charge in the locality where the service is provided, or any charge for services or articles not medically necessary;
 - (5) any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the services or articles;
 - (6) any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred;
 - (7) any charge for routine physical examinations;
 - (8) any charge for the services of blood donors and any fee for the failure to replace the first three pints of blood provided to an eligible person annually; or
 - (9) any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.
- (E)(1) The board shall provide for at least two choices of annual deductibles for major medical expenses, plus the benefits payable under any other type of insurance coverage or workers' compensation, provided that if two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.
- (F) (1) The board shall annually determine the schedule of premium rates for each benefit plan option offered by the pool.
- (2) Rates and rate schedules may be adjusted for appropriate risk factors including age and variation in claim costs, and the board may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(3) The board shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for such coverage. Initial pool rate may not be less than 135 percent and may not exceed 150 percent of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall pool rates exceed 150 percent of rates applicable to individual standard risks.

(4) All rates and rate schedules shall be submitted to the state commissioner of insurance for approval, and the commissioner must approve the rates and rate schedules of the pool before the pool uses them. The commissioner in evaluating the rates and rate schedule of the pool shall consider the factors provided by this section.

(G) The Board shall provide that the pool shall be the last payer of benefits whenever any other benefit or source of third party payment is available.

Section 12. {Severability clause.}

Section 13. {Repealer clause.}

Section 14. {Effective date.}

Were your laws repealed?

As amended by the HHS Task Force at the States and Nation Policy Summit in December 2002. Approved by the ALEC Board of Directors January, 2003.

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