

MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT

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Statement of Principles

Each state is urged to determine, through independent study, whether a pooling mechanism is needed and whether enactment of the model would be cost effective.

Uninsurable plans may not be needed in every state, nor present the most effective answer to questions of availability of health insurance and health benefits coverage in every state. The establishment of such programs is costly and their cost effectiveness should be weighed in relation to whether there is a demonstrated need for a plan in a given state.

By definition, a plan consisting of uninsurable risks will necessitate premium rates substantially greater than applicable for standard risks. The bill establishes an initial minimum rate of 125-150 percent of applicable standard risk rates. Thereafter rates are expected to fluctuate according to experience; however, in no event shall rates exceed 200 percent of standard risk rates. A minimum rate of 125-150 percent is admittedly inadequate for the risks insured, and the 200 percent maximum will prevent the rates from becoming prohibitive. Plan losses in excess of the 200 percent maximum rate must be financed through other sources of revenue. Section 7 of the Model Act contains several alternative methods for financing plan losses. It is important to note that if plan losses are financed by assessments against insurers, the plan's cost effectiveness can be substantially impaired unless contributions from both insured and self-funded health benefit plans can be secured. Without the inclusion of self-funded plans, the financial base necessary to support the pooling mechanism may be insufficient.

For the obvious cost containment reasons, the plan coverage is the coverage of "last resort" and may not necessarily duplicate coverages from any other source, private or public. The model contains two alternative methods for establishing plan benefits. The mechanics of the plan and its operations and functions must all be established under a plan of operation approved by the commissioner. The plan is subject to the requirements of the insurance code and has the general powers and authority of an insurer licensed to provide health insurance coverage.

BE IT ENACTED BY THE STATE OF [insert state].

[adapt caption and formal portions to local requirements and statutes]

Section 1. Definitions

For the purposes of this act:

- A. "Board" means the board of directors of the plan.
- B. "Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.
- C. "Commissioner" means the Insurance Commissioner.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

- D. (1) “Creditable coverage” means, with respect to an individual, coverage of the individual provided under any of the following:
- (a) A group health plan;
 - (b) Health insurance coverage;
 - (c) Part A or Part B of Title XVIII of the Social Security Act;
 - (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
 - (e) Chapter 55 of Title 10, United States Code;
 - (f) A medical care program of the Indian Health Service or of a tribal organization;
 - (g) A state health benefits risk pool;
 - (h) A health plan offered under Chapter 89 of Title 5, United States Code;
 - (i) A public health plan as defined in federal regulations; or
 - (j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).
- (2) A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this Act, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.
- E. “Department” means the Insurance Department.
- 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. “Federally defined eligible individual” means an individual:
- (1) For whom, as of the date on which the individual seeks coverage under this Act, the aggregate of the periods of creditable coverage, as defined in Subsection D, is eighteen (18) or more months;
 - (2) 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;
 - (3) 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;
 - (4) 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;
 - (5) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and
 - (6) Who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in Paragraph (5).

- H. “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.
- I. “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, as defined in Subsection N, and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.
- J. (1) “Health insurance coverage” means any hospital and medical expense incurred policy, nonprofit health care service 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.
- (2) “Health insurance coverage” shall not include one or more, or any combination of, the following:
- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (3) “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:
- (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (4) “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:
- (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.

- (5) “Health insurance coverage” shall not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
- K. “Health maintenance organization” [reference applicable state laws].
- L. “Hospital” [reference applicable state laws].

Drafting Note: Definitions of “physician” and “hospital” are needed only if the benefit package is specified in the Act.

- M. “Insurer” means any entity that provides health insurance coverage in this state. For the purposes of this Act, insurer includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, and any other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation.
- N. “Medical care” means amounts paid for:
- (1) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 - (2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and
 - (3) Insurance covering medical care referred to in Paragraphs (1) and (2).
- O. “Medicare” means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 USC 1395 *et seq.*, as amended.
- P. “Participating insurer” means any insurer providing health insurance coverage to residents of this state.
- Q. “Physician” [reference applicable state laws].
- R. “Plan” means the [State] Health Insurance Plan as created in Section 2 of the Act.
- S. “Plan of operation” means the articles, bylaws, and operating rules and procedures adopted by the board pursuant to Section 2 of this Act.
- T. “Resident” means an individual who has been legally domiciled in this state for a period of at least thirty (30) days, except that for a federally defined eligible individual, there shall not be a thirty-day requirement.
- 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 2. Operation of the Plan

- A. There is hereby created the [State] Health Insurance Plan.
- B. The plan shall operate subject to the supervision and control of the board. The board shall consist of the commissioner or his or her designated representative, who shall serve as an *ex officio* member of the board and shall be its chairperson, and [insert even number] members appointed by the Governor [or elected commissioner]. At least two (2) board members shall be individuals, or the parent, spouse or child of individuals, reasonably expected to qualify for coverage by the plan. At least two (2) board members shall be representatives of insurers. A majority of the board shall be composed of individuals who are not representatives of insurers or health care providers.

Drafting Note: A state may wish to establish the plan as a public entity. Establishment as a public entity is most appropriate if public funds are used to subsidize plan losses.

- C. The initial board members shall be appointed as follows: one-third of the members to serve a term of two (2) years; one-third of the members to serve a term of four (4) years; and one-third of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed.
- D. Vacancies in the board shall be filled by the Governor [or elected commissioner]. Board members may be removed by the Governor [or elected commissioner] for cause.
- E. Board members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.
- F. The board shall submit to the commissioner a plan of operation for the plan and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the plan. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this Act must be made available. If the board fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner.
- G. The plan of operation shall:
 - (1) Establish procedures for operation of the plan;
 - (2) Establish procedures for selecting an administrator in accordance with Section 6 of this Act;
 - (3) Establish procedures to create a fund, under management of the board, for administrative expenses;
 - (4) Establish procedures for the handling, accounting and auditing of assets, monies and claims of the plan and the plan administrator;
 - (5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment; and to maintain public awareness of the plan;
 - (6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board after completion of the review. The board shall retain all written complaints regarding the plan for at least three (3) years; and

- (7) Provide for other matters as may be necessary and proper for the execution of the board's powers, duties and obligations under this Act.
- H. The plan shall have the general powers and authority granted under the laws of this state to health insurers and in addition thereto, the specific authority to:
- (1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;
 - (2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the plan;
 - (3) Take such legal action as necessary:
 - (a) To avoid the payment of improper claims against the plan or the coverage provided by or through the plan;
 - (b) To recover any amounts erroneously or improperly paid by the plan;
 - (c) To recover any amounts paid by the plan as a result of mistake of fact or law; or
 - (d) To recover other amounts due the plan;
 - (4) 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 plan. 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;
 - (5) Issue policies of insurance in accordance with the requirements of this Act;
 - (6) 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 pool;
 - (7) Borrow money to effect the purposes of the plan. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets;
 - (8) Establish rules, conditions and procedures for reinsuring risks of participating insurers desiring to issue plan coverages in their own name. Provision of reinsurance shall not subject the plan to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers;

Drafting Note: Optional Paragraph: A state may wish to utilize the existing distribution systems of insurers for the issuance of pool coverage. If so, such a provision should authorize the establishment of specific rules under which the pool would approve and serve as a reinsurer for coverage issued by participating insurers in their own names. Paragraph (8) is designed to allow states to implement this option.

- (9) Employ and fix the compensation of employees. Such employees may be paid on a warrant issued by the state treasurer pursuant to a payroll voucher certified by the board and drawn by the comptroller against appropriations or trust funds held by the state treasurer;
- (10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public;

- (11) Provide for reinsurance of risks incurred by the plan;
- (12) Issue additional types of health insurance policies to provide optional coverages, including Medicare supplemental insurance coverage;

Drafting Note: Due to the inability of some individuals to obtain Medicare supplement insurance, especially individuals who are eligible for Medicare by reason of disability, a state may wish to require the plan to offer Medicare supplement insurance coverage.

- (13) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost effective;
 - (14) 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; and
 - (15) Adopt bylaws, policies and procedures as may be necessary or convenient for the implementation of this Act and the operation of the plan.
- I. The board shall make an annual report to the Governor which shall also be filed with the legislature. The report shall summarize the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.
 - J. Neither the board nor its employees shall be liable for any obligations of the plan. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Act, unless such act or omission constitutes willful or wanton misconduct. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

Section 3. Establishment of Rules

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 this Act.

Section 4. Eligibility

- A.
 - (1) An individual person, who is and continues to be a resident shall be eligible for plan coverage if evidence is provided:
 - (a) Of a notice of rejection or refusal to issue substantially similar insurance for health reasons by one insurer; or
 - (b) Of 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) A rejection or refusal by an insurer offering only stop loss, excess of loss or reinsurance coverage with respect to an applicant under Paragraph (1) shall not be sufficient evidence under this subsection.
- B. 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 pursuant to Subsection A(1). 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 A(1). The list shall be effective on the first day of the operation of the plan and may be amended from time to time as may be appropriate.

- C. Each resident dependent of a person who is eligible for plan coverage shall also be eligible for plan coverage.
- D. A person shall not be eligible for coverage under the plan if:
- (1) 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:
 - (a) A person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy; and
 - (b) 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;
 - (2) The person is determined to be eligible for health care benefits under [reference state Medicaid law];
 - (3) The person has previously terminated plan coverage unless twelve (12) months have lapsed since such termination, except that this paragraph shall not apply with respect to an applicant who is a federally defined eligible individual;
 - (4) The plan has paid out \$[insert number] in benefits on behalf of the person;
 - (5) The person is an inmate or resident of a public institution, except that this paragraph shall not apply with respect to an applicant who is a federally defined eligible individual; or
 - (6) 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.
- E. Coverage shall cease:
- (1) On the date a person is no longer a resident of this state;
 - (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; or
 - (5) At the option of the plan, thirty (30) days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.
- F. Except under the circumstance described in Subsection D, a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period for which the necessary premiums have been paid.

Drafting Note: Plans may wish to consider establishing reciprocal agreements with plans for uninsurables in other states to provide coverage to covered persons who move between states with such plans. In such cases, the plan may wish to consider counting benefits provided to the person by another plan toward the person's lifetime maximum benefits.

Drafting Note: With regard to lifetime limits on benefits referred to in Subsection D(4) of this section, HIPAA requires generally that federally defined eligible individuals have a choice of coverage available to them and that one of those choices be comprehensive coverage. State high risk pools with low lifetime limits might not qualify as an acceptable alternative mechanism under HIPAA.

Section 5. Unfair Referral to Plan

It shall constitute an unfair trade practice for the purposes of [insert reference to state’s unfair trade practices act] for an insurer, insurance producer or third-party administrator to refer an individual employee to the plan, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee’s employment.

Drafting Note: This section generally prohibits insurers and agents from “carving out” the sickest members of an insured group and referring them to the plan. The intent is to reduce the plan’s costs by keeping coverage for these employees in the private voluntary market.

Section 6. Plan Administrator

- A. The board shall select a plan administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:
 - (1) The plan administrator’s proven ability to handle health insurance coverage to individuals;
 - (2) The efficiency and timeliness of the plan administrator’s claim processing procedures;
 - (3) An estimate of total charges for administering the plan;
 - (4) The plan administrator’s ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner; and
 - (5) The financial condition and stability of the plan administrator.
- B.
 - (1) The plan administrator shall serve for a period specified in the contract between the plan and the plan administrator subject to removal for cause and subject to any terms, conditions and limitations of the contract between the plan and the plan administrator.
 - (2) At least one year prior to the expiration of each period of service by a plan administrator, the board shall invite eligible entities, including the current plan administrator to submit bids to serve as the plan administrator. Selection of the plan administrator for the succeeding period shall be made at least six (6) months prior to the end of the current period.
- C. The plan administrator shall perform such functions relating to the plan as may be assigned to it, including:
 - (1) Determination of eligibility;
 - (2) Payment of claims;
 - (3) Establishment of a premium billing procedure for collection of premium from persons covered under the plan; and
 - (4) Other necessary functions to assure timely payment of benefits to covered persons under the plan.
- D. The plan administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the report shall be specified in the contract between the board and the plan administrator.
- E. Following the close of each calendar year, the plan administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the Department on a form prescribed by the commissioner.
- F. The plan administrator shall be paid as provided in the contract between the plan and the plan administrator.

Section 7. Funding of the Plan

A. Premiums

- (1) The plan shall establish premium rates for plan coverage as provided in Paragraph (2). Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the commissioner for approval prior to use.
- (2) The plan, with the assistance of the commissioner, shall determine a 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 rates for plan coverage shall not be less than [125-150] percent of rates established as applicable for individual standard risks. Subject to the limits provided in this paragraph, 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 herein. In no event shall plan rates exceed 200 percent of rates applicable to individual standard risks.

B. Sources of Additional Revenue

Drafting Note: Health plans for uninsurables cannot be supported by premiums and must be subsidized by additional revenues. States may wish to consider one or more of the following sources for revenues to fund plan deficits. The order of the additional sources of revenue does not indicate any preference among the options. States that wish to use more than one source of additional revenue should include the bracketed language in the appropriate alternatives below and should include an additional paragraph specifying the percentage of revenue to come from each additional revenue source.

ALTERNATIVE ONE. Assessment of health insurers based upon their health insurance premiums written in the state.

- (1) In addition to the powers enumerated in Section 2 of this Act, the plan shall have the authority to assess participating insurers in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the plan's organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year.
- (2) Following the close of each fiscal year, the plan administrator shall determine the net premiums (premiums less administrative expense allowances), the plan expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the plan shall be recouped by assessments apportioned by the board among participating insurers [and from other sources of revenue as provided by this section].

Drafting Note: In the case of plans that do not offer coverage to supplement Medicare benefits, for equity purposes the state may wish to consider exempting Medicare supplement coverage from the assessment under this section.

- (3) Each participating insurer's assessment shall be determined by multiplying the total assessment of all participating insurers as determined in Paragraph (2) by a fraction, the numerator of which equals that participating insurer's premium and subscriber contract charges for health insurance coverage written in the state during the preceding calendar year and the denominator of which equals the total of all health insurance premiums by all participating insurers.
- (4) If assessments exceed the plan's actual losses and administrative expenses the excess shall be held at interest and used by the board to offset future losses or to reduce future assessments. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

- (5) Each participating insurer's assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the participating insurer with the board.
- (6) A participating insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer, in whole or in part, such assessment if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the participating insurer to fulfill its contractual obligations. In the event an assessment against a participating insurer is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred shall be assessed against the other participating insurers in a manner consistent with the basis for assessments set forth in this subsection. The participating insurer receiving such abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.

Drafting Note: A state may wish to provide for some form of offset against applicable taxes in the amount of the assessments incurred by the participating insurers of the plan. If so, such a provision should allow appropriate reductions in assessments as to participating insurers not subject to the taxes against which offsets are allowed.

ALTERNATIVE TWO. Assessment of health insurers and reinsurers based upon the number of persons they cover through primary, excess and stop loss insurance in this state.

- (1) For the purposes of this subsection, "participating insurer" includes all insurers providing health insurance coverage, including excess or stop loss coverage, to residents of this state.
- (2) In addition to the powers enumerated in Section 2 of this Act, the plan shall have the authority to assess participating insurers in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the plan's organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year.
- (3) Following the close of each fiscal year, the administrator shall determine the net premiums (premiums less reasonable administrative expense allowances), the plan expenses of administration, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the plan shall be recouped by assessments apportioned under this section by the board among participating insurers [and from other sources of revenue as provided in this section].
- (4) Each participating insurer's assessment shall be determined by multiplying the total assessment of all participating insurers as determined in Paragraph (3) by a fraction, the numerator of which equals the number of individuals in this state covered under health insurance policies (including by way of excess or stop loss coverage) by each participating insurer, and the denominator of which equals the total number of all individuals in this state covered under health insurance policies (including by way of excess or stop loss coverage) by all participating insurers, all determined as of the end of the prior calendar year.
- (5) The board shall make reasonable efforts designed to ensure that each insured individual is counted only once with respect to any assessment. For that purpose, the board shall require each participating insurer that obtains excess or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured (including by way of excess or stop loss coverage) in whole or part. The board shall allow a participating insurer who is an excess or stop loss insurer to exclude from its number of insured individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its assessment under this subsection.

- (6) Each participating insurer's assessment shall be determined by the board based on annual statements and other reports deemed to be necessary by the board and filed by the participating insurer with the board. The board may use any reasonable method of estimating the number of insureds of a participating insurer if the specific number is unknown. With respect to participating insurers that are reinsurers or excess or stop loss insurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer or excess or stop loss insurer.
- (7) A participating insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer, in whole or in part, the assessment if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the participating insurer to fulfill its contractual obligations. In the event an assessment against a participating insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other participating insurers in a manner consistent with the basis for assessments set forth in this subsection. The participating insurer receiving such abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.

Drafting Note: A state may wish to provide for some form of offset against applicable taxes in the amount of the assessments incurred by the participating insurers of the plan. If so, such a provision should allow appropriate reductions in assessments as to participating insurers not subject to the taxes against which offsets are allowed.

ALTERNATIVE THREE. Service Charge on Hospital and Surgical Centers

- (1) The deficit incurred by the plan shall be subsidized by the state through the service charge provided for in this subsection [and from other sources of revenue as provided in this section]. The board shall operate the plan in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed total income the plan expects to receive from policy premiums and service charges provided for in this subsection [and from other sources of additional revenue as provided in this section]. After determining the amount of funds available to it for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to assure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.
- (2)
 - (a) Each patient, except a private pay patient, a patient covered by Medicare or a patient covered by any other public program that is directly subsidized by the federal government, who is admitted to a hospital for treatment shall be assessed a service charge of two (2) dollars for each day, or portion thereof, during which the patient is confined as an inpatient in that facility. For purposes of this section only, "hospital" does not include any hospital operated by the state or any hospital created or operated by the Department of Veteran Affairs or other agency of the United States of America. Each hospital in which a patient is confined shall calculate the total service charge due for that service charge in the bill for services rendered to the patient. The service charge shall be collected as provided in Subparagraph (c).
 - (b) Each patient, except a private pay patient, a patient covered by Medicare or a patient covered by any other public program that is directly subsidized by the federal government, who is admitted to an ambulatory surgical center or to a hospital for outpatient ambulatory surgical care shall be assessed a service charge of one dollar for each admission to that facility. The service charge shall be included in the bill for services or supplies, or both, rendered to the patient by the ambulatory surgical center or hospital.

- (c) Each hospital and ambulatory surgical center shall collect the service charges assessed under this section. In the event that no payment is made by or on behalf of the patient for services rendered, the fee assessed under this section shall be waived. Each hospital and ambulatory surgical center shall remit to the plan for each reporting period, as established in the plan of operation, but no more frequently than [insert time period], charges collected during that reporting period in accordance with the reporting and remittance procedures established by the board. Failure to pay within sixty (60) days after the end of the reporting period shall cause the hospital or ambulatory surgical center to be liable to the plan for an amount determined by the board, not to exceed \$500, plus interest. Any hospital or ambulatory surgical center found to have failed to pay according to this section on three (3) or more occasions during a six-month period shall be liable for an amount determined by the board, no less than \$500 and not to exceed \$1,500 per failure, together with attorney fees, interest and court costs.
- (d) For the purposes of this subsection, “private pay patient” means a person whose admission to a hospital or ambulatory surgical center is not reimbursed through health or other insurance or any other health benefit plan or arrangement.

ALTERNATIVE FOUR. Appropriation of General Revenue

The deficit incurred by the plan shall be funded through amounts appropriated by the state legislature [and from other sources of revenue as provided in this section]. The board shall operate the plan in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed total income the plan expects to receive from policy premiums and funds appropriated by the state legislature [and from other sources of additional revenue as provided in this section]. After determining the amount of funds appropriated to it for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to assure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

Drafting Note: States may wish to consider using other sources of dedicated revenues to support state plans, including tobacco and alcohol taxes, per-person payroll taxes, income tax surcharges, or revenues from state lotteries.

Section 8. Benefits

Drafting Note: Two alternatives for Subsection A are offered for establishing covered services for the plan. Alternative One provides for the plan board to establish the covered services and exclusions, subject to the approval of the commissioner. The advantages of this alternative are that legislators can leave the benefit determinations to experts in plan design and that benefits can be easily modified from time to time to recognize changes in marketplace standards and medical technology.

Alternative Two contains a list of covered services and exclusions for states that wish to include the benefits and exclusions in the statute. The advantage of Alternative Two is that the list contains the benefits and exclusions found in some high risk plans in operation at the time the model was adopted. The list is intended to be inclusive and states may wish to add or delete benefits or exclusions to reflect the state’s policy preferences. The list is an outline of the benefits and exclusions; it is not policy language.

Consideration should be given prior to enactment to the cost effectiveness of inclusion or deletion of benefit mandates or other minimum benefit standards. Consideration also should be given to providing sufficient flexibility in the plan to allow for the delivery of services through health maintenance organizations, preferred provider organizations and other managed care arrangements.

Drafting Note: HIPAA requires that federally defined eligible individuals have a choice of coverage available to them. This requirement is satisfied by the plan offering at least two different deductible options to such individuals.

ALTERNATIVE ONE

- A. The plan shall offer health care coverage consistent with comprehensive 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 subject to the approval of the commissioner.

ALTERNATIVE TWO

- A. (1) Outline of Benefits. Covered expenses shall be the usual, customary and reasonable charge in the locality for the following services and articles when prescribed by a physician and determined by the plan to be medically necessary for the following areas of services, subject to provisions of Subsection B:
- (a) Hospital services;
 - (b) Professional services for the diagnosis or treatment of injuries, illnesses or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction;
 - (c) Drugs requiring a physician's prescription;
 - (d) Skilled nursing services of a licensed skilled nursing facility for not more than 120 days during a policy year;
 - (e) Services of a home health agency up to a maximum of 270 services per year;
 - (f) Use of radium or other radioactive materials;
 - (g) Oxygen;
 - (h) Anesthetics;
 - (i) Prostheses other than dental;
 - (j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which is prescribed;
 - (k) Diagnostic X-rays and laboratory tests;
 - (l) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
 - (m) Services of a physical therapist;
 - (n) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest facility qualified to treat a covered condition;
 - (o) Outpatient services for diagnosis and treatment of mental and nervous disorders provided that a covered person shall be required to make a fifty percent (50%) copayment, and that the plan's payment shall not exceed \$[insert number].
- (2) Exclusions. Covered expenses shall not include the following:
- (a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;
 - (b) Care which is primarily for custodial or domiciliary purposes;

- (c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is medically necessary;
- (d) That part of any charge for services rendered or articles prescribed by a physician, dentist or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary;
- (e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;
- (f) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred;
- (g) Dental care except as provided in Subsection A(1)(l);
- (h) Eyeglasses and hearing aids;
- (i) Illness or injury due to acts of war;
- (j) Services of blood donors and any fee for failure to replace the first three (3) pints of blood provided to an eligible person each policy year;
- (k) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service;
- (l) Routine maternity charges for a pregnancy, except where added as optional coverage with payment of additional premiums;
- (m) Any expense or charge for services, drugs or supplies that are not provided in accord with generally accepted standards of current medical practice;
- (n) Any expense or charge for routine physical examinations or tests;
- (o) Any expense for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay;
- (p) Any expense incurred for benefits provided under the laws of the United States and this state, including Medicare and Medicaid and other medical assistance, military service-connected disability payments, medical services provided for members of the armed forces and their dependents or employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States;
- (q) Any expense or charge for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy;
- (r) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures;
- (s) Any expense or charge for sterilization or sterilization reversals;
- (t) Any expense or charge for weight loss programs, exercise equipment or treatment of obesity, except when certified by a physician as morbid obesity (at least two (2) times normal body weight);

- (u) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery;
 - (v) Any expense or charge for organ or bone marrow transplants other than those performed at a hospital with a board approved organ transplant program that has been designated by the board as a preferred provider organization for that specific organ or bone marrow transplant; or
 - (w) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical specialty college for general use within the medical community.
- B. 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.
- C. The board may adjust any deductibles and coinsurance factors annually according to the Medical Component of the Consumer Price Index.
- D. Preexisting Conditions.
- (1) Plan coverage shall exclude charges or expenses incurred during the first six (6) months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such conditions during the six-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

Drafting Note: In order to reduce the premiums and costs of the plan, states may wish to provide for a longer exclusion period for preexisting conditions; as noted above, however, no preexisting condition exclusion may be applied to a federally defined eligible individual. States will need to weigh the need to provide access to individuals with preexisting conditions with the increased costs associated with a shorter preexisting condition exclusion period.

- (2) Subject to Paragraph (1), the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that
 - (a) Application for pool coverage is made not later than sixty-three (63) days following such involuntary termination and, in such case, coverage in the plan shall be effective from the date on which such prior coverage was terminated; and
 - (b) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to plan coverage.
- E. Nonduplication of Benefits.
- (1) The plan shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan 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 under or provided pursuant to any state or federal law or program.

- (2) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this paragraph.

Section 9. Collective Action

Neither the participation in the plan as participating insurers, the establishment of rates, forms or procedures nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability or penalty against the plan or any participating insurer.

Section 10. Taxation

The plan established pursuant to this Act shall be exempt from any and all taxes.

Section 11. Effective Date

The provisions of this Act shall become effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1983 Proc. I 6, 35, 644, 741-742, 755-762 (adopted).

1983 Proc. II 16, 22, 638, 693, 698-712 (amended and reprinted).

1984 Proc. I 6, 31, 576, 585, 590-592 (adopted The Health Insurance

Availability Act of 1983 as NAIC policy).

1992 Proc. II 8, 62, 672, 719, 726-740 (amended and reprinted).

2000 Proc. 3rd Quarter 13, 14, 163, 200, 311-323 (amended and reprinted).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. CODE §§ 27-52-1 to 27-52-6 (1997/2014) (portions of previous version of model); ALA. ADMIN. CODE r. 482-1-115 (1997/2010).
Alaska		ALASKA STAT. §§ 21.55.010 to 21.55.500 (1992/2010).
American Samoa	NO CURRENT ACTIVITY	
Arizona	NO CURRENT ACTIVITY	
Arkansas	ARK. CODE ANN. §§ 23-79-501 to 23-79-517 (1997/2013) (portions of model).	
California	NO CURRENT ACTIVITY	
Colorado	NO CURRENT ACTIVITY	
Connecticut		CONN. GEN. STAT. § 38a-556 (1975/2003).
Delaware	NO CURRENT ACTIVITY	
District of Columbia	NO CURRENT ACTIVITY	
Florida	NO CURRENT ACTIVITY	
Georgia		GA. CODE ANN. §§ 33-44-1 to 33-44-10 (1989/1990) (previous version of model); GA. COMP. R. & REGS. 111-4-1-.01 to 111-4-1-.13 (2005).
Guam	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Hawaii	NO CURRENT ACTIVITY	
Idaho		IDAHO CODE ANN. §§ 41-5501 to 41-5509 (2000/2005).
Illinois	215 ILL. COMP. STAT. 105/1 to 105/15 (1984/2005) (portions of model).	
Indiana		IND. CODE §§ 27-8-10-0.1 to 27-8-10-11.2 (1981/2013) (comprehensive health insurance).
Iowa		IOWA CODE §§ 514E.1 to 514E.11 (1986/2005) (portions of previous version of model).
Kansas	KAN. STAT. ANN. §§ 40-2117 to 40-2131 (1992/2004) (portions of model).	
Kentucky		KY. REV. STAT. ANN. §§ 304.17B-001 to 304-17B-031 (2000/2019).
Louisiana	NO CURRENT ACTIVITY	
Maine		ME. REV. STAT. ANN. tit. 24A, §§ 6901 to 6981 (2009/2013).
Maryland		MD. CODE ANN., HEALTH GEN. §§ 15-1001 to 15-1006 (2002/2014) (senior drug); MD. CODE REGS. 31.17.01.01 to 31.17.03.19 (2003/2013).
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	
Minnesota		MINN. STAT. §§ 62E.01 to 62E.19 (1976/2013).
Mississippi		MISS. CODE ANN. §§ 83-9-201 to 83-9-222 (1991/2009).
Missouri		MO. REV. STAT. §§ 376.960 to 376.989 (1991/2013) (portions of previous model).
Montana	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Nebraska		NEB. REV. STAT. §§ 44-4201 to 44-4235 (1987/2004) (portions of previous version of model); 210 NEB. ADMIN. CODE ch. 44, §§ 001 to 012 (1987/2004).
Nevada	NO CURRENT ACTIVITY	
New Hampshire		N.H. REV. STAT. ANN. §§ 404-G:1 to 404-G:12 (2001/2010).
New Jersey	NO CURRENT ACTIVITY	
New Mexico		N.M. STAT. ANN. §§ 59A-54-1 to 59A-54-21 (1987/2005) (portions of previous version of model); 13 N.M. CODE R. §§ 10.10.1 to 10.10.24 (1998).
New York	NO CURRENT ACTIVITY	
North Carolina	NO CURRENT ACTIVITY	
North Dakota		N.D. CENT. CODE §§ 26.1-08-01 to 26.1-08-14 (1983/2005).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	NO CURRENT ACTIVITY	
Oklahoma		OKLA. ADMIN. CODE § 365:45-3-1 (2009).
Oregon	NO CURRENT ACTIVITY	
Pennsylvania	NO CURRENT ACTIVITY	
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island	NO CURRENT ACTIVITY	
South Carolina	S.C. CODE ANN. §§ 38-74-10 to 38-74-80 (1989/2003) (portions of model).	
South Dakota	NO CURRENT ACTIVITY	
Tennessee	NO CURRENT ACTIVITY	
Texas	NO CURRENT ACTIVITY	
Utah	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Vermont	NO CURRENT ACTIVITY	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	NO CURRENT ACTIVITY	
Washington		WASH. REV. CODE ANN. §§ 48.41.010 to 48.41.920 (1987/2013).
West Virginia	W. VA. CODE §§ 33-48-1 to 33-48-12 (2004/2009).	
Wisconsin		WIS. ADMIN. CODE INS. §§ 18.01 to 18.18 (1981/2001).
Wyoming		WYO. STAT. ANN. §§ 26-43-101 to 26-43-118 (1990/2013); WYO. CODE R. 044.0002.41 §§ 1 to 4 (1996/2016).

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In 1970, a paper was presented to the NAIC by a trade association. It suggested a comprehensive program for health care in the 1970s, including a proposal for a plan to provide coverage for those who are considered uninsurable. **1971 Proc. I 209.**

In the years following, Congress considered a number of proposals for a national health insurance program. The NAIC adopted a resolution encouraging the development of health care coverage programs on a state level. One provision resolved to make benefits available through state plans to provide coverage for those who are uninsurable. **1975 Proc. I 576-579.**

A paper was presented to the Accident and Health Subcommittee exploring state alternatives to a comprehensive federal national health insurance program. One of the factors to be considered was how to make health insurance available to all, including low income persons and uninsurables or very high risk persons. **1975 Proc. II 366-383.**

The subcommittee considered a resolution to seek and support federal legislation to encourage the establishment of state health insurance plans. Federal action was deemed necessary in order to encourage participation in such pools by self-insurers, which are now exempted by ERISA. **1981 Proc. I 424.** The parent committee voted against adoption of the resolution, deciding it raised more questions of interpretation than it resolved. Sufficient authority now exists for the NAIC to develop a pooling concept, and it was the sense of the committee that this authority also included supporting changes in tax laws which would create incentives for self-insurers and other financing mechanisms not in the jurisdiction of the insurance departments to participate in the cost of the plan. **1981 Proc. I 420.**

In 1982, a subgroup began work on drafting a state pooling mechanism model. A joint committee made up of members of the NAIC and the Conference of Insurance Legislators (COIL) also supported drafting a new state pooling bill. They felt it was necessary to move quickly in this area, even if the self-insurers could not be included under the state legislation at this point. **1982 Proc. II 657.**

The working group first examined three drafts that had been prepared by the Health Insurance Association of America (HIAA), COIL and the NAIC. They found none of them completely satisfactory and began drafting a substitute. It was the opinion of the working group that the NAIC should not appear to be endorsing the concept of pooling as anything more than one of several alternatives for dealing with an uninsurable population. The group also decided it might be important to gain information on the extent of the uninsurable population. This information may differ by state and would be important to each state in determining whether health insurance pooling was a viable and necessary alternative. **1982 Proc. II 676.**

The greatest problem identified was getting the federal law changed so that state pools would include self-insured plans in their funding base. HIAA presented a proposal which provided that employers would only get a tax deduction on funds expended for employee health plans if the state had passed legislation for a health insurance pool. Some in the group thought this had scant change of passage at the federal level because of lobbying by employer groups, and would face constitutional challenges in that it penalized employers for something their state had failed to do. **1982 Proc. II 660.**

When the model bill was proposed for consideration by the NAIC, it was with the caveat that the NAIC does not necessarily endorse the concept of pooling. **1983 Proc. I 644.** Some members of the task force did not consider it appropriate for the NAIC to advocate what appears to be social legislation that may burden a few companies rather than spreading the cost of a social problem more fairly among all taxpayers. **1983 Proc. I 742.**

The Statement of Principles was added by the subgroup in June 1983 to voice concerns of the subgroup and to emphasize that each state needed to make its own decision regarding its needs. **1983 Proc. II 693.** Most of the Statement of Principles was deleted when the model was amended. **1992 Proc. IIB 726.**

The AIDS Advisory Committee considered whether risk pooling legislation might be suitable for consideration by state legislatures to address the anticipated high costs connected with the treatment of AIDS and AIDS-related conditions. **1986 Proc. II 653.**

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According to the advisory committee report of December 1987, the existing model was drafted to provide states a means of assuring to the medically uninsurable the availability of individual major medical coverage for catastrophic expenses. It did not, nor was it intended, to deal with affordability of coverage nor with access to coverage for the uninsured. The risk pool was, in essence, an insurer of last resort for those who were financially able to purchase coverage where coverage was not otherwise available to them in the private market. The pool was given the administrative structure and the powers of an insurer because that was to be its function. **1988 Proc. I 729.**

In 1999 amendments were considered. These amendments were necessary for a state's high risk pool to be in conformance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **1999 Proc. 2nd Quarter 559.**

Section 1. Definitions

The drafting committee studied plans which had been in place for several years and reported on their experiences. The drafters defined a pool or plan as a mechanism to increase the availability of insurance. High-risk individuals or groups could purchase insurance from a group of insurers who agreed to share the risk by dividing the expense of claims. **1982 Proc. II 664.**

The first version adopted did not include HMOs in the definition of insurance, but it was added when the June 1983 amendments were adopted. **1983 Proc. I 755, 1983 Proc. II 700.**

B. This definition was added as a result of amendments adopted to conform to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **1999 Proc. 3rd Quarter 887.**

D. The definition of "creditable coverage" was necessitated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The group agreed to consider a further amendment that would make clear that the periods of coverage preceding a significant break in coverage were not to be counted toward the aggregate periods of creditable coverage. **1999 Proc. 3rd Quarter 881.**

F. The definition of dependent was added in 1992. The drafting committee considered excluding dependents from coverage, but decided to keep dependent coverage but reduce the age limit for college-aged children. **1992 Proc. IB 1117.**

G. This definition was added as a result of amendments adopted to conform to HIPAA requirements. **1999 Proc. 3rd Quarter 887-888.**

H. The definition of government plan was added with the HIPAA amendments of 1999. **1999 Proc. 3rd Quarter 888.**

I. When the task force began discussing issues related to implementation of HIPAA, concern was raised that the definition of group health plans was tied to employment, and there are many health plans that are considered group health plans by the state that are not employer based. Under HIPAA, non-employer based health plans must be considered individual plans. **1998 Proc. 4th Quarter II 717.**

J. The definition of health insurance was revised to exclude dental-only or vision-only policies. Plan benefits for pools generally do not cover dental and vision benefits, so the amendment was added to prevent these policies from being assessed to cover plan losses. **1992 Proc. IIB 724.**

Paragraphs (2) through (5) were added with the 1999 HIPAA amendments. **1999 Proc. 3rd Quarter 888.**

M. The question was raised whether the definition of insurer was intended to cover self-funded employer plans. The chair noted it was not. It was suggested that the definition from the third-party administrator model be considered, since it was drafted to include all insuring entities subject to regulation by a state. **1991 Proc. IB 797.**

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Section 1M (cont.)

The definition of insurer in Subsection M was amended to conform to the definition contained in the NAIC Small Employee Health Insurance Availability Model Acts. This change would ensure that all entities subject to state insurance department regulation, including multiple employer welfare arrangements, would be included for the purpose of plan assessments. **1992 Proc. IIB 724.**

N. This definition was added with the 1999 HIPAA amendments. **1999 Proc. 3rd Quarter 889.**

T. The definition of resident was added to the model in 1992. **1992 Proc. IIB 728.** The drafters considered various time periods; one state regulator reported their statute used 60 days, another reported a 30-day requirement. **1991 Proc. IB 797.**

U. The uninsurable model followed the HIPAA 63-day break in creditable coverage minimum standard for the purposes of determining whether an individual has had a significant break in coverage. The draft amendments to some other models provide for a 90-day break in creditable coverage. The task force members did not change this. **1999 Proc. 3rd Quarter 881.**

Section 2. Operation of the Plan

In studying existing pools, the drafters noted that the primary intent of plans already in existence was to extend the availability of insurance to medically uninsurable individuals. Though the pools were not intended to provide health care coverage for the poor, the plans in existence all had legislated a cap on premium rates to keep the insurance reasonably affordable. **1982 Proc. II 664.**

B. The model as first adopted provided for a seven-member board of directors. Three were to be appointed by the commissioner and four by the members of the pool. Provisions for a chairman and staggered terms of office were included. **1983 Proc. I 756-757.**

The amendments to the model in June 1983 completely revised the first part of this section. The model no longer specified how many members will be on the board or provided for a specified term of office. The members were to be selected by the pool members with the approval of the commissioner. **1983 Proc. II 700-701.**

A working group was appointed in 1987 to look at several significant issues with regards to the health pooling model. Some of those issues were the mechanics of implementing risk pools, HMO representation on pools and a more active commissioner role in the operations of the plans. **1987 Proc. II 743.**

Extensive amendments to this section were considered in 1991 and 1992. The membership of the board was changed from being insurer driven by adding a provision specifically requiring that the majority of the board *not* be individuals who are representatives of insurers or health care providers. **1992 Proc. IB 1103.**

In earlier drafts the working group considered setting a board size. They wanted the board to be relatively small. The drafters considered 10, but decided 11 would be a better number to avoid tie votes. **1991 Proc. IB 797.**

A last minute change before exposure was addition of a provision which allowed appointment of the board to be either by the governor or the elected commissioner. **1992 Proc. IB 1116.**

It was suggested that insurer premium tax offsets should be included in the model as a standard option rather than as a drafting note. An industry spokesman argued that the change in the board's composition made it logical to include the offset. In the draft being considered there was no requirement that any insurer be on the board. **1992 Proc. IB 1117.** The draft adopted did include a requirement for insurer representation. **1992 Proc. IIB 724.**

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Section 2B (cont.)

The drafting committee considered whether it was appropriate to require the risk pool to be non-profit. The existing model had specified this, but the language was deleted in the draft adopted in 1992. **1992 Proc. IIB 728.**

The language considered to replace the non-profit section spoke of creating a public entity. This status provided the fund with immunity for its operation, but did not subject it to rules for state agencies such as civil service and competitive bidding. The group decided to leave open the issue of whether a state might want to create a public entity. According to one industry representative, the important points are that the entity be nonprofit, have the right to collect money and pay benefits, and be able to assess insurers, employers, providers or other sources of funds. **1991 Proc. IB 797.**

One regulator suggested that whether a plan was a governmental agency might depend on its method of financing. Another expressed the opinion that being a governmental entity might be more valuable at start up, and once a plan achieved a certain size, it could function very well on its own. **1992 Proc. IB 1118.**

G. The plan of operation was expanded by the amendments considered in 1991 and 1992. One late revision to the draft was a provision to ensure that the plan of operation would establish procedures for claims handling as well as accounting of monies. In addition, those procedures would extend to auditing of the plan administrator as well as the plan itself. **1992 IB 1116.**

H. The general powers were expanded to include specific authority for the plan to hire staff and to borrow money. **1992 Proc. IB 1116.** In addition, the plan was authorized in the draft to reinsure risks, to provide additional types of coverage, such as Medicare supplements, and to employ cost containment measures. **1992 Proc. IB 1105.**

A drafting note was added to Subsection H(12) stating that states may wish to require plans to offer coverage to supplement Medicare. Some Medicare-eligible individuals, especially those eligible by reason of disability, may be unable to secure supplemental coverage in the private market. **1992 Proc. IIB 725.**

One regulator pointed out a problem that had occurred in his state in interpreting the section on setting rates. The plan interpreted the model to mean that they should take the rates of the five leading carriers, adjust them to reflect the plan's population, and then multiply by 150 percent. The working group agreed to modify the section by removing the second sentence of Section 4H(4) to make it clear that plan rates were to be a percentage of standard rates without adjustment for the risk profile of the plan's population. **1992 Proc. IB 1117.**

Modifications were made to the draft language to make it clear that the plan could use managed care arrangements including health maintenance organizations and preferred provider organizations. **1992 Proc. IB 1117.**

I. The provisions of Subsection I were added in 1992. **1992 Proc. IIB 730.**

J. The provisions of Subsection J were added in 1992. **1992 Proc. IIB 730.**

Section 3. Establishment of Rules

This section was adopted when the model was revised in 1992. **1992 Proc. IIB 730.**

The working group considered whether it was appropriate to grant authority to the insurance commissioner to adopt regulations regarding operation of the plan. One industry representative suggested that since the board has the authority to propose a plan of operation, subject to the approval of the commissioner, giving the commissioner independent authority to adopt regulations on pool operations would permit the commissioner to nullify board decisions. A regulator clarified that this language was included to give the commissioner adequate authority to deal with unforeseen events. **1991 Proc. IB 797.**

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Section 4. Eligibility

The chair of the drafting committee asked meeting participants whether the eligibility rules should list affirmatively those classes of people who are eligible, or whether a negative approach (everyone is eligible except...) would be better. The intent of the current model is not to require certain health conditions; it takes the approach that everyone is eligible except those with access to certain types of coverage. One regulator thought it would be clearer to consumers to state eligibility in the affirmative. Another attendee suggested that consumer information could be presented in the affirmative. **1991 Proc. IB 797.**

A. In studying existing pools, the drafters found that all plans required applicants to be state residents. Most states required applicants to submit evidence of having been rejected by insurance carriers or having their coverage substantially reduced through expensive premiums or restrictive riders. A plan open to any individual would have the possible effect of improving their experience by including standard risks. Not only could this positively affect premium rates, it could also serve the coverage needs of the temporarily uninsured. **1982 Proc. II 664.**

In the process of preparing an initial model draft, several questions arose which needed to be resolved before the model could be finalized. One of the most pressing problems was whether to deal only with the truly uninsurable or include uninsureds (e.g., the unemployed). **1983 Proc. I 746.** The first draft contained an optional section requiring rejection by at least two carriers before an individual would be eligible for coverage. The version adopted no longer contained that language. **1983 Proc. I 747, 756.**

A drafting note was added in June 1983 to make clear that only those unable to purchase coverage in the marketplace would be expected to apply, and to leave to states the option of adding rejection of coverage by a specified number of carriers as a criterion for pool coverage. **1983 Proc. II 703.**

The first draft excluded any person on whose behalf \$500,000 in covered benefits had been paid out. Before adoption that number was enlarged to \$1,000,000. **1983 Proc. I 747, 756.**

The task force did not believe that rejection by an insurer should be necessary. They recommended reviewing the range of premiums and method of premium calculation as a preferable method by which to limit the pool to the uninsurable and to assure that charges properly reflect the nature of the coverage and the population. **1988 Proc. I 730.**

When revising the model in 1991, the group was encouraged to require two rejections rather than one. The consensus of the working group was that two rejection letters placed an unnecessary burden on enrollees and the version later adopted provided for one letter of rejection. **1992 Proc. IB 1116.**

In the late 1980's the NAIC and the federal government studied ways to make health insurance coverage more available and affordable. For a time the working group revising the model considered expanding its availability, but decided to recommend the plan be only for the uninsurable, and be coverage of last resort. **1990 Proc. IB 661.**

Paragraph (2) was added as part of the amendments developed in response to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **1999 Proc. 3rd Quarter 891.**

B. An industry spokesman recommended that Section 4B, which was added in 1992, not require the promulgation of a list of medical or health conditions for eligibility. He suggested that the proliferation of different lists would result in difficult coordination efforts. The working group rejected that suggestion, noting the significance of requiring a list on the first day of operation. They did, however, support efforts to keep the list as short as possible. **1992 Proc. IB 1116.**

C. The drafters considered excluding dependents from coverage, but instead added this subsection limiting coverage to dependents in the household. They also included a definition of dependent. **1992 Proc. IB 1117.**

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Section 4 (cont.)

D. The drafting group considered whether to allow double coverage during the pool's preexisting condition exclusion period. Two states said their pool laws allowed individuals to maintain double coverage during a preexisting condition period. **1991 Proc. IIB 964.**

Section 4D(1) was added to permit an individual to maintain plan coverage while satisfying a preexisting condition exclusion period in a health policy intended to replace the plan coverage. This change would protect an individual from having to go without coverage for a certain condition if the person finds other health insurance coverage. **1992 Proc. IIB 724.**

Consideration was given to the issue of eligibility for group continuation or conversion coverage. An industry participant in the discussion suggested that the eligibility of continuation coverage should exclude a person from the plan. However, a regulator pointed out that cost should also be considered. In some cases pool coverage may be cheaper for the individual than continuation coverage. **1991 Proc. IB 797-798.**

Reference was added in Paragraphs (3) and (5) to federally defined eligible individuals as part of the 1999 amendments developed in response to HIPAA. **1999 Proc. 3rd Quarter 887-888.**

F. One suggestion was to make coverage reciprocal if an individual was covered by a similar pool in another state. One regulator said it was a nice idea but wouldn't want to see an individual coming in from another state step in front of his own state's resident who was on the waiting list to get into the pool. **1991 Proc. IIB 964.**

The draft finally adopted contained a drafting note saying states could consider reciprocity. **1992 Proc. IIB 731.**

A second drafting note was added as part of the HIPAA amendments developed in 1999. **1999 Proc. 3rd Quarter 892.**

Section 5. Unfair Referral to Plan

The working group appointed in 1987 to study the possibility of revisions to the model act reported that some states had expressed concerns with "dumping." **1987 Proc. I 743.**

One regulator reported on the experience of the pool in his state regarding "dumping" of sick employees by employer plans. He described a provision in his state's law which excludes employees who have been dropped from a group plan from eligibility for pool coverage. Another regulator pointed out that risk pools are often called upon to provide coverage to individuals dumped from self-funded ERISA plans, which states cannot regulate. Another state law which makes it an unfair competitive practice for brokers and agents to refer individual employees outside the group plan was considered. **1991 Proc. IB 797.**

To the extent that all of the states adopt the discontinuance and replacement law, this other law will serve to protect individual employees or members of groups who are carved out of existing groups. **1991 Proc. IB 801.**

One insurance regulator reported on the law in his state which prohibited employers with more than 10 employees dumping high risks into the pool. The state legislature had decided not to prohibit individuals from the smallest groups from being placed in the pool because it was concerned about the whole group being canceled if the high risk employee could not get pool coverage. For a time the model exempted groups of fewer than ten employees. That provision was deleted when amendments were adopted to respond to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **1991 Proc. IIB 964.**

States that have adopted the NAIC models on small group reforms will not have a dumping problem with small groups. **1991 Proc. IB 964.**

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Section 5 (cont.)

When the drafting group decided to add Section 5 to the model, they also decided to include a drafting note suggesting that the number of employees to which this prohibition applied could be varied by states. That part was deleted when the HIPAA amendments were adopted. **1992 Proc. IB 1115.**

Section 6. Plan Administrator

The original model referred to the “administrating insurer” in this section. The reference was changed to “plan administrator” so that the contracting of administrative duties is not limited to insurers only. **1992 Proc. IB 1116.**

Section 7. Funding of the Plan

In studying existing pools, the drafters found different funding mechanisms in existence. They varied from an attempt to make the plan self-sufficient to setting rates near those of insurers and assessing insurers for the difference. **1982 Proc. II 665-666.**

B. The drafters had several issues to resolve before adopting a final draft. One of those dealt with the manner of assessment, and whether there should be special recognition of companies directly writing coverage for uninsurables. **1983 Proc. I 742.**

The working group which began studying the possibility of modifications to the model in 1987 said some states had expressed interest in funding alternatives, regional administration and cost data. **1987 Proc. II 743.** They found that most of the plans in existence financed the pools with premiums paid by participants and all deficits were assessed to participating insurers, with credit applied against their premium tax. **1987 Proc. II 756.**

An advisory committee report issued in December 1987 addressed several issues. With respect to funding, the committee concluded that, while the model does not provide for specific tax-based funding, general revenues might be a viable option in some states for funding the plans. They also noted it was inequitable to fund the pool only with contributions from insurers. The advisory committee recommended that, if changing the Employee Retirement Income Security Act (ERISA) to allow for assessments of self-funded benefit plans is no longer a goal of the NAIC, then the advisory committee would recommend that formal consideration be given to including a tax offset in the model or otherwise providing for broad-based funding. **1988 Proc. I 714.**

A technical actuarial advisory committee was given the task of analyzing the mechanisms for funding the various state pools and recommending an alternative pricing mechanism. The committee reported that they were unable to come to any conclusions because of the variations in benefits, funding and rates. **1989 Proc. I 838.**

The working group discussed alternative funding sources presented in a letter from one state regulator. The group was interested in finding a method to compel self-funded employers to contribute to plan financing. One regulator said that his state’s experience was that 10 to 20 percent of those covered by the pool were previously covered by a self-funded employer plan which either dumped them or was terminated. **1992 Proc. IB 798, 805-806.**

One industry attendee asked whether it would be appropriate to continue insurers assessments as a major source of funding if insurers no longer had a majority of members on the board. He suggested that board members would have an incentive to keep premiums low, with the knowledge that any shortfall would be charged to the industry through assessments. **1991 Proc. IB 798.**

An industry association representative suggested that a drafting note be added to the second financing alternative suggesting that states consider providing for premium tax offsets. He also suggested that if there is no premium tax offset, the composition of the board of directors should be amended to provide for an insurer majority. **1992 Proc. IB 1101.**

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Section 7B (cont.)

Since federal law exempts federal benefit plans from premium tax assessment, they would be exempt from assessments under the drafting note for the first funding alternative. An industry representative at the meeting suggested it was appropriate to include this in a drafting note for the second alternative too, for consistency. **1992 Proc. IB 1101.**

It was suggested that Medicare supplement insurance be exempt from assessment due to the new open enrollment provisions for such plans, since they were not contributing to uninsurability. A regulator pointed out that open enrollment provisions do not apply to Medicare beneficiaries who qualify by reason of disability. **1992 Proc. IB 1101.**

It was suggested that both premiums from federal employees health benefit plans and from Medicare supplement insurance be excluded from the assessment use. It was pointed out that federal law already excludes premiums paid for federal employees so an exclusion in state law is unnecessary. One regulator expressed the opinion that exclusion of Medicare supplement insurance premium is inconsistent with the working group's effort to encourage plans to provide coverage for supplemental services to Medicare. The working group decided to include a drafting note saying states that did not provide supplements to Medicare may wish to exclude premiums for supplemental coverage from the assessment base. **1992 Proc. IIB 725.**

An industry representative suggested that guaranteed issue products be exempted from assessments to fund the plan. After discussion by the working group, the suggested change was rejected. **1992 Proc. IB 1117.**

One proposed funding source looked to a tax on hospitals to ensure that self-funded payers participated in funding the plan. Public hospitals would be excluded from the tax. The drafters wanted to assure that private paying individuals would not be assessed. Several members of the working group wondered how the hospital could distinguish the private pay from insured individuals in every case. A hospital tax provision needed to be drafted carefully. **1991 Proc. IIB 964-965.**

The draft contained an exclusion in Alternative Three for services related to psychiatric care and chemical dependency. Before adopting the revised model, that exclusion was removed. The intent was to access all hospital services. **1992 Proc. IIB 725.**

The working group decided it would be most appropriate to include alternative funding approaches and to clarify the section to accommodate the possibility that a combination of funding sources may be needed in some states. **1992 Proc. IB 1117.**

Paragraph (6) in Alternative One and Paragraph (7) in Alternative Two, describing alternative forms for funding, were revised to empower the commissioner to defer or abate assessments made against insurers by the plan board. The previously adopted model had given the power to defer to the board. **1992 Proc. IIB 725.**

Section 8. Benefits

One of the major issues considered by the drafting subgroup was the level of benefits to provide. They asked, "Should the model be providing basic coverage, major medical coverage, or a combination? How should the deductibles and coinsurance apply?" The initial draft only included the provisions of what later become the first alternative. **1983 Proc. I 746, 750.**

According to the advisory committee report received in December 1987, the benefit structure envisioned by the model was major medical in nature, with deductibles, co-payments and maximum benefit levels intended to assure catastrophic protection. Mandated benefits were generally not included nor referenced since these were intended to be state specific. Each state should evaluate its own particular situation based on need, cost and existing state standards for individual policies. If the subject of mandates was to be dealt with in the model, the advisory committee recommended a drafting note advising each state to review its own statutes and make the benefits in the pool comparable to those included in individual major medical policies. **1988 Proc. I 730.**

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Section 8 (cont.)

The drafters of amendments considered whether or not to exempt the plans from state mandated benefits. The groups did not arrive at a conclusion, but instead included a drafting note suggesting states consider whether to include the mandates. **1992 Proc. IB 1117.**

When a drafting group was considering amendments to the model in 1990, one industry observer suggested that the alternative which contained a detailed list of benefits be eliminated and the other alternative, which provided that benefits be determined by the insurance commissioner with advise from pool members, be retained. The drafting committee rejected this suggestion for several reasons. Eliminating the alternative with the detailed list would ignore the fact that most states have followed that approach. Also the working group members felt it was appropriate for the state to provide direction on whether mandated benefits should apply. The chair suggested that a drafting note be included suggesting the type of benefits a state should consider if it wished to incorporate the benefit package into legislation. **1991 Proc. IB 798.**

The benefit for transportation was expanded to cover emergency and other medically necessary transportation. **1992 Proc. IIB 725.**

The task force considering amendments in response to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) decided to add a drafting note to Section 8 with respect to the fact that the choice of coverage requirement under HIPAA would be satisfied by the high risk pool offering the same plan with different deductibles. **1999 Proc. 2nd Quarter 559.**

A. The amendments being considered in 1991 added a number of exclusions to the list of items not covered by the plan under Alternative Two. Shortly before releasing the exposure draft, the group considered whether to leave in the exclusion for experimental treatments. The group decided it was appropriate to retain the language. **1992 Proc. IB 1112-1113, 1115.**

At one point the list of exclusions being considered included an exclusion for abortions. Before exposure the working group decided to eliminate that issue. **1992 Proc. IB 1116.** An explicit exception for service related to a gender transformation operation was also removed. **1992 Proc. IIB 737.**

The working group added an extensive list of exceptions to the model. One regulator suggested that several of the explicit exceptions be removed because the list was too specific. Another regulator expressed the opinion that it was helpful to make the states aware of all the exceptions they might want to use. A drafting note was added to clarify the point that the list is intentionally inclusive and that each state should choose the exclusions that best fit its needs. One commissioner suggested that if an exclusion is not included in the list, states might think the NAIC has taken a position against the exclusion. **1992 Proc. IIB 725.**

B. This subsection was added in 1992. **1992 Proc. IIB 738.**

C. The earlier model had low and high alternative deductibles. While drafting amendments in 1991, the working group eliminated the two types of deductibles. The determination of appropriate deductibles will be a decision of the board. **1992 Proc. IB 1116.**

D. It was suggested that the preexisting condition exclusion period be reduced from twelve months to six months. One attendee reported that no state presently had a period longer than six months. **1992 Proc. IB 1117.**

The draft prepared for exposure in December of 1991 contained a revision to the preexisting condition subsection. The old model had contained a twelve-month exclusion, but the working group proposed reduction to a six-month waiting period. An industry spokeswoman suggested an option for a twelve-month period and state that he felt the working group's decision had been based on the erroneous assumption that most or all states with risk pools had adopted six-month periods. The regulator chairing the meeting said the working group had determined that a six-month limitation was more appropriate. **1992 Proc. IB 1101, 1113.**

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Section 8 (cont.)

At later meetings of the drafters, debate continued over whether it was appropriate to include a twelve-month preexisting condition exclusion or at least include it as an alternative choice. Some states had increased their exclusion periods to reduce premiums and costs. The working group decided to include a drafting note suggesting that states may want to increase the six-month preexisting exclusion period in order to reduce plan premiums and costs. **1992 Proc. IIB 725.**

An exception for federally defined eligible individuals was added as part of the 1999 amendments. **1999 Proc. 3rd Quarter 898.**

Section 9. Collective Action

This section was added when the model was amended in June of 1983. **1983 Proc. II 712.**

Section 10. Taxation

This section was added when the model was amended in June of 1983. The footnote was also added at that time. **1983 Proc. II 712.**

Section 11. Effective Date

Chronological Summary of Action

December 1982: Model adopted.

June 1983: Revisions adopted included a Statement of Principles and drafting notes, as well as alternative provisions for minimum benefits.

December 1983: Adopted suggested federal legislation to provide tax incentives for self-insured plans to join state health insurance pool. This is found at 1984 Proc. I 590-592.

June 1992: Completely revised model. Operation of the board revised to include persons who qualify for coverage. Duties of board expanded, eligibility section substantially revised. Added Section 5 on referrals. Included four alternative sources for additional funding of plan.

December 2000: Model revised to address issues raised by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the federal rules promulgated pursuant to HIPAA.