
THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 348 Session of
2013

INTRODUCED BY FOLMER, MENSCH, GREENLEAF, VULAKOVICH, BROWNE,
ERICKSON, ALLOWAY AND BAKER, JANUARY 30, 2013

REFERRED TO BANKING AND INSURANCE, JANUARY 30, 2013

AN ACT

1 Establishing the Pennsylvania High-Risk Health Insurance Pool,
2 the Pennsylvania High-Risk Health Insurance Pool Fund and the
3 State Comprehensive Health Insurance Pool Board; providing
4 for the powers and duties of the pool and the board, for
5 selection of administering insurer and for payment of plan
6 costs; and prescribing plan benefits.

7 The General Assembly of the Commonwealth of Pennsylvania
8 hereby enacts as follows:

9 Section 1. Short title.

10 This act shall be known and may be cited as the High-Risk
11 Health Insurance Pool Act.

12 Section 2. Definitions.

13 The following words and phrases when used in this act shall
14 have the meanings given to them in this section unless the
15 context clearly indicates otherwise:

16 "Board." The State Comprehensive Health Insurance Pool
17 Board.

18 "Commissioner." The Insurance Commissioner of the
19 Commonwealth.

20 "Fund." The Pennsylvania High-Risk Health Insurance Pool

1 Fund.

2 "Health insurance." A hospital or medical expense incurred
3 policy, nonprofit health care services plan contract, health
4 maintenance organization, subscriber contract or any other
5 health care plan or arrangement that pays for or furnishes
6 medical or health care services whether by insurance or
7 otherwise, when sold to an individual or as a group policy. This
8 term does not include short-term, accident, dental-only, fixed
9 indemnity, limited benefit or credit insurance, coverage issued
10 as a supplement to liability insurance, insurance arising out of
11 a workers' compensation or similar law, automobile medical-
12 payment insurance or insurance under which benefits are payable
13 with or without regard to fault and which is statutorily
14 required to be contained in any liability insurance policy or
15 equivalent self-insurance.

16 "Insured." A person who is a legal resident of this
17 Commonwealth and a citizen of the United States who is eligible
18 to receive benefits from the pool. The term includes a dependent
19 and family member.

20 "Insurer." An entity that is authorized in this Commonwealth
21 to write health insurance or that provides health insurance in
22 this Commonwealth. The term includes an insurance company,
23 nonprofit health care services plan, fraternal benefits society,
24 health maintenance organization, third-party administrators,
25 State or local governmental unit, to the extent permitted by
26 Federal law any self-insured arrangement covered by section 3 of
27 the Employee Retirement Income Security Act of 1974 (Public Law
28 93-406, 29 U.S.C. § 1002), that provides health care benefits in
29 this Commonwealth, any other entity providing a plan of health
30 insurance or health benefits subject to State insurance

1 regulation and any reinsurer or stop-loss plan providing
2 reinsurance or stop-loss coverage to a health insurer in this
3 Commonwealth.

4 "Medicare." Coverage under both Parts A and B of Title XVIII
5 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et
6 seq.).

7 "Physician." An individual licensed to practice medicine
8 under the laws of this Commonwealth.

9 "Plan." The Comprehensive Health Insurance Plan as adopted
10 by the State Comprehensive Health Insurance Board.

11 "Pool." The Pennsylvania High-Risk Health Insurance Pool.

12 "Preexisting condition." A condition for which medical
13 advice, care or treatment was recommended or received during the
14 six months prior to effective date of coverage under the pool.

15 "Producer." A person who is licensed to sell health
16 insurance in this Commonwealth.

17 "Resident." Any of the following:

18 (1) An individual who has been legally domiciled in this
19 Commonwealth for a minimum of 90 days.

20 (2) An individual who is legally domiciled in this
21 Commonwealth and is eligible for enrollment in the pool as a
22 result of the Health Insurance Portability and Accountability
23 Act of 1996 (Public Law 104-191, 110 Stat. 1936).

24 (3) An individual who is legally domiciled in this
25 Commonwealth and is eligible for enrollment as a result of
26 the Trade Adjustment Assistance Reform Act of 2002 (Public
27 Law 107-210, 116 Stat. 933).

28 Section 3. Pennsylvania High-Risk Health Insurance Pool.

29 (a) Establishment.--A nonprofit legal entity to be known as
30 the Pennsylvania High-Risk Health Insurance Pool is established.

1 (b) Availability date for health insurance policies.--Health
2 insurance policies available in accordance with this act shall
3 be available for sale within one year from the effective date of
4 this section.

5 (c) Fund.--The Pennsylvania High-Risk Health Insurance Pool
6 Fund is established in the State Treasury.

7 Section 4. Pool coverage eligibility.

8 (a) General rule.--Any individual person who is and
9 continues to be a resident of this Commonwealth and a citizen of
10 the United States shall be eligible for coverage from the pool
11 if evidence is provided of one of the following:

12 (1) (i) A notice of rejection or refusal to issue
13 substantially similar insurance for health reasons by two
14 insurers, provided that at least two insurers offer
15 individual health insurance coverage in this
16 Commonwealth.

17 (ii) If only one insurer offers individual market
18 health insurance coverage in this Commonwealth then one
19 rejection shall be sufficient.

20 (iii) A rejection or refusal by an insurer offering
21 only stop-loss, excess loss or reinsurance coverage with
22 respect to the applicant shall not be sufficient except
23 under this subsection.

24 (2) (i) A refusal by two insurers to issue insurance
25 except at a rate exceeding the pool rate, provided that
26 at least two insurers offer individual health insurance
27 coverage in this Commonwealth.

28 (ii) If only one insurer offers individual market
29 health insurance coverage in this Commonwealth, then one
30 quote that exceeds the pool rate shall be sufficient.

1 (3) A diagnosis of the individual with one of the
2 medical or health conditions listed by the board in
3 accordance with section 6. A person diagnosed with one or
4 more of these conditions shall be eligible for a pool
5 coverage without applying for health insurance coverage.

6 (4) For persons eligible due to eligibility under the
7 Health Insurance Portability and Accountability Act of 1996
8 (Public Law 104-191, 110 Stat. 1936), the maintenance of
9 health insurance coverage for the previous 18 months with no
10 gap in coverage greater than 63 days of which the most recent
11 coverage was through an employer-sponsored plan.

12 (5) For persons eligible as a result of certification
13 for Federal trade adjustment assistance or for pension
14 benefit guarantee corporation assistance as provided by the
15 Trade Adjustment Assistance Reform Act of 2002 (Public Law
16 107-210. 116 Stat. 933), coverage with no preexisting
17 conditions limitation for individuals with three months of
18 prior creditable coverage with a break in coverage of no more
19 than 63 days.

20 (b) Dependents.--Each dependent of a person who is eligible
21 for coverage from the pool shall also be eligible for coverage
22 from the pool. In the instance of a child who is the primary
23 insured, resident family members shall also be eligible for
24 coverage.

25 (c) Preexisting waiting periods.--A person may maintain pool
26 coverage for the period of time the person is satisfying a
27 preexisting waiting period under another health insurance policy
28 or insurance arrangement intended to replace the pool policy.

29 (d) Conditions for ineligibility.--A person is ineligible
30 for coverage from the pool if the person:

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

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

7 (i) coverage, including COBRA continuation, other
8 continuation or conversion coverage, maintained for the
9 period of time the person is satisfying any preexisting
10 condition waiting period under a pool policy;

11 (ii) employer group coverage conditioned by the
12 limitations described by subsection (a)(4) and (5); or

13 (iii) individual coverage conditioned by the
14 limitation described by subsection (a)(1), (2) or (3);

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

18 (4) is confined in a county jail or imprisoned in a
19 State correctional institution; or

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

22 (e) Waiver of preexisting condition requirements.--Pool
23 preexisting condition requirements shall be waived for the
24 following individuals:

25 (1) an individual for whom, as of the date on which the
26 individual seeks plan coverage, the aggregate of the periods
27 of creditable coverage is 18 months or more and whose most
28 recent prior creditable coverage was under group health
29 insurance coverage offered by a health insurance issuer, a
30 group health plan, a governmental plan, or a church plan, or

1 health insurance coverage offered in connection with any such
2 plans, or any other type of creditable coverage that may be
3 required by the Health Insurance Portability and
4 Accountability Act of 1996, or the regulations under that
5 act;

6 (2) an individual who is eligible for Federal trade
7 adjustment assistance or for pension benefit guarantee
8 corporation assistance, as provided by the Trade Adjustment
9 Assistance Reform Act of 2002, provided that as of the date
10 on which the individual was certified as eligible for Federal
11 trade adjustment assistance, the individual had at least
12 three months of prior creditable coverage with no longer than
13 a 63-day break in coverage as established by the Trade
14 Adjustment Assistance Reform Act of 2002 or the regulations
15 under that act.

16 (f) Termination of pool coverage.--Pool coverage shall
17 terminate:

18 (1) on the date a person is no longer a resident of this
19 Commonwealth, except for a child who is a student under 23
20 years of age and who is financially dependent on a parent, a
21 child for whom a person may be obligated to pay child support
22 or a child of any age who is disabled and dependent on a
23 parent;

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

25 (3) on the death of the covered person;

26 (4) on the date State law requires cancellation of the
27 policy;

28 (5) at the option of the pool, 30 days after the pool
29 sends to the person an inquiry concerning the person's
30 eligibility, including an inquiry concerning the person's

1 residence, to which the person does not reply;

2 (6) on the 31st day after the day on which a premium
3 payment for pool coverage becomes due, if the payment is not
4 made before that date; or

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

7 (g) Termination due to eligibility.--A person who ceases to
8 meet the eligibility requirements of this section may have the
9 person's coverage terminated at the end of the policy period.

10 Section 5. State Comprehensive Health Insurance Pool Board.

11 (a) Establishment.--The State Comprehensive Health Insurance
12 Pool Board is established. The board members shall be appointed
13 as follows:

14 (1) One representative of a domestic insurance company
15 appointed by the President pro tempore of the Senate from a
16 list supplied by the Insurance Federation of Pennsylvania,
17 Inc., or its successor.

18 (2) One representative of a domestic insurance company
19 appointed by the Speaker of the House of Representatives from
20 a list supplied by the Insurance Federation of Pennsylvania,
21 Inc., or its successor.

22 (3) One representative of a nonprofit health care
23 service plan appointed by the President pro tempore of the
24 Senate.

25 (4) One representative of a health maintenance
26 organization appointed by the Speaker of the House of
27 Representatives.

28 (5) One member representing the medical provider
29 community, such as a physician licensed to practice medicine
30 in this Commonwealth or a hospital administrator appointed by

1 the Secretary of Health from lists supplied by the
2 Pennsylvania Medical Society, or its successor, and the
3 Hospital & Healthsystem Association of Pennsylvania, or its
4 successor.

5 (6) Five members of the general public who are not
6 employed by or affiliated with an insurance company or plan,
7 group hospital or other health care provider and are not
8 reasonably expected to qualify for coverage in the pool, with
9 one appointment by each of the following: the Majority Leader
10 of the Senate, the Minority Leader of the Senate, the
11 Majority Leader of the House of Representatives, the Minority
12 Leader of the House of Representatives and the Insurance
13 Commissioner.

14 No elected official may be a member of the board.

15 (b) Special qualification.--In making appointments to the
16 board, efforts shall be made to ensure that at least one person
17 serving on the board is at least 60 years of age.

18 (c) Terms of board members.--The original members of the
19 board shall be appointed for the following terms:

20 (1) Four members for a term of one year.

21 (2) Three members for a term of two year.

22 (3) Three members for a term of three years.

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

25 (d) Chairman.--The board shall elect one of its members as
26 chairman, who may serve in that capacity only for two years.

27 (e) Reimbursement of expenses.--Members of the board may be
28 reimbursed from moneys of the pool for actual and necessary
29 expenses incurred by them in the performance of their official
30 duties as members of the board but shall not otherwise be

1 compensated for their services.

2 (f) Limitation of liability.--Members of the board are not
3 liable for an action or omission performed in good faith in the
4 performance of powers and duties under this act, and no cause of
5 action may arise against a member for the action or omission.

6 (g) Plan to be submitted.--

7 (1) The board shall adopt a plan pursuant to this act
8 and submit its articles, bylaws and operating rules to the
9 commissioner for approval.

10 (2) If the board fails to adopt a plan and suitable
11 articles, bylaws and operating rules within 180 days after
12 appointment of the board, the commissioner shall promulgate
13 rules to effectuate the provisions of this act and such rules
14 shall remain in effect until superseded by a plan and
15 articles, bylaws and operating procedures submitted by the
16 board and approved by the commissioner.

17 Section 6. Board duties.

18 The board shall:

19 (1) Operate, supervise and administer the pool.

20 (2) Establish administrative and accounting procedures
21 for the operation of the pool.

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

25 (4) Select an administering insurer in accordance with
26 section 8.

27 (5) Require that all policy forms issued by the board
28 conform to standard forms developed by the board. The forms
29 shall be approved by the commissioner.

30 (6) Develop a program to publicize the existence of the

1 plan, the eligibility requirements of the plan, the
2 procedures for enrollment in the plan and shall maintain
3 public awareness of the plan.

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

9 (8) No later than June 1 of each year, make an annual
10 report to the Governor, the General Assembly and the
11 commissioner. The report shall summarize the activities of
12 the pool in the preceding calendar year, including
13 information regarding net written and earned premiums, plan
14 enrollment, administration expenses and paid and incurred
15 losses.

16 Section 7. Operation of pool.

17 (a) General rule.--The pool may exercise any of the
18 authority that an insurance company authorized to write health
19 insurance in this Commonwealth may exercise under the laws of
20 this Commonwealth.

21 (b) Specific powers.--As part of its authority, the pool
22 may:

23 (1) Provide health benefits coverage to persons who are
24 eligible for that coverage under this act.

25 (2) Enter into contracts that are necessary to carry out
26 this act, including, with the approval of the commissioner,
27 entering into contracts with similar pools in other states
28 for the joint performance of common administrative functions
29 or with other organizations for the performance of
30 administrative functions.

1 (3) Sue or be sued, including taking any legal actions
2 necessary or proper to recover or collect assessments due the
3 pool.

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

10 (5) Establish appropriate rates, copayments,
11 deductibles, rate schedules, rate adjustments, expense
12 allowance, agents' referral fees and claim reserve formulas
13 and perform any actuarial function appropriate to the
14 operation of the pool.

15 (6) Adopt policy forms, endorsements and riders and
16 applications for coverage.

17 (7) Issue insurance policies subject to this act and the
18 plan of operation.

19 (8) Appoint appropriate legal, actuarial and other
20 committees that are necessary to provide technical assistance
21 in operating the pool and performing any of the functions of
22 the pool.

23 (9) Employ and set the compensation of any persons
24 necessary to assist the pool in carrying out its
25 responsibilities and functions.

26 (10) Contract for stop-loss insurance for risks incurred
27 by the pool.

28 (11) Issue additional types of health insurance policies
29 to provide optional coverage which comply with applicable
30 provisions of Federal and State law, including Medicare

1 supplemental health insurance.

2 (12) Provide for and employ cost containment measures
3 and requirements, including, but not limited to, preadmission
4 screening, second surgical opinion and concurrent utilization
5 case management for the purpose of making the benefit plans
6 more cost effective.

7 (13) Design, utilize, contract or otherwise arrange for
8 delivery of cost-effective health care services, including
9 establishing or contracting with preferred provider
10 organizations and health maintenance organizations.

11 (14) Provide for reinsurance on either a facultative or
12 treaty basis, or both.

13 (15) Comply with the provisions of 62 Pa.C.S. Pt. I
14 (relating to Commonwealth Procurement Code) in the award of
15 any contract for goods or services.

16 (16) Develop and implement bylaws that prohibit a member
17 of the board from voting on the selection of an insurer as
18 the plan's administrating insurer or on a contract for goods
19 or services, where the board member has a conflict of
20 interest resulting from employment or membership on the
21 governing board of the insurer or the company that would
22 provide the goods or services under the contract. The bylaws
23 shall include a procedure for a board member to disclose
24 potential voting conflicts to the other board members.

25 Section 8. Selection of administering insurer.

26 (a) General rule.--The board shall select an insurer,
27 through a competitive bidding process, to administer the plan.
28 The board shall evaluate the bids submitted under this
29 subsection based on criteria established by the board, which
30 criteria shall include, but not be limited to, the following:

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

3 (2) The efficiency of the insurer's claims-paying
4 procedures.

5 (3) An estimate of total charges for administering the
6 plan.

7 (b) Term of contract.--

8 (1) The administering insurer must enter into a contract
9 with the board. The term of the contract shall be for a
10 period of three years.

11 (2) At least one year prior to the expiration of each
12 three-year period of service by an administering insurer, the
13 board shall invite all insurers, including the current
14 administering insurer, to submit bids to serve as the
15 administering insurer for the succeeding three-year period.

16 (3) The selection of the administering insurer for the
17 succeeding three-year period shall be made at least six
18 months prior to the end of the current three-year period.

19 (c) Duties of administering insurer.--The administering
20 insurer shall:

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

23 (2) Pay an agent's referral fee as established by the
24 board to each agent who refers an applicant to the plan, if
25 the applicant is accepted. The selling or marketing of plans
26 shall not be limited to the administering insurer or its
27 agents. The referral fees shall be paid by the administering
28 insurer from moneys received as premiums for the plan.

29 (3) Establish a premium billing procedure for collection
30 of premiums from persons insured under the plan.

1 (4) Perform all necessary functions to assure timely
2 payment of benefits to covered persons under the plan,
3 including, but not limited to, the following:

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

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

10 (iii) Notifying each claimant within 30 days after
11 receiving a properly completed and executed proof of
12 loss, whether the claim is accepted, rejected or
13 compromised.

14 (5) Submit regular reports to the board regarding the
15 operation of the plan. The frequency, content and form of the
16 reports shall be determined by the board.

17 (6) Following the close of each calendar year, determine
18 net premiums, reinsurance premiums less administrative
19 expenses allowance, the expense of administration pertaining
20 to the reinsurance operations of the pool and the incurred
21 losses for the year, and report this information to the board
22 and the commissioner.

23 (7) Pay claims expenses from the premium payments
24 received from or on behalf of covered persons under the plan.

25 Section 9. Payment of plan costs.

26 (a) General rule.--The board shall pay plan costs, first
27 from Federal funds, that are transferred to the fund under
28 subsection (b). The remainder of the plan costs, excluding
29 premium, deductible and copayment subsidy costs, shall be paid.

30 (b) Application for Federal funds.--The board shall make

1 application for any Federal grants or other sources under which
2 the plan may be eligible to receive moneys. To the extent
3 allowable, the board shall use any moneys received from a
4 Federal grant or other source to offset plan deficits before
5 drawing from any alternative funding sources.

6 (c) Surplus funds.--

7 (1) If grants, assessments and other receipts by the
8 pool exceed the actual losses and administrative expenses of
9 the plan, the excess shall be held at interest and used by
10 the board to offset future losses or to reduce premiums.

11 (2) As used in this subsection, the term "future losses"
12 include reserves for claims incurred but not reported.

13 Section 10. Direct insurance by pool.

14 The coverage provided by the plan shall be directly insured
15 by the pool and the policies administered through the
16 administering insurer.

17 Section 11. Plan benefits.

18 (a) General rule.--The plan shall offer in an annually
19 renewable policy the coverage specified in this section for each
20 eligible person. In approving any of the benefit plans to be
21 offered by the plan, the board shall establish such benefit
22 levels, deductibles, coinsurance factors, exclusions and
23 limitations as it may deem appropriate and that it believes to
24 be generally reflective of and commensurate with individual
25 market health insurance that is provided in the individual
26 health insurance market in this Commonwealth.

27 (b) High deductible health plan option.--Notwithstanding any
28 other provisions of this section, the plan shall provide every
29 eligible person the option of selecting a health plan option
30 from at least one high deductible health plan that would qualify

1 to be used in conjunction with a health savings account under
2 section 223 of the Internal Revenue Code of 1986 (Public Law 99-
3 514, 26 U.S.C. § 1 et seq.). In conjunction with such a high
4 deductible health plan, the plan shall provide for the
5 establishment and administration of health savings accounts on
6 behalf of eligible persons who chose to be covered by a high
7 deductible health plan under this section.

8 (c) Major medical expense coverage.--The plan shall offer
9 major medical expense coverage to every eligible person who is
10 not eligible for Medicare. Major medical expense coverage
11 offered under the plan shall pay an eligible person's covered
12 expenses.

13 (d) Covered expenses.--

14 (1) The usual customary charges or negotiable
15 reimbursement for the following services and articles, when
16 prescribed by a physician and medically necessary, shall be
17 covered expenses:

18 (i) Hospital services.

19 (ii) Professional services for the diagnosis or
20 treatment of injuries, illness or conditions, other than
21 dental, which are rendered by a physician or by others at
22 his direction.

23 (iii) Drugs requiring a physician's prescription.

24 (iv) Services of a licensed skilled nursing facility
25 for eligible individuals, ineligible for Medicare, for
26 not more than 100 calendar days during a policy year, if
27 the services and reimbursements are the type which would
28 qualify as reimbursable services under Medicare.

29 (v) Services of a home health agency, which services
30 are of a type that would qualify reimbursable services

1 under Medicare.

2 (vi) Use of radium or other radioactive materials.

3 (vii) Oxygen.

4 (viii) Anesthetics.

5 (ix) Prosthesis, other than dental prosthesis.

6 (x) Rental or purchase, as appropriate, of durable
7 medical equipment, other than eyeglasses and hearing
8 aids.

9 (xi) Diagnostic X-rays and laboratory tests.

10 (xii) Oral surgery for partially or completely
11 erupted, impacted teeth and oral surgery with respect to
12 the tissues of the mouth when not performed in connection
13 with the extraction or repair of teeth.

14 (xiii) Services of a physical therapist.

15 (xiv) Transportation provided by a licensed
16 ambulance service to the nearest facility qualified to
17 treat a condition.

18 (xv) Processing of blood, including, but not limited
19 to, collecting, testing, fractioning and distributing
20 blood.

21 (xvi) Services for the treatment of alcohol and drug
22 abuse, but the insured shall be required to make a 50%
23 copayment, and the payment of the plan shall not exceed
24 \$4,000.

25 (xvii) As an option, made available at an additional
26 premium, services provided by a duly licensed
27 chiropractor.

28 (e) Excluded expenses.--Covered expenses shall not include
29 the following:

30 (1) A charge for treatment for cosmetic purposes, other

1 than for repair or treatment of an injury or congenital
2 bodily defect to restore normal bodily functions.

3 (2) A charge for care which is primarily for custodial
4 or domiciliary purposes which does not qualify as an eligible
5 service under Medicaid.

6 (3) A charge for confinement in a private room, to the
7 extent that the charge is in excess of the charge by the
8 institution for its most common semiprivate room unless a
9 private room is prescribed as medically necessary by a
10 physician.

11 (4) Any part of a charge for services or articles
12 rendered or provided by a physician or other health care
13 personnel that exceeds the prevailing charge in the locality
14 where the service is provided or any charge for services or
15 articles not medically necessary.

16 (5) A charge for services or articles the provision of
17 which is not within the authorized scope of practice of the
18 institution or individual providing the services or articles.

19 (6) An expense incurred prior to the effective date of
20 the coverage under the plan for the person on whose behalf
21 the expense was incurred.

22 (7) A charge for routine physical examinations.

23 (8) A charge for the services of blood donors and any
24 fee for the failure to replace the first three pints of blood
25 provided to an eligible person annually.

26 (9) A charge for personal services or supplies provided
27 by a hospital or nursing home or any other nonmedical or
28 nonprescribed services or supplies.

29 (f) Annual deductible choices.--The board shall provide for
30 at least two choices of annual deductibles for major medical

1 expenses, plus the benefits payable under any other type of
2 insurance coverage or workers' compensation, provided that if
3 two individual members of a family satisfy the applicable
4 deductible, no other members of the family shall be required to
5 meet deductibles for the remainder of that calendar year.

6 (g) Schedule of premium rates to be determined.--

7 (1) The board shall annually determine the schedule of
8 premium rates, copayments and deductibles for each benefit
9 plan option offered by the pool.

10 (2) Rates and rate schedules may be adjusted for
11 appropriate risk factors, including age and variation in
12 claim costs, and the board may consider appropriate risk
13 factors in accordance with established actuarial and
14 underwriting practices. The adjustment in rates and rating
15 schedules attributed to the difference in age between the
16 oldest insured person and the youngest insured person shall
17 not exceed a 4-to-1 ratio.

18 (3) (i) The board shall determine the standard risk
19 rate by considering the premium rates charged by other
20 insurers offering health insurance coverage to
21 individuals. The standard risk rate shall be established
22 using reasonable actuarial techniques and shall reflect
23 anticipated experience and expenses for such coverage.

24 (ii) The initial pool rate may not be less than 150%
25 and may not exceed 200% of rates established as
26 applicable for individual standard rates.

27 (iii) Subsequent rates shall be established to
28 provide fully for the expected costs of claims, including
29 recovery of prior losses, expenses of operation,
30 investment income of claim reserves and any other cost

factors subject to the limitations described in this subsection.

(iv) In no event shall pool rates exceed 200% of rates applicable to individual standard risks.

(4) All rates and rate schedules shall be submitted to the commissioner for approval, and the pool may not use them unless the commissioner approves the rates and rate schedules. The commissioner in evaluating the rates and rate schedule of the pool shall consider the factors provided by this section.

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

Section 20. Effective date.

This act shall take effect in 60 days.