SB-161 S

FILED

2004 MAR 30 P 4:08

OFFICE WEST VIRGINIA
SECRETARY OF STATE

WEST VIRGINIA LEGISLATURE

Regular Session, 2004

ENROLLED

Committee Substitute for

SENATE BILL NO. 161

(By Senators Tomblin, Mr. President, and Sprouse, **)**
By Request of the Executive)

PASSED March 13, 2004

In Effect July 4 2004 ~~**Passage**~~

ENROLLED

COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 161

(BY SENATORS TOMBLIN, MR. PRESIDENT, AND SPROUSE,
BY REQUEST OF THE EXECUTIVE)

[Passed March 13, 2004; to take effect July 1, 2004.]

AN ACT to amend the code of West Virginia, 1931, as amended, by adding thereto a new article, designated §33-47-1, §33-47-2, §33-47-3, §33-47-4, §33-47-5, §33-47-6, §33-47-7, §33-47-8, §33-47-9, §33-47-10, §33-47-11 and §33-47-12, all relating to creating a West Virginia insurance plan; defining terms; creating a body corporate and politic to be known as the West Virginia health insurance plan; providing for its supervision and control by a board of directors to be appointed by the governor; providing the board of directors' administrative requirements; requiring a plan of operation to be approved by the insurance commissioner; requiring the plan to be operated so as to qualify as an acceptable alternative mechanism under the federal health insurance portability and accountability act and as an option to provide health insurance coverage for individuals eligible for the federal health care tax credit; describing procedural requirements

for the plan; describing powers of the plan; requiring the board to annually report to the governor summarizing preceding year activities; shielding the board and its employees from any liability resulting from obligations of the plan; authorizing the board of directors to promulgate rules to implement the act; defining eligibility for persons seeking coverage from the plan and when such coverage shall cease; making it an unfair trade practice to arrange for an employee to apply for coverage with the plan for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment; providing for the selection of a plan administrator; providing for funding for the plan; defining the benefits to be offered; providing that participation in the plan by an insurer is not the basis of any legal action against the participating insurer; providing that the plan is exempt from taxes; and providing an effective date.

Be it enacted by the Legislature of West Virginia:

That the code of West Virginia, 1931, as amended, be amended by adding thereto a new article, designated §33-47-1, §33-47-2, §33-47-3, §33-47-4, §33-47-5, §33-47-6, §33-47-7, §33-47-8, §33-47-9, §33-47-10, §33-47-11 and §33-47-12, all to read as follows:

ARTICLE 47. MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT.

§33-47-1. Definitions.

For purposes of this article:

(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 federal Employee Retirement Income Security Act of 1974.

(c) "Commissioner" means the insurance commissioner of this state.

(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, U. S. C.;

(F) A medical care program of the federal 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, U. S. C.;

(I) A public health plan as defined in federal regulations; or

(J) A health benefit plan under Section 5(e) of the federal 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 article if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(e) "Department" means the insurance commissioner of West Virginia.

(f) "Dependent" means a resident spouse or resident unmarried child under the age of nineteen years, a child who is a student under the age of twenty-three 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 article, the aggregate of the periods of creditable coverage as defined in subsection (d) of this section is eighteen 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 said 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 the continuation coverage under this provision or program, if the individual elected the continuation coverage described in subdivision (5) of this subsection.

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

(i) "Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in

subsection (m) of this section 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 healthcare 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 PL 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 PL 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, U. S. C. (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" means an organization licensed in this state pursuant to the provisions of article twenty-five-a of this chapter.

(l) "Insurer" means any entity that provides health insurance coverage in this state. For the purposes of this article, insurer includes an insurance company, a prepaid limited health service organization as operating under a certificate of authority pursuant to article twenty-five-d of this chapter, 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.

(m) "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 subdivision (1) of this subsection; and

(3) Insurance covering medical referred to in subdivisions (1) and (2) of this subsection.

(n) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U. S. C. 1395, *et seq.*, as amended.

(o) "Participating insurer" means any insurer providing health insurance coverage to residents of this state.

(p) "Plan" means the West Virginia health insurance plan as created in section two of this article.

(q) "Plan of operation" means the articles, bylaws and operating rules and procedures adopted by the board pursuant to section two of this article.

(r) "Resident" means an individual who has been legally domiciled in this state for a period of at least thirty days, except that for a federally defined eligible individual, there shall not be a thirty-day requirement. "Resident" also means an individual who is legally domiciled in this state on the date of application to the plan and is eligible

for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986.

(s) "Significant break in coverage" means a period of sixty-three 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.

Terms within this article with meaning ascribed by federal law shall have the meaning as in effect in federal law the thirty-first day of December, two thousand three.

§33-47-2. Operation of the plan.

(a) There is hereby created within the West Virginia department of tax and revenue a body corporate and politic to be known as the West Virginia health insurance plan which shall be deemed to be an instrumentality of the state and a public corporation. The West Virginia health insurance plan shall have perpetual existence and any change in the name or composition of the plan shall in no way impair the obligations of any contracts existing under this chapter.

(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 six members appointed by the governor. At least two 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 board members shall be representatives of insurers. At least one board member shall be a hospital administrator. A majority of the board shall be composed of individuals who are not representatives of insurers or health care providers.

(c) The initial board members shall be appointed as follows: One third of the members to serve a term of two years; one third of the members to serve a term of four years; and one third of the members to serve a term of six years. Subsequent board members shall serve for a term of three 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. Board members may be removed by the governor 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 article must be made available. If the board fails to submit a suitable plan of operation within one hundred eighty 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: *Provided*, That the plan shall be operated so as to qualify as an acceptable alternative mechanism under the federal Health Insurance Portability and Accountability Act and

as an option to provide health insurance coverage for individuals eligible for the federal health care tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002 (Section 35 of the Internal Revenue Code of 1986);

(2) Establish procedures for selecting an administrator in accordance with section six of this article;

(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, moneys 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 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 article.

(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 article, 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 article;

(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;

(9) Employ and fix the compensation of employees;

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance procedures 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;

(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 article 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) Study and recommend to the Legislature in January of two thousand six, alternative funding mechanisms for the continuation of the health plan for uninsurable individuals.

(k) 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 article, 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.

§33-47-3. Establishment of rules.

The board may promulgate rules, in accordance with article three, chapter twenty-nine-a of this code, as may be necessary to implement the provisions of this article.

§33-47-4. Eligibility.

(a) (1) Any 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.

(C) That the individual is legally domiciled in this state and is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986.

(2) Any 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 subdivision (1) of this subsection 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 subdivision (1), subsection (a) of this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to prove the evidence specified in said subdivision . 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 the state medicaid law;

(3) The person has previously terminated plan coverage unless twelve months have lapsed since such terminations, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual;

(4) The plan has paid out one million dollars in benefits on behalf of the person;

(5) The person is an inmate or resident of a public institution, except that this subdivision 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 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) of this section, 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.

§33-47-5. Unfair referral to plan.

It shall constitute an unfair trade practice for the purposes of article eleven of this chapter for an insurer, insurance agent or insurance broker 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.

§33-47-6. 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 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 commission on a form prescribed by the commissioner.

(f) Notwithstanding any other provision in this section to the contrary, the board may elect to designate the public employees insurance agency as the plan administrator. If so designated, the public employees insurance agency shall provide the services set forth in subsection (c) of this section and shall be subject to the reporting requirements of subsections (d) and (e) of this section. The plan shall, if the public employees insurance agency is designated by the board as the plan administrator, reimburse health care providers at the same health care reimbursement rates then in effect for the West Virginia public employees insurance agency.

§33-47-7. Funding of the plan.

(a) *Premiums.* –

(1) The plan shall establish premium rates for plan coverage as provided in subdivision (2) of this subsection. 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 one hundred twenty-five percent of rates established as applicable for individual standard risks. Subject to the limits provided in this subdivision, 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 one hundred fifty percent of rates applicable to individual standard risks.

(b) *Sources of additional revenue.* –

(1) The plan may be additionally funded by an assessment on hospitals. Notwithstanding the provisions of subsection (c), section eight, article twenty-nine-b, chapter sixteen of this code and not to be construed as in conflict therewith, the health care authority is authorized to increase the assessment obligation of hospitals. The increase shall not exceed a maximum of twenty-five percent above the one tenth of one percent specified in this section. The entire assessment, including the in-

crease, shall be collected as specified in subsection (c), section eight, article twenty-nine-b, chapter sixteen of this code. Upon receipt of the assessment fees, the health care authority shall transfer all proceeds generated from the new fee collected to a special revenue account established in the state treasury by the commissioner and designated the "West Virginia Health Insurance Plan Account" for the sole purpose of providing additional funding for the plan.

§33-47-8. Benefits.

(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.

(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 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.

(2) Subject to subdivision (1) of this subsection, 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 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 subdivision.

§33-47-9. 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 article shall be the basis of any legal action, criminal or civil liability or penalty against the plan or any participating insurer.

§33-47-10. Taxation.

The plan established pursuant to this article shall be exempt from the premium taxes assessed under sections fourteen and fourteen-a, article three, chapter thirty-three.

§33-47-11. Continuation of model health plan for uninsurable individuals.

The model health plan for uninsurable individuals shall continue to exist, pursuant to the provisions of article ten, chapter four of this code, until the first day of July, two thousand seven, unless sooner terminated, continued or reestablished pursuant to the provisions of that article.

§33-47-12. Effective date.

The provisions of this article shall become effective on the first day of July, two thousand four.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originated in the Senate.

To take effect July 1, 2004.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker House of Delegates

The within ..... this the .....

Day of ....., 2004.

Governor

PRESENTED TO THE
GOVERNOR
DATE 3/26/04
TIME 3:10 pm