ALABAMA DEPARTMENT OF INSURANCE
ADMINISTRATIVE CODE

CHAPTER 482-1-115
ALABAMA HEALTH INSURANCE PLAN

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482-1-115-.01 Authority And Short Title.

This chapter is adopted pursuant to Sections 27-2-17 and 27-52-1, et seq., Code of Ala. 1975. This chapter shall be known and may be cited as the Alabama Health Insurance Plan chapter.
Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
History: New Rule: July 23, 1997; effective August 30, 1997.
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482-1-115-.02 Purpose.

The purpose and intent of this chapter is to implement the Alabama Health Insurance Plan as created in the Act.
Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
History: New Rule: July 23, 1997; effective August 30, 1997.
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482-1-115-.03 Definitions.

The following definitions shall apply for purposes of this chapter:

(a) BENEFIT PLAN or PLANS. The major medical indemnity plan or plans and the managed care plan or plans offered under the Plan.

(b) BOARD. The Board of Directors of the Plan. The Board shall be the Plan Administrator.

(c) CLAIMS ADMINISTRATOR. The entity or entities chosen by the Board in accordance with Rule 482-1-115-.07 to administer the Plan and to process benefit claims of members of the Plan.

(d) COMMISSIONER. The Alabama Commissioner of Insurance.

(e) CONTINUOUS COVERAGE. Coverage having no breaks of 63 full days or more.

(f) DEPARTMENT. The Alabama Department of Insurance.

(g) DEPENDENT. A child under the age of 26, or a child of any age who is disabled and dependent upon the parent.

(h) HEALTH INSURANCE. 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, that meets the definition of creditable health insurance coverage as described by 45 C.F.R. 146.113. The term does not include, accident, dental-only, vision-only, fixed indemnity, limited benefit, disability income, long-term care, Medicare supplement, or credit insurance, nor coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(i) HEALTH MAINTENANCE ORGANIZATION. As defined in Section 27-21A-1, Code of Ala. 1975.

(j) HOSPITAL. As defined in Section 22-21-20, Code of Ala. 1975.

(k) INSURER. Any entity that provides health insurance in this state, including an insurance company licensed pursuant to Section 27-3-1, et seq.; a health care service plan licensed pursuant Section 10-4-100, et seq.; a fraternal benefit society licensed pursuant to Section 27-34-1, et seq.; a health maintenance organization licensed pursuant to Section 27-21A-1, et seq.; and any other entity providing a plan of health insurance or health benefits whether or not subject to state insurance regulation. In the case of a self-funded health benefit plan operating through a third party administrator, the third party administrator shall be the insurer for the purposes of this chapter.

(l) MEDICAID. Coverage under Title XIX of the Social Security Act, 42 USC 1396, et seq.

(m) MEDICARE. Coverage under Title XVIII of the Social Security Act, 42 USC 1395, et seq.

(n) OPERATIONS ADMINISTRATOR. The entity or entities chosen by the Board in accordance with Rule 482-1-115-.06 to conduct the daily activities of the Plan.

(o) PARTICIPATING INSURER. Any insurer providing health insurance to residents of this state.

(p) PHYSICIAN. As defined in Section 25-5-310, Code of Ala. 1975.

(q) PLAN. The Alabama Health Insurance Plan as created in Section 27-52-1, Code of Ala. 1975.

(r) PLAN ADMINISTRATOR. The Alabama Health Insurance Board.

(s) PLAN OF OPERATION. The operating rules and procedures adopted by the Board pursuant to Section 27-52-2, Code of Ala. 1975.

(t) PRE-EXISTING MEDICAL CONDITION. Any condition, no matter how caused, for which an individual received medical advice, diagnosis, care, or for which treatment was recommended or received during the six months before the effective date coverage began.

(u) PRIOR CONTINUOUS COVERAGE. 18 months of continuous coverage of health insurance.

(v) PROVIDER. A physician or other individual licensed to provide health care services available under health insurance in this state and operating within the scope of that license.

(w) RESIDENT. An individual who is legally domiciled in this state. For the purposes of this chapter, no particular period

of time is required to establish legal domicile, however a person may have only one legal domicile at a time.

(x) THE ACT. Chapter 52 of Title 27, beginning with Section 27-52-1, Code of Ala. 1975.

Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
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482-1-115-.04 Board Of Directors.

(1) The Plan shall operate subject to the supervision and control of a Board of Directors. The Board, which shall be the Plan Administrator, 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 chairman, and eight members appointed by the Commissioner. At least two (2) Board members shall be individuals not representing insurers or health care providers. At least two (2) Board members shall be representatives of insurers.

(2) The initial Board members shall be appointed as follows: two members to serve a term of one (1) year; three members to serve a term of two (2) years; and three members to serve a term of three (3) 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.

(3) Vacancies in the Board shall be filled by the Commissioner. Board members may be removed by the Commissioner for cause.

(4) Board members shall not be compensated in their capacity as Board members but may be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

(5) 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 Plan 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 rule. 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.

(6) The plan of operation shall include, but not be limited to, the following:

(a) Procedures for Board meetings.

(b) Procedures for operation of the Plan.

(c) Procedures for selecting an Operations Administrator and a Claims Administrator or Administrators.

(d) Procedures to create a fund, under management of the Board, for administrative expenses.

(e) Procedures for premium and assessment billings.

(f) Procedures for the managing, accounting and auditing of assets, monies and claims of the Plan.

(g) Procedures to publicize the existence of the Plan, the eligibility requirements, and procedures for enrollment; and to maintain public awareness of the Plan.

(h) Procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Board.

(i) Procedures for other matters as may be necessary and proper for the execution of the Board's powers, duties and obligations under this chapter.

(7) In accordance with Section 27-52-2, 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 do all of the following:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposed of this chapter, 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.

(b) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the Plan.

(c) Take such legal action as necessary to do any of the following:

1. To avoid the payment of improper claims against the Plan or the coverage provided by or through the Plan.

2. To recover any amounts erroneously or improperly paid by the Plan.

3. To recover any amounts paid by the Plan as a result of mistake of fact or law.

4. To recover other amounts due the Plan.

(d) Establish, and modify from time to time as appropriate, premiums, premium schedules, premium adjustments, expense allowances, claim reserve formulas and any other actuarial function appropriate to the operation of the Plan. Premiums and premium 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.

(e) Issue policies of insurance in accordance with the requirements of the Act and this chapter.

(f) 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 plan.

(g) 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.

(h) Establish rules, conditions and procedures for participating insurers desiring to issue plan coverages in their own name.

(i) Employ and fix the compensation of employees.

(j) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(k) Provide for reinsurance of risks incurred by the Plan.

(l) Issue additional types of health insurance policies to provide optional coverages.

(m) 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.

(n) 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.

(o) Adopt bylaws, policies and procedures as may be necessary or convenient for implementation of the Act and the operation of the Plan.

(8) The Board shall make an annual report to the Commissioner. 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.

(9) 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 the Plan, 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.
Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
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482-1-115-.05 Eligibility.

(1) Any individual person, who is and continues to be a resident and who has prior continuous coverage shall be eligible for Plan coverage if evidence is provided of all of the following:

(a) That prior coverage was not terminated because of fraud or nonpayment of premium by the individual.

(b) That if the person was offered the option of continuation coverage under federal or state law, the person has both elected and exhausted the continuation coverage.

(c) That the person's most recent prior continuous coverage was under a "group health plan", a "government plan" or a "church plan," (or health insurance offered in connection with any of these plans) as these plans are defined by federal law or regulation.

(1) Each resident dependent of an individual person who is eligible for Plan coverage shall be eligible for Plan coverage.

(2) An individual person shall not be eligible for coverage under the Plan in any of the following instances:

(a) The person is eligible for group coverage under other health insurance.

(b) The person is determined to be eligible for health insurance under Medicaid.

(c) The person is determined to be eligible for health insurance under Medicare.

(d) The person is enrolled in any other health insurance plan.

(4) Coverage shall cease upon any of the following events:

(a) On the date a person requests coverage to end.

(b) Upon the death of the covered person.

(c) On the date state law requires cancellation of the policy.

(d) Nonpayment of the required premiums.

(e) On the date a person ceases to be a resident.

(f) On the last day of the month in which a covered person is no longer eligible for the Plan.

Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
History: **New Rule:** July 23, 1997; effective August 30, 1997.
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482-1-115-.06 Operations Administrator.

(1) The Board shall select an Operations Administrator to conduct the daily operations of the Board. In so doing, the Board may select an agency of the State of Alabama as Operations Administrator or may utilize a competitive bidding process for private entities. If a competitive bidding process is utilized, the Board shall evaluate bids submitted on the basis of criteria which shall include, but not be limited to, the following:

(a) The Operations Administrator's proven ability to conduct the daily activities of a health insurance plan.

(b) The expertise and efficiency of the Operations Administrator's staff.

(c) The Operations Administrator's estimate of total charges to conduct the daily activities of the Plan.

(d) The Operations Administrator's ability to apply effective cost containment programs and procedures and to administer the Plan in a cost efficient manner.

(e) The financial condition and stability of the Operations Administrator.

(2) The Operations Administrator shall serve for a period specified in the contract between the Operations Administrator and the Board, subject to removal for cause and subject to any terms, conditions and limitations of the contract.

(3) The Operations 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 Operations Administrator.
Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
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482-1-115-.07 Claims Administrator.

(1) The Board shall select a Claims Administrator or Administrators through a competitive bidding process to process claims of members of the benefit plan or plans and other

administrative duties as determined by the Board. The Board shall evaluate bids submitted based on criteria established by the Board which shall include all of the following:

(a) The Claims Administrator's proven ability to handle health insurance coverage for individuals.

(b) The efficiency and timeliness of the Claims Administrator's claim processing procedures.

(c) An estimate of total charges for the services to be provided.

(d) The Claims Administrator's ability to apply effective cost containment programs and procedures and to administer the claims of the benefit plan or plans in a cost efficient manner.

(e) The financial condition and stability of the Claims Administrator.

(2) The Claims Administrator or Administrators shall serve for a period specified in the contract between the Claims Administrator or Administrators and the Board, subject to removal for cause and subject to any terms, conditions and limitations of the contract.

(3) The Claims Administrator or Administrators shall perform such functions relating to the benefits plan or plans as may be assigned, including, but not limited to, the following:

(a) Provider network negotiations.

(b) Payment of claims.

(c) Customer service.

(4) The Claims Administrator or Administrators shall submit regular reports to the Board regarding the functions performed pursuant to the contract. The frequency, content and form of the report shall be specified in the contract between the Board and the Claims Administrator or Administrators.

Author: Elizabeth Bookwalter, Associate Counsel

Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.

History: New Rule: July 23, 1997; effective August 30, 1997. **Revised:** November 13, 2002; effective December 29, 2002. Filed with LRS December 19, 2002. Rule is not subject to the Alabama Administrative Procedure Act.

482-1-115-.08 Funding Of The Plan.

(1) Premiums.

(a) The Board shall establish premium rates for the Plan as provided in Subparagraph (b). 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.

(b) The Board, 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 the Plan shall not be less than 125 percent of rates established as applicable for individual standard risks. Subject to the limits provided in this subparagraph subsequent rates shall consider 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.

(2) Assessment.

(a) The Board shall have the authority to assess participating insurers in accordance with the provisions of this rule, 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.

(b) Following the close of each fiscal year, the Board 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.

(c) Each participating insurer's assessment shall be determined by multiplying the total assessment of all participating insurers as determined in Subparagraph (b) by a fraction, the numerator of which equals that participating insurer's premium and subscriber contract charges for health insurance 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. For purposes of this assessment calculation, health insurance premiums shall exclude Medicare supplement health insurance premiums.

(d) 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 Paragraph (2), "future losses" include reserves for incurred but not reported claims.

(e) 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 Commissioner.

(f) 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 Paragraph (2). The participating insurer receiving such abatement or deferment shall remain liable to the Plan for the deficiency for four (4) years.

(g) Each participating insurer may offset any applicable premium taxes otherwise payable in respect of health insurance premiums paid to them by the amount of any assessment applied to them pursuant to this Paragraph (2). The offset must be against premium taxes incurred in respect of premiums paid in the same calendar year as the assessment. If the participating insurer is not subject to premium taxes on health insurance premiums it receives, the assessment made under this Paragraph (2) may be reduced by the premium taxes which would otherwise have been payable had it been so subject.

Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
History: New Rule: July 23, 1997; effective August 30, 1997.
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482-1-115-.09 Benefits.

(1) The Plan shall make available health care coverage consistent with the requirements of the Act and the federal Health Insurance Portability and Accountability Act of 1996. In particular, the Plan will make available two or more policy forms, at least one of which provides coverage comparable to comprehensive major medical coverage offered in the individual health insurance market in the state of Alabama.

(2) The policy forms to be issued by the Plan, along with the schedule of benefits, exclusions and other limitations, shall be established by the Board, subject to the approval of the Commissioner. The Plan benefits shall be inclusive of the provisions of Sections 27-1-10 and 27-19-39, Code of Ala. 1975.

(3) Coverage under all policy forms will be available to all individuals eligible for the Plan, as defined in Rule 482-1-115-.05, on a "guaranteed issue" basis, with no exclusions of coverage for pre-existing medical conditions, and on a "guaranteed renewable" basis.
Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
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482-1-115-.10 Consultation With State Board Of Health.

All bylaws, policies, guidelines or directives issued by the Board related to the delivery of medical services, including but not limited to those items specified in Subparagraphs (h), (m), (n), and (o) of Paragraph (7) of Rule 482-1-115-.04 and in Rule 482-1-115-.09, shall be promulgated with the concurrence of the State Board of Health.
Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
History: New Rule: July 23, 1997; effective August 30, 1997.
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482-1-115-.11 Separability.

If any provision of this chapter or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the chapter and the application of its provisions to other persons or circumstances shall not be affected thereby.
Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
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482-1-115-.12 Effective Date.

The provisions of this chapter shall become effective upon its approval by the Commissioner of Insurance, with the concurrence of the State Board of Health, and upon its having been on file as a public document in the office of the Secretary of State for ten days.
Author: Elizabeth Bookwalter, Associate Counsel
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-52-1, et seq.
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