ALABAMA DEPARTMENT OF INSURANCE
ADMINISTRATIVE CODE

CHAPTER 482-1-083
GOVERNING RULES OF THE ALABAMA HEALTH MAINTENANCE ORGANIZATION GUARANTY ASSOCIATION

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482-1-083-.01 Authority. This chapter is adopted and promulgated by the Commissioner of Insurance pursuant to the provisions of Sections 27-2-17, 27-21A-19, Code of Ala. 1975 which govern the promulgation of insurance regulations by the Commissioner, and 27-21A-12(i), Code of Ala. 1975 which provides that the Commissioner may promulgate regulations for the implementation of a Health Maintenance Organization Guaranty Association modeled on the Alabama Life and Disability Guaranty Association as established in Chapter 44 of Title 27, Code of Ala. 1975.
Author: Commissioner of Insurance
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: New Rule: Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.02 Definitions. As used in this chapter:

(a) ASSOCIATION. The Health Maintenance Organization Guaranty Association created under Section 27-21A-12(i), Code of Ala. 1975.

(b) COMMISSIONER. The Commissioner of Insurance of this state.

(c) CONTRACTUAL OBLIGATION. Any covered health care services owed to an enrollee residing in Alabama and arising from an evidence of coverage issued in the State of Alabama to which this chapter applies, issued or assumed by a member HMO which becomes an insolvent HMO after the effective date of this chapter. A contractual obligation shall not include an amount in excess of $300,000 in the aggregate under one or more evidence(s) of coverage on any one enrollee; nor shall a contractual obligation include any debt or amounts owed by the insolvent HMO to any provider of health care services, or other goods and services except to the extent that any enrollee of the insolvent HMO may be held legally accountable to such provider for the reasonable amount of such debt. The Association shall be not liable for any amount claimed by owners or officers of the insolvent HMO. An amount owed by the insolvent HMO to a provider of health care services whose agreement with the HMO included a “hold-harmless” provision that sought to prevent such provider from looking to the enrollee for payment shall not be a contractual obligation for purposes of this chapter but may be considered a claim against the estate.

(d) COVERED HEALTH CARE SERVICES. Those services provided to the enrollee by the evidence of coverage, including any conditions or limitations on those services, by the insolvent HMO.

(e) ENROLLEE. Any subscriber or covered dependent of an individual who is enrolled in a member health maintenance organization.

(f) EVIDENCE OF COVERAGE. Any contract or certificate of coverage issued to a group or individual, as defined by Section 27-21A-1(5), Code of Ala. 1975, which is required by Section 27-21A-7 and which is within the scope of this chapter and is in force and issued by a member HMO which becomes insolvent after the effective date of this chapter.

(g) HOLD HARMLESS AGREEMENT. The requirement specified in Section 27-21A-3(b)(4) that all contracts for basic health care services contain a provision that providers shall hold the enrollee harmless for the payment of the cost of health care services in any event including, but not limited to, nonpayment of the health maintenance organization, or the health maintenance organizations insolvency.

(h) IMPAIRED HEALTH MAINTENANCE ORGANIZATION. A member health maintenance organization which, after the effective date of this chapter, is not an insolvent health maintenance organization, and (a) is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations and (b) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(i) INSOLVENCY INSURANCE PROTECTION. Those provisions in reinsurance contracts which provide that after the HMO is found to be insolvent the enrollees will have their coverages continued for at least the period of time for which their premiums have been paid, that the plans benefits will be continued for enrollees who are confined in an acute care hospital or skilled nursing facility until their discharge, and that the reinsurer will make available to all enrollees for a period of thirty-one (31) days after the date of insolvency without evidence of insurability replacement health conversion insurance coverage of the same benefit schedule and rates as it is then offering to other prospective insureds within Alabama, as outlined in Chapter 482-1-080. Insolvency insurance protection also includes any agreement between the HMO and an Alabama licensed insurer or nonprofit health service plan under which the insurer or nonprofit health service plan agrees to issue to enrollees in the HMO a plan of hospital, medical and surgical insurance at standard conversion premium rates without any underwriting or other requirement, other than an application and payment of the first monthly premium by the enrollee, in the event the HMO is unable to continue in operation, as required by Chapter 482-1-079.

(j) INSOLVENT HEALTH MAINTENANCE ORGANIZATION. A member HMO which, after the effective date of this Plan, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(k) MEMBER HEALTH MAINTENANCE ORGANIZATION (HMO). Any health maintenance organization authorized by the Commissioner to transact the business of a health maintenance

organization in this state to which Section 27-21A-1 et seq., Code of Ala. 1975 applies.

(l) Other terms expressed in this chapter shall have the meanings as defined in Sections 27-21A-1 et seq., Code of Ala. 1975.

Author: Commissioner of Insurance
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: **New Rule:** Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.03 Powers And Duties Of The Association. The Association, acting by and through its Board of Directors, shall have the following powers and duties.

(a) Insolvency: If a member HMO becomes an insolvent HMO, as that term is herein defined, the Association shall, subject to any reasonable conditions imposed by the Association and approved by the Commissioner, either:

1.(i) guarantee, assume, or reinsure, or cause to be guaranteed, assumed or reinsured, any or all of the evidences of coverage of such insolvent HMO; or

(ii) assure payment of the contractual obligations of the insolvent HMO; and

(iii) provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge such duties; or

2. Provide benefits as follows:

(i) assure payment of covered health care services (except for terms of conversion and renewability) that would have been payable under the evidences of coverage of the insolvent HMO, for contractual obligations incurred

(I) with respect to group contracts, not later than the earlier of the next renewal date under such contracts or 45 days, but in no event less than 30 days for which premium has

been paid, from the date on which the member HMO is declared insolvent and ordered liquidated;

(II) with respect to individual contracts, not later than the earlier of the next renewal date or 90 days, but in no event less that 30 days for which premiums have been paid, from the date on which the member HMO is declared insolvent and ordered liquidated;

(III) with respect to an enrollee who is confined in an acute care hospital or skilled nursing facility, in the event there is no other coverage or reinsurance available, the Association will continue to provide the covered health care services until the enrollee is discharged from such facility to extent that this was a contractual obligation of the HMO before insolvency.

(ii) make diligent efforts to insure that the liquidator/receiver provides all known enrollees 30 days notice of the termination of benefits provided; and

(iii) make available to each known enrollee substitute coverage either through a member HMO or through reinsurance or conventional insurance, without requiring evidence of insurability, and without any waiting period or exclusion that would not have applied under the cancelled evidence of coverage. If such substitute coverage is made available through a member HMO, it must comply with the State Public Health Department Rules and Regulations concerning health care services. If the enrollee declines the substitute coverage, then the Association’s obligation to that enrollee ceases as to any obligation incurred after the refusal of said substitute coverage or the deadline set for accepting such coverage.

(b) Impairment: If a member HMO becomes an impaired HMO, as that term is herein defined, the Association’s powers, duties and/or responsibilities may include, but are limited to, the following:

to function as an advisory board to the Commissioner and/or the supervising court with regard to the rehabilitation of the impaired HMO; and/or

to assist the Commissioner and/or supervising court in reviewing, revising and negotiating with providers of health care services for enrollees of the impaired HMO; and/or

to function as a review board at the request of the Commissioner and/or supervising court in determining the appropriateness and/or effectiveness of loans, notes, guarantees, pledges or any other means entered to assure payment of the contractual obligations of the impaired HMO with regard to such HMOs rehabilitations; and/or

(iv) to assist the Commissioner and/or supervising court in determining whether to seek a buyer for the impaired HMO, and further assist in soliciting potential buyers;

(c) The Association's obligations with respect to coverage under any evidence of coverage of the impaired or insolvent HMO shall cease on the date such evidence of coverage is replaced by any similar coverage secured by the enrollee, the contract holder, the Association or the Receiver or Liquidator. If the enrollee declines the substitute coverage, then the Association's obligation to that enrollee ceases as to any obligation incurred after the refusal of said substitute coverage or the deadline set for accepting said coverage.

(d) The obligation of the Association for any covered health care services does not include payment to any affiliated health care provider for services covered by a hold-harmless agreement and does not preempt coverage provided through insolvency insurance provided as part of or an endorsement to a reinsurance agreement or otherwise. In the event a provider of insolvency reinsurance attempts to avoid its obligation to pay claims, the Liquidator will notify the Association within ninety (90) days of the insolvency or earlier, if at all possible. The Association will work with the Liquidator to insure payment of uncovered expenses on behalf of the enrollee, and if alternative means of payment have not been made within one hundred-twenty (120) days of the insolvency, the Association will proceed to process and pay claims for covered health care services. If such payments are made, the Association will have the right to reimbursement on any proceeds ultimately recovered from the reinsurer under the insolvency insurance coverage.

(e) The Association may render assistance and advice to the Commissioner, upon his request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent HMO.

(f) The Association shall have standing to appear before any court with jurisdiction over an impaired or insolvent

HMO concerning which the Association is or may become obligated under the Act. Such standing shall extend to all matters germane to the powers and duties of the Association, including, but not limited to, submitting proposals for reinsuring or guaranteeing the covered contractual obligations of the impaired or insolvent HMO and the determination of the covered contractual obligations.

(g) The contractual obligations of the insolvent HMO for which the Association becomes or may become liable shall be no greater than the contractual obligations of the insolvent HMO would have been in the absence of an insolvency. The aggregate liability of the Association shall not exceed $300,000 under one or more covered evidence(s) of coverage with respect to any enrollee.

(h) In addition to the powers and duties enumerated elsewhere, the Board of Directors of the Association shall have the following powers and duties:

(I) The Board may:

I. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of the Act and this chapter.

II. Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments:

III. Borrow money to effect the purposes of the Act and this Plan.

IV. Employ or retain such persons as are necessary to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under the Act or this chapter.

V. Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the Association;

VI. Take any legal action as may be necessary to avoid payment of improper claims or contractual obligations;

VII. Exercise, for the purpose of the Act and this chapter, and to the extent approved by the Commissioner, the

powers of a health maintenance organization, but in no case may the Association issue evidence(s) of coverage other than those issued to perform the contractual obligations of the impaired or insolvent HMO.

(II) It shall be the duty of the Board of Directors, upon two-thirds vote of the full Board, to notify the Commissioner of any information indicating any member HMO may be an impaired or insolvent HMO.

(III) The Board of Directors may, upon two-thirds vote of the full Board, request that the Commissioner order an examination of any member HMO which the Board in good faith believes may be an impaired or insolvent HMO. The Commissioner shall begin such examination as soon as practicable. The examination may be conducted as a National Association of Insurance Commissioner's examination or may be conducted by such person as the Commissioner designates. The Commissioner shall notify the Board of Directors when the examination is completed. The request for an examination shall be kept on file by the Commissioner but the report shall not be available to the Board prior to the release of the examination report to the public. The Association shall pay the reasonable cost for any examination made at the request of its Board of Directors.

(IV) The Board of Directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of HMO insolvencies.

(V) The Board of Directors may, at the conclusion of any HMO insolvency in which the Association was obligated to pay covered claims, prepare a report to the Commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The Board may cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular HMO, and may adopt by reference any report prepared by such other associations.

Author: Commissioner of Insurance

Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).

History: New Rule: Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.04 Assessments.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the Board of Directors shall assess the member HMOs at such time and for such amounts as the Board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to member HMOs and shall accrue interest at six percent per annum on and after the due date. The Board in its discretion may provide for installment payments of an assessment in a manner deemed appropriate to meet the needs of the Association.

(2) There shall be two classes of assessments, as follows:

(a) Class A assessments shall be made for the purpose of meeting administrative costs, costs of examinations of HMOs requested by the Board, and other general expenses of the Association not related to a particular insolvent HMO.

(b) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under Section 27-21A-12(i), the Plan, and any other Insurance Departmental Regulations or Public Health Departmental Regulations with regard to an insolvent HMO.

(c) The amount of any Class A Assessment shall be determined by the Board and may be made on a non-pro rata basis. Such assessment shall not exceed $2,000 per member HMO per calendar year. This assessment for administrative expenses shall not be deductible from premium taxes payable by member HMOs in excess of the amount deductible by life insurers.

(d) Class B assessments against member HMOs shall be in the proportion that the premiums received on all business conducted in this state by each assessed member HMO for the calendar year preceding the assessment bears to such premiums received on all business conducted in this state by all assessed member HMOs for said year.

(e) Assessments for funds to meet the requirements of the Association with respect to an insolvent member HMO shall be made when necessary to implement the purposes of the Association. Computation of assessments shall be made with a reasonable degree of accuracy, based upon premium information provided to the Association by the Commissioner.

(f) The Association may abate or defer, in whole or in part, the assessment of a member HMO if, in the opinion of the Board, payment of the assessment would endanger the ability of the member HMO to fulfill its contractual obligations to enrollees. In the event an assessment against a member HMO is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member HMOs in a manner consistent with the basis for assessments set forth in this rule.

(g) The total of all assessments upon a member HMO shall not in any one calendar year exceed one percent of such HMO's premiums received on covered contracts in this state during the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the Association, does not provide in any one year an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by the Plan.

(h) The Board may refund to member HMOs, in proportion to the contribution of each HMO, the amount by which the assets of the account exceed the amount the Board finds is necessary to carry out during the coming year the obligations of the Association, including assets accruing from net realized gains and income from investments. A reasonable amount may be maintained in any account to provide funds for the continued expenses of the Association and for future losses.

(i) The Association shall issue to each HMO paying an assessment, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. A certificate of contribution may be shown by the HMO in its financial statement as an admitted asset and for such amount not to exceed ten percent of admitted assets for a period of five years after the contribution is made, if any, or until the HMO has fully deducted its contribution from its premium tax liability in such form or in such amount as the Commissioner may approve.

(j)(1) A member HMO may offset against its premium tax liability (or liabilities) to this states an assessment described in this rule to the extent of twenty (20) percent of the amount of such assessment for each of the five calendar years following the year in which such assessment is paid.

(2) Any sums which are acquired by refund, pursuant to this rule, from the Association by member HMOs, and which theretofore have been offset against premium taxes as provided in Paragraph (1) above, shall be paid by such HMOs to this state in such manner as the Commissioner may require. The Association shall notify the Commissioner that such refunds have been made.
Author: Commissioner of Insurance
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: New Rule: Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.05 Immunity Under Regulation. There shall be no liability on the part of and no cause of action of any nature shall arise against any member HMO or its agents or employees, the association or its agents or employees, members of the board of directors, or the representatives of the Commissioner for any action taken by them in the performance of their powers and duties granted to them under Section 27-21A-12(i) Code and this chapter.
Author: Commissioner of Insurance
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: New Rule: Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.06 Stay Of Proceedings; Reopening Default Judgments. With the concurrence of and the order of the proper court, all proceedings in which the insolvent HMO is a party in any court in this state shall be stayed 60 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on its merits.
Author: Commissioner of Insurance

Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: New Rule: Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.07 General Provisions.

(1) For the purpose of carrying out its obligations under this Plan, the Association shall be deemed to be a creditor of the insolvent HMO to the extent of assets attributable to covered contracts reduced by any amount collected by the Association as subrogee. All assets of the insolvent HMO attributable to covered contracts and all assets to which covered contract holders are given a right of priority shall be used to continue all covered contracts and to pay all contractual obligations of such HMO as required by the Act and this chapter.

(2) Upon the issuance of a proper court order placing a domestic HMO in receivership or placing a foreign HMO in ancillary receivership for rehabilitation or liquidation, all enrollees, unaffiliated health care providers for uncovered expenditures, beneficiaries and insured of such insolvent HMO, with respect to claims arising from and within the coverage of and not in excess of the applicable limits of evidences of coverages and other health care contracts issued by the insolvent HMO and the Alabama Health Maintenance Organization Guaranty Association shall be preferred creditors of said HMO.

(3)1. Prior to the termination of any receivership, liquidation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders and contract holders of the insolvent HMO, and any other party with a bona fide interest in making an equitable distribution of the ownership rights of such insolvent HMO. In such a determination, consideration shall be given the welfare of the contract holders of the continuing or successor HMO.

2. No distribution to stockholders, if any, of an insolvent HMO shall be made until and unless the total amount of assessments levied by the Association with respect to such HMO have been fully recovered by the Association.

(4) Any person having a claim against any HMO under any provision in an insurance policy or in an evidence of coverage other than one issued by an impaired or insolvent HMO, when such claim is also a contractual obligation under the terms of the Act and the Plan, shall be required to exhaust first his rights under such other insurance policy, contract or evidence of coverage. Any amount payable on a contractual obligation under the Act or this Plan shall be reduced by the amount of any recovery under such other insurance policy, contract or evidence of coverage. This provision does not apply to any insurance policy which does not contain a coordination of benefits clause or to which Regulation No. 56 does not apply, such as individual indemnity policies.

Author: Commissioner of Insurance

Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).

History: New Rule: Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.08 Assignment And Subrogation.

(1) Any person receiving covered health care services under Section 27-21A-12(i), Code of Ala. 1975 or the Plan shall be deemed to have assigned the rights under the covered evidence of coverage to the Association to the extent of the benefits received because of the Act or the Plan. The Association may require an assignment to it of such rights by any payee, contract owner, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by the Act or the Plan upon such person. The Association shall be subrogated to these rights against the assets of any insolvent or impaired HMO.

(2) The subrogation rights of the Association under this rule shall have the same priority against the assets of the insolvent HMO as that possessed by the person entitled to receive covered health care services under the Act or the Plan.

(3) If the Association provides medical benefits or payments to an enrollee who suffers injury, disease or illness by virtue of the negligent act or omission of a third party the Association is entitled to reimbursement from such third party

for the reasonable value of the benefits or payments provided, just as the insolvent HMO would be entitled to such reimbursement pursuant to Section 27-21A-30(b).
Author: Commissioner of Insurance
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: **New Rule:** Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.09 Examination And Regulation Of Association; Annual Report. The Association shall be subject to examination and regulation by the Commissioner. The board of directors shall submit to the Commissioner, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner and a report of its activities during the preceding calendar year.
Author: Commissioner of Insurance
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: **New Rule:** Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.10 Membership. Pursuant to Section 27-21A-12(i), Code of Ala. 1975 ("the Act"), the HMOs which are authorized by the Commissioner to transact business in the State of Alabama shall be members of the Alabama Health Maintenance Guaranty Association ("the Association"). Each HMO obtaining a certificate of authority from the Commissioner to transact the kinds of business covered by the Act shall automatically become, effective on the date of its admission, a member HMO of the Association. A member HMO which ceases to be authorized after said date shall automatically cease to be a member effective on the day following the termination or expiration of its certificate to transact the kinds of business covered by said Act; provided, however, such HMO shall remain liable for any assessment or assessments based on an insolvency or impairment occurring prior to the cessation of its status as a member HMO in the Association.
Author: Commissioner of Insurance

Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: New Rule: Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.11 Effective Date. This chapter shall become effective October 20, 1988.
Author: Commissioner of Insurance
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: New Rule: Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.

482-1-083-.12 Separability. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.
Author: Commissioner of Insurance
Statutory Authority: Code of Ala. 1975, §§27-2-17, 27-21A-19, 27-21A-12(i).
History: New Rule: Filed October 3, 1988; effective October 20, 1988. Filed for codification in the Alabama Administrative Code by the Department of Insurance on April 23, 2004, pursuant to the Code of Ala. 1975, §27-7-43.