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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 1035

RELATING TO: Health Insurance

SPONSOR(S): Rep. C. Green

COMPANION BILL(S): SB 1800 (s), HB 959 and SB 1802 (c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES
(2) INSURANCE
(3) GOVERNMENTAL RULES AND REGULATIONS
(4) HEALTH AND HUMAN SERVICES APPROPRIATIONS
(5)

I. SUMMARY:

HB 1035 creates the Florida Health Endowment Association as a nonprofit entity to provide insurance coverage to individuals whose health insurance has been involuntarily terminated or whose pre-existing medical conditions prevent them from obtaining coverage in the standard individual health insurance market. The bill repeals the Florida Comprehensive Health Association, the existing health insurance high-risk pool that was created in 1983 and closed to new enrollment in 1991, and places pool insureds into the new association.

This bill creates a Board of Directors to supervise the association and to be composed of: the Secretary of the Department of Health, or his or her designee; the Insurance Commissioner, or his or her designee; and three members appointed by the Governor, including a policyholder representative, a health insurance industry representative, and a member of the public.

The bill authorizes the board to perform the functions necessary for the operation of the association including: adopting a plan of operations; selecting an administrator; and offering a renewable policy of major medical coverage with various premiums and deductibles and coinsurance. In addition, the bill: specifies that the coverage is not an entitlement; provides a cause of action for the association for recovery of benefits; and authorizes the board to contract with insurers for disease management services.

The bill provides tax credits for insurance companies that contribute to the Florida Health Endowment Association, allows for the transference of unused tax credits and provides for the plan to be terminated if it becomes financially infeasible.

The bill provides for an appropriation from the General Revenue Fund to the Florida Health Endowment Trust Fund. The amount of the appropriation is not specified. (The trust fund is created by a companion bill, HB 959.)

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

In recent years, many states have created health insurance risk pools to address the needs of the uninsured. Sections 627.648-627.6498, F.S., are known and cited as the "Florida Comprehensive Health Association Act (the Act). Section 627.6488, F.S., provides for the creation of a nonprofit, legal entity to be known as the Florida Comprehensive Health Association (FCHA). The State Comprehensive Health Association (the predecessor of the FCHA) was created in 1983 to offer residents of the state, through the participation of health insurance companies, a program of health insurance. The FCHA is subject to the supervision of a three-member board of directors, appointed by the Insurance Commissioner. The board includes the chairman, who is the Insurance Commissioner or his designee, one representative of policyholders, and one representative of insurers.

FCHA Eligibility, Benefits, and Premiums

Effective July 1, 1990, the FCHA was amended to require the association to pattern their coverage after the state group health insurance program including benefits, exclusions, and other limitations, except as otherwise provided by the Act. The major medical expense coverage under FCHA includes a $500,000 lifetime limit per covered life. The plan provides for an annual deductible in the amount of $1,000 or more, as approved by the Department of Insurance. The plan provides for a 12-month exclusion of coverage with respect to a condition that manifested itself with 6 months of the effective date of the coverage or medical advice or treatment recommended or received within a period of 6 months before the effective date of the coverage.

As a condition for being considered eligible for enrollment in the FCHA, an individual must be rejected by two insurers for coverage substantially similar to the plan coverage and no insurer has been found through the market assistance plan that is willing to accept the application. Rejection is defined to mean an offer of coverage with a material underwriting restriction or an offer of coverage at a rate greater than the association plan rate. Therefore, the rejection may or may not be due to being medically uninsurable.

Legislative changes in 1990 required the FCHA board or administrator to verify the residency of an applicant and to prohibit the enrollment of a person who is eligible for Medicaid from receiving benefits from the FCHA unless: (1) such person has an illness or disease which requires supplies or services which are covered by the association, but not under Florida's Medicaid program, and (2) the person is not receiving benefits under Medicaid. In addition, the law was clarified to allow FCHA to terminate an enrollee immediately if a person ceases to meet the eligibility requirements.

Policyholders pay premiums that are up to 250 percent of standard rates. The FCHA is authorized to establish a separate premium schedule for low, moderate, or high risk individuals. The FCHA is authorized to charge up to a maximum of 200 percent of the standard risk rate for individuals classified as low-risk, 225 percent for moderate risk enrollees, and 250 percent for high-risk enrollees.

Assessments

As a condition of doing business in Florida, health insurers are required to pay assessments to fund the deficits of the FCHA. Companies subject to the assessment include all health insurance companies, health maintenance organizations, fraternal benefit societies, multiple employer welfare arrangements, and prepaid health clinics. Self-funded employers and governmental entities are not subject to the assessment.

Each insurer is assessed annually by the board a portion of incurred operating losses of the plan, based on the insurer's market share in Florida as measured by premium volume. The total of all assessments upon a participating insurer is capped at 1 percent of such insurer's health insurance premium earned in Florida during the calendar year preceding the year for which the assessment is levied.

Florida's Uninsured and the Closure and Reopening of the FCHA

Pursuant to law, on July 1, 1991, the FCHA ceased accepting applications due to the Legislature's concerns over mounting financial losses. At that time, two actuarial firms estimated the 1992 deficit of the FCHA to be between $48 - 56 million, as compared to the maximum $27 million that could be assessed against insurers under the funding formula enacted in 1990. In 1991, legislation revised the funding formula providing for maximum assessments against the insurers of 1 percent of health insurance premiums written in Florida. The following assessments/losses were incurred for fiscal years 1991 - 1997: $5.6 million (1991), $7.1 million (1992), $5.8 million (1993), $11.8 million (1994), $9.8 million (1995), $3.2 million (1996), and $1.9 million (1997). It is estimated that assessments/losses for fiscal year 1998 is $4.6 million.

Recently, the Florida Comprehensive Health Association released a report (compiled by William M. Mercer, Inc.) entitled, *Florida's Uninsured Population in the Post-Health Care Reform Environment* (September 1997), which evaluated the characteristics of the uninsured in Florida and offered recommendations to provide coverage for the uninsured. The report noted anecdotal examples of uninsured individuals, including: workers without access to group coverage who are medically uninsurable, workers who lost access to group coverage prior to the enactment of HIPAA, disabled individuals, and Medicare-eligible retirees who do not currently have supplemental coverage.

In the FCHA report, disabled individuals were identified as a significant percentage of the uninsured. The report noted that disabled children, in particular, present a coverage concern. According to the report, "If employers provide dependent coverage, it typically lasts until the dependent reaches age 19, or age 23, if a full-time student." Pursuant to s. 627.6615, F.S., a group health insurance policy or health maintenance organization contract delivered or issued in Florida that provides coverage of a dependent child of an employee or other member of a covered group will not terminate coverage of the dependent child upon attaining the limiting age while the child continues to be both: (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (2) chiefly dependent upon the employee or member for support and maintenance.

Individuals eligible for Medicare who did not purchase coverage when they first qualified were identified as a significant group of the uninsured. According to the FCHA report, the federal OBRA Act of 1990 prohibits carriers from denying coverage based " . . . on health status, claims experience, or medical condition during the 6 months a Medicare beneficiary age 65 or older enrolls in Part B of Medicare." However, based on an informal survey of carriers, some large carriers offer certain Medigap policies on a guaranteed-issue basis, regardless of age.

In the *Summary of Plan Activities, 1997-98,* the FCHA offered the following solutions to provide coverage for the uninsured:

1. Open enrollment for the state's high-risk pool, the FCHA;
2. Guarantee issue by individual insurers and health maintenance organizations;
3. Expansion of the small group market guarantee-issue requirement;
4. Allow uninsurable individuals access to the State Employee Health Insurance Plan;
5. Allow access to Medicaid, regardless of income status; or
6. Allow alternative sources of funding for FCHA.

High-risk pools may provide a safety net for otherwise uninsurable individuals; however, they enroll a relatively small number of individuals. In the majority of states that have risk pools (22 of 25), the General Accounting Office (GAO) noted that less than 5 percent of the non-elderly, with individual coverage, obtain coverage through a risk pool (November 1996). GAO noted reasons for low enrollment including: limited funding, lack of public awareness, and the relative expense. As of 1999, there are 28 states which have high-risk pools.

Some uninsured individuals in Florida choose not to purchase insurance coverage; however, there is a segment of medically uninsured that may purchase insurance, if it was available. According to the FCHA, a portion of the uninsured population would be willing to pay higher premiums if they were allowed to purchase health insurance coverage. The FCHA noted that 32 percent of the current enrollees have a household income of $40,000 or more.

The FCHA report estimated the number of individuals (based on 1990 FCHA enrollment data) that would enroll, if FCHA was reopened. The report estimated that between 3,700 - 6,200 individuals might enroll.

The report strongly recommended that, if the FCHA was to be reopened, funding (assessment/tax) base needs to be addressed to effectively finance the high-risk pool. The report suggested the following funding options:

1. Appropriate General Revenue monies;
2. Creation of another business tax;
3. Increase sales tax;
4. Provide premium tax offset for assessment;
5. Raise risk-pool premiums;
6. Tax hospital revenues;
7. Place service charge on hospitals and surgical centers;
8. Assess health insurance policyholders; and/or
9. Increase taxes on cigarettes, alcohol, or other products.

Premiums

According to the *Comprehensive Health Insurance for High-Risk Individuals, A State-by-State Analysis (1997)*, issued by Communicating for Agriculture, "The key to financing a state plan is to realize that premiums collected from the enrollees probably will only cover 50 percent of the cost to operate the plan." Pursuant to s. 627.6498(4)(a), F.S., the Department of Insurance annually establishes the standard risk rate that serves as the basis for determining premiums established for the FCHA (ch. 98-159, L.O.F.). The department uses reasonable actuarial techniques, and standards adopted by rule. As currently provided, the maximum rates for the FCHA would be 200 percent, 225 percent, and 250 percent of the standard risk rate for low, medium, and high risk individuals, respectively.

Based on an analysis of FCHA audited financial statements, the average assessment per member for the period of 1990-95 experienced a slight decline/stabilization through 1993 and increased significantly during the next 2 years. In 1996, the average assessment per enrollee was $2,211. In contrast, the average assessment for 1995 was $5,193. Since 1991, average premiums have declined slightly and have stabilized around $3,500. In 1995 and 1996, the average annual premium for an FCHA policyholder was approximately $3,600. The average total expense per enrollee has increased significantly since 1991, appearing to be stabilizing. As of April 1999, enrollment totaled 900 and was declining at a rate of approximately 15 percent per year.

Enrollment in the risk pool is restricted to individuals who, due to pre-existing medical conditions, are unable to purchase individual health insurance at any price. Premiums are capped at 250% of the standard rate. Revenue from premiums does not cover the entire cost of each risk pool insured. All insurers, health maintenance organizations, and prepaid health clinics in Florida are currently assessed for the annual operating losses of the association, based on market-share formula. Since 1991, the average additional cost per risk pool insured has been $2,766.

The average assessment per enrollee, premium paid by enrollee, and average expense per enrollee for fiscal years 1991-98 is depicted in the following chart:

FY	Average Number of Enrollees	Avg.Cost To Insurers (Amt assessed per member)	Average Premium Paid by Enrollee	Average Total Expenses Per Enrollee
1998	991	4652	3536	* 8538
1997	1182	1637	3531	5653
1996	1458	2211	3576	6016
1995	1891	5193	3580	8880
1994	2775	4258	3521	7814
1993	3702	1566	3610	5064

FY	Average Number of Enrollees	Avg.Cost To Insurers (Amt assessed per member)	Average Premium Paid by Enrollee	Average Total Expenses Per Enrollee
1992	4528	1576	3355	5036
1991	5639	990	3824	4911

*** Estimated**

Net losses (assessments) declined from a high of $33.9 million in 1990 to $5.8 million at the end of 1993, before increasing to $11.8 million in 1994 and $9.8 million for 1995. For the calendar year ended 1996, net losses totaled $3.2 million, while for 1997 net losses totaled $1.9 million and for 1998 totaled $4.6 million.

B. EFFECT OF PROPOSED CHANGES:

The Florida Health Endowment Association (FHEA) will be created to replace the Florida Comprehensive Health Association (FCHA). FHEA will provide individual health insurance coverage to individuals who are considered uninsurable in the standard market. It will also allow existing FCHA policyholders to purchase FHEA health coverage.

Funding for the association will be provided by premiums paid by policyholders and by earnings from the endowment created by General Revenue Funds. This funding will replace the current funding mechanism for the risk pool which assesses insurance companies and health maintenance organizations for the operating losses of the association, based on a market-share formula. Insurers will be allowed to contribute to the Florida Health Endowment Association and will earn a vested credit against premium tax liability equal to 100 percent of the contribution. The insurance company can use no more than 25% of the vested premium tax credit, including carry-forward credits, per year.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

N/A

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

The Secretary of the Department of Health or his or her designee would serve as the chairperson of the association board of directors. The association would submit a plan of operations to the department for approval.

(3) any entitlement to a government service or benefit?

N/A

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

This bill eliminates the Florida Comprehensive Health Association (FCHA) and replaces it with the Florida Health Endowment Association (FHEA). The new organization would assume the role of the FCHA to function as the high risk pool for individual health

insurance in Florida. Responsibilities, costs, and powers are similar. The board of directors is enlarged, includes appointees by the Governor and is chaired by the Secretary of the Department of Health or his or her designee.

(2) what is the cost of such responsibility at the new level/agency?

Costs of the FHEA would be comparable to those of the FCHA.

(3) how is the new agency accountable to the people governed?

Meetings of the Florida Health Endowment Association are subject to the same public notice and open meeting requirements that applied to the FCHA. Policyholders of the FHEA would have rights similar to those of the FCHA.

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

N/A

b. Does the bill require or authorize an increase in any fees?

N/A

c. Does the bill reduce total taxes, both rates and revenues?

N/A

d. Does the bill reduce total fees, both rates and revenues?

N/A

e. Does the bill authorize any fee or tax increase by any local government?

N/A

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

N/A

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Yes. Policyholders of the FHEA would pay premiums established by the FHEA board of directors and approved by the Department of Insurance that could be no more than 250% of the standard rate determined by the Department of Insurance.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

Yes. This bill would allow individuals who have been unable to purchase health insurance in the standard market to buy coverage from the FHEA. They would pay premiums much higher than those in the standard market. Since unpaid medical bills are a leading cause of bankruptcy filings, this bill could allow individuals to remain independent, taxpaying citizens rather than being forced to spend down to qualify for a government subsidy or entitlement program.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 627.648, 627.6482, 627.6484, 627.6486, 627.6487, 627.64871, 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, 627.6498, F.S., are all repealed.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates the "Florida Health Endowment Association" (FHEA) as a nonprofit legal entity.

Provides for the association to be governed by a five member board of directors comprised of the following: the chairperson is the Secretary of the Department of Health or his or her designee; the Insurance Commissioner or his or her designee; three persons appointed by the Governor including one representative of policyholders who is not associated with the medical profession or a hospital, one representative of the health insurance industry, and one member of the public. In addition, this section: prohibits the plan administrator from serving as a member of the board; provides for removal of any appointed board member at any time without cause; specifies that the members shall be appointed to staggered 3-year terms; allows for reimbursement of board member expenses; provides immunity from liability for board members and employees of the association; and specifies that meetings of the board are subject to s. 286.011, F.S.

Authorizes the board to do the following: adopt a plan of operations, subject to approval by the Department of Health; establish administrative and accounting procedures; administer the trust fund; contract with an actuary to recommend the opening and closing of the plan, based on the income of the trust fund, premiums, and other revenues; establish eligibility requirements for individuals participating in the plan to ensure the actuarial soundness of the insurance pool; develop policy forms to be used by the association which are subject to approval by the Department of Insurance; contract with preferred provider organizations and health maintenance organizations; employ a case manager to manage or coordinate the medical care of policyholders; appoint an executive director to serve as the chief administrative and operational officer to the board; establish an investment plan with approval of the State Board of Administration; contract with a trustee services firm to supervise investment proposals for the board; and make a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and the House of Representatives, not later than October 1 of each year.

Section 2. Specifies that the board shall select an administrator to administer the plan through a competitive bidding process and describes the duties and responsibilities of the administrator.

Section 3. Specifies that: the plan will be an annually renewable policy; no persons eligible for Medicare coverage will be reimbursed for any expenses paid by Medicare; and the coverage provided to a person who is eligible for Medicare benefits may not be issued as a Medicare supplement and will separately rated. Provides that a person who is involuntarily terminated for any reason other than non-payment of premium may apply for coverage; and provides a mechanism to qualify for coverage effective as of the termination of the previous coverage.

Requires the plan to offer major medical expense coverage and pay an eligible person's covered expenses, subject to limits on deductible and coinsurance. The maximum lifetime benefits allowed are $500,000 per covered individual.

Establishes that the minimum deductible available for this plan is $1,000. The board and Department of Health may approve other deductibles and the association shall establish the schedule of premiums, which are subject to approval by the department.

Specifies that the board shall establish separate premium schedules for low-risk, medium-risk and high-risk individuals and describes how claims will be paid, after satisfaction of the deductible, for individuals in case management, for individuals using the preferred provider network and others. Coverage is excluded for pre-existing conditions for a period of 12 months following the effective date of coverage for conditions that were manifested or for which medical advice or treatment was recommended within 6 months before the effective date of coverage.

Provides that other sources of coverage are primary and the association has a cause of action against a participant for any benefits paid to the participant which should not have been claimed.

Specifies that this coverage is not an entitlement and coverage provided under this plan shall be directly insured by the Florida Health Endowment Association.

Section 4. Permits the association to contract with insurers to provide disease management services for insurers. Money collected by the association for this purpose shall be used by the association to pay administrative expenses associated with this function.

Section 5. Allows any insurance company subject to premium tax liability pursuant to s. 624.509, F.S., to contribute to the Florida Health Endowment Association and earn a vested credit against premium tax liability equal to 100 percent of the contribution, but limits the annual use of the vested premium tax credit, including carry-forward, to 25 percent of tax liability. Clarifies that the credit may not exceed the premium tax liability of a company for that taxable year, and exempts the company from any additional retaliatory tax levied under s. 624.5091, F.S. It also permits the limited transfer of a company's unused premium tax credits.

Section 6. Allows the state to terminate the plan if it determines the plan to be financially infeasible. Each participant shall be entitled to exercise the complete benefits for which he or she has contracted, but additional participants may not be permitted to enter the plan.

Section 7. Specifies certain sections of Florida statutes relating to FCHA to be repealed effective upon the opening of the plan by the board. Allows policyholders of the Florida Comprehensive Health Association to be issued coverage under the new plan.

Section 8. Specifies an undesignated appropriation from the General Revenue Fund to the Florida Health Endowment Trust Fund.

Section 9. Provides an effective date of July 1, 1999.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

The intent of this bill is to fund the Florida Health Endowment Association so that the investment return from the endowment would supplement premiums paid by FHEA policyholders in an actuarially sound manner.

2. Recurring Effects:

The bill provides that if the endowment is fully funded, there should be no recurring effects on state funds.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

Unknown.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

None.

2. Direct Private Sector Benefits:

Individuals who are not able to obtain health insurance will benefit from the establishment of the FHEA.

3. Effects on Competition, Private Enterprise and Employment Markets:

N/A

D. FISCAL COMMENTS:

None.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to expend funds nor does it require them to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

The Department of Insurance has the following concerns with HB 1035:

- The residency requirements on page 5, line 3, may not be enforceable.
- The provision on page 5, line 13, requires the department to approve policy forms, but it does not require the forms to comply with the Insurance Code.
- On page 13, line 16, the department feels that this provision would allow for coverage of persons whose coverage was terminated for fraud or intentional misrepresentation. In addition, the 60 day provision in this paragraph does not comply with federal HIPAA requirements.
- The $500,000 lifetime limit on page 14, line 4, is very low, and moving to a higher lifetime limit will probably not have a material premium impact.
- Beginning on page 15, line 1, the bill states that the department would approve rates, but on page 15, line 5, the bill states that the entity shall establish premium schedules. According to the department, this means that actual rates charged could vary from what the department approves. Insurers and HMOs are not permitted by the department to do this.
- The actual provisions of policyholder payment beginning on page 15, line 17, through page 16, line 6, are not clear.

Staff observes that the bill may require the Department of Health to perform regulatory oversight functions relating to insurance for which the Department of Health does not have significant expertise. Such functions are usually charged to the Department of Insurance, which does have expertise in this area.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Amy K. Guinan	Phil E. Williams