By the Committee on Banking and Insurance; and Senator Latvala

311-2029-99

A bill to be entitled

An act relating to health insurance; creating the Florida Health Endowment Association as a nonprofit entity to provide insurance coverage to individuals whose health insurance has been involuntarily terminated for reasons other than nonpayment of premiums; providing for the association to be governed by a board of directors; providing membership of the board; providing terms of office; providing for the board members to be reimbursed for expenses; providing immunity from liability for board members and employees of the association; requiring the board to adopt a plan and rules to administer the act; providing additional duties of the board; requiring that the board report to the Governor and Legislature each year; specifying the powers of the board; providing definitions; providing eligibility criteria; providing exceptions; requiring the board to select a plan administrator; specifying the period of service of the administrator; providing duties of the administrator; providing for payment of the administrator for expenses; requiring that the plan offer a renewable policy that provides specified coverage; requiring that the plan offer major medical expense coverage similar to that provided by the state group health insurance program; providing for covered expenses; providing for premiums, deductibles,

and coinsurance; requiring that the board establish premium schedules; providing for payment of coverage if the costs exceed the deductible within a policy year; providing an exclusion for preexisting conditions under specified circumstances; providing for other sources of insurance to be primary; providing a cause of action for the association for the recovery of benefits; providing that the provision of health insurance is not an entitlement; providing for coverage to be insured by the Florida Health Endowment Association; authorizing the board to contract with insurers for disease management services; providing tax credits for insurance companies that contribute to the Florida Health Endowment Association; providing for unused tax credits to be claimed by a transferee; providing for the plan to be terminated if it becomes financially infeasible; repealing ss. 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, Florida Statutes; providing an appropriation; providing a contingent effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Florida Health Endowment Association.--

(1) There is created a nonprofit legal entity to be known as the "Florida Health Endowment Association."

(2)(a) The association shall operate subject to the supervision and approval of a five-member board of directors. The board of directors shall be composed as follows:

1. The Secretary of Health, or his or her designee from the Department of Health, who shall be the chairperson of the board.

2. The Insurance Commissioner, or his or her designee from the Department of Insurance.

3. The Governor shall appoint three members as follows:

a. One representative of policyholders who is not associated with the medical profession or a hospital.

b. One representative of the health insurance industry.

c. One member of the public.

The administrator of the plan, or his or her affiliate, may not be a member of the board. Any board member appointed may be removed and replaced by his or her appointor at any time without cause.

(b) All board members, including the chairperson, shall be appointed to staggered 3-year terms beginning on a date established in the plan of operation.

(c) The board of directors may employ persons to perform the administrative and financial transactions and responsibilities of the association and to perform other necessary and proper functions not prohibited by law.

(d) Board members may be reimbursed from moneys of the association for actual and necessary expenses incurred by them as members, but may not otherwise be compensated for their services.

(e) There is no liability on the part of, and no cause of action of any nature shall arise against, any employee of the association, member of the board of directors of the association, or a representative of the Department of Health for any act or omission taken by them in the performance of their powers and duties under this act, unless such act or omission by such person is in intentional disregard of the rights of the claimant.

(f) Meetings of the board are subject to section 286.011, Florida Statutes.

(3) The board of directors of the association shall adopt a plan pursuant to this act and submit its articles, bylaws, and operating rules to the Department of Health for approval. If the board of directors fails to adopt such plan and suitable articles, bylaws, and operating rules within 180 days after the appointment of the board, the department shall adopt rules to implement this act, and such rules shall remain in effect until superseded by a plan and articles, bylaws, and operating rules submitted by the board of directors and approved by the department.

(4) The board of directors of the association shall:

(a) Establish administrative and accounting procedures for the operation of the association.

(b) Contract with an actuary to evaluate the pool of insureds in the plan and monitor the financial status of the Florida Health Endowment Trust Fund. The actuary shall recommend to the board the opening and closing of the plan, which must be based on an analysis of the trust fund; the income of the trust fund; and any premiums, deductibles, and coinsurance paid to the association.

(c) Establish eligibility requirements for individuals participating in the plan to ensure an actuarially sound insurance pool.

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

(e) Select an administrator in accordance with section 4 of this act.

(f) Require that all policy forms issued by the association conform to standard forms developed by the association. The forms shall be approved by the Department of Insurance.

(g) Develop and implement a program to publicize the existence of the plan, the eligibility requirements for the plan, and the procedures for enrollment in the plan, and maintain public awareness of the plan.

(h) Design and employ cost-containment measures and requirements that shall include, but are not limited to, preadmission certification, any out-of-state health care, home health care, hospice care, negotiated purchase of medical and pharmaceutical supplies, and individual case management.

(i) Contract with preferred provider organizations and health maintenance organizations giving due consideration to the preferred provider organizations. If cost-effective and available in the county where the policyholder resides, the board, upon application or renewal of a policy, shall place a high-risk individual, as established under section 5 of this act, with the plan case manager who shall determine the most cost-effective quality care system or health care provider and shall place the individual in such system or with such health care provider. If cost-effective and available in the county

where the policyholder resides, the board, with the consent of the policyholder, may place a low-risk or medium-risk individual, as established under section 5 of this act, with the plan case manager who may determine the most cost-effective quality care system or health care provider and shall place the individual in such system or with such health care provider. Prior to and during the implementation of case management, the plan case manager shall obtain input from the policyholder, parent, guardian, and health care providers.

(j) Employ a case manager or managers to supervise and manage the medical care or coordinate the supervision and management of the medical care of specified individuals. The case manager, with the approval of the board, shall have final approval over the case management for any specific individual.

(k) Appoint an executive director to serve as the chief administrative and operational officer of the board and to perform other duties assigned to him or her by the board.

(l) Administer the Florida Health Endowment Trust Fund in a manner that is sufficiently actuarially sound to defray the obligations of the program. The board shall annually evaluate or cause to be evaluated the actuarial soundness of the fund. If the board perceives a need for additional assets in order to preserve actuarial soundness, the board may adjust the benefits of the plan to ensure such soundness.

(m) Establish a comprehensive investment plan with the approval of the State Board of Administration. The comprehensive investment plan must specify the investment policies to be used by the board in administering the fund. The board may place assets of the fund in savings accounts or use the fund to purchase fixed or variable life insurance or annuity contracts, securities, evidence of indebtedness, or

other investment products pursuant to the comprehensive investment plan and in such proportions as are designated or approved under the investment plan. Such insurance, annuity, savings, or investment products must be underwritten and offered in compliance with the applicable federal and state laws and rules by persons who are authorized by applicable federal and state authorities. Within the comprehensive investment plan, the board may authorize investment vehicles, or products incident thereto, as are available or offered by qualified companies or persons.

(n) Solicit proposals and contract, pursuant to section 287.057, Florida Statutes, for a trustee services firm to select and supervise investment programs on behalf of the board. The goals of the board in selecting a trustee services firm shall be to obtain the highest standards of professional trustee services, to allow all qualified firms interested in providing such services equal consideration, and to provide such services to the state at no cost and to the purchasers at the lowest cost possible. The trustee services firm must agree to meet the obligations of the board to qualified beneficiaries if moneys in the fund fail to offset the obligations of the board as a result of imprudent selection or supervision of investment programs by such firm. Evaluations of proposals submitted under this paragraph must include, but not be limited to, the following criteria:

1. Adequacy of trustee services for supervising and managing the program, including current operations and staff organization and commitment of management to the proposal.

2. Capability to execute plan responsibilities within time and regulatory constraints.

3. Past experience in trustee services and current ability to maintain regular and continuous interactions with the board, records administrator, and product provider.

4. The minimum purchaser participation assumed within the proposal and any additional requirements of purchasers.

5. Adequacy of technical assistance and services proposed for the staff.

6. Adequacy of a management system for evaluating and improving overall trustee services to the plan.

7. Adequacy of facilities, equipment, and electronic data processing services.

8. Detailed projections of administrative costs of trustee services, including the amount and type of insurance coverage, and detailed projections of total costs.

(o) 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. The report must summarize the activities of the plan for the 12-month period ending December 31 of the previous year, including then-current data and estimates as to net written and earned premiums, the expense of administration, the paid and incurred losses for the year, the financial status of the Florida Health Endowment Trust Fund, and any recommendations by the actuary for the opening or closing of the plan. The report shall also include analysis and recommendations for legislative changes regarding utilization review, quality assurance, an evaluation of the administrator of the plan, access to cost-effective health care, and the cost-containment and case-management policy and recommendations concerning the opening of enrollment.

(p) Establish a plan of operation which must include the assumption of all liabilities of the Florida Comprehensive Health Association and the transition of its remaining policyholders into the plan.

(5) The board of directors of the association shall have the powers necessary or proper to carry out the provisions of this act, including, but not limited to, the power to:

(a) Adopt an official seal and rules.

(b) Exercise powers granted to insurers under the laws of this state.

(c) Sue or be sued.

(d) Make and execute contracts and other necessary instruments.

(e) Prepare or contract for a performance audit of the administrator of the association.

(f) Invest funds not required for immediate disbursement.

(g) Appear in its own behalf before boards, commissions, or other governmental agencies.

(h) Hold, buy, and sell any instruments, obligations, securities, and property determined appropriate by the board.

(i) Restrict the number of participants in the plan based on actuarial estimates. However, any person denied participation solely on the basis of such restriction shall be granted priority on a first-come, first-served basis for participation in the succeeding years in which the plan is reopened for participants.

(j) Contract for necessary goods and services; employ necessary personnel; and engage the services of private

consultants, actuaries, managers, legal counsel, and auditors for administrative or technical assistance.

(k) Solicit and accept gifts, grants, loans, and other aids from any source or participate in any other way in any government program to carry out the purposes of this section.

(l) Require and collect administrative fees and charges in connection with any transaction and impose reasonable penalties, including default, for delinquent payments or for entering into the plan on a fraudulent basis.

(m) Procure insurance against any loss in connection with the property, assets, and activities of the fund or the board.

(n) Establish other policies, procedures, and criteria to implement and administer this section.

(o) Adopt procedures to govern contract dispute proceedings between the board and its vendors.

Section 2. Definitions.--As used in sections 1-8, the term:

(1) "Association" means the Florida Health Endowment Association created in section 1.

(2) "Board" means the board of directors of the association.

(3) "Case management" means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the plan case manager.

(4) "Department" means the Department of Health.

(5) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations thereunder, as administered in this state by the agency.

(6) "Medicare" means coverage under both parts A and B of Title XVII of the Social Security Act, 42 U.S.C. ss. 1395 et seq., as amended.

(7) "Plan case manager" means the person or persons employed by the association to supervise and manage or coordinate with the administrator the supervision and management of the medical care provided or prescribed for a specific individual.

(8) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the board pursuant to section 1 of this act.

(9) "Plan" means the comprehensive health insurance plan adopted by the association.

(10) "Resident" means a person who is legally domiciled in this state.

Section 3. Eligibility.--

(1) Except as provided in subsection (2), any individual person, who has been for the previous year and continues to be a resident of the state, shall be eligible for plan coverage if evidence is provided of:

(a) A notice of rejection or refusal to issue substantially similar insurance for health reasons by an insurer licensed to do business in this state; or

(b) A refusal by an insurer to issue insurance except at a rate exceeding the plan rate.

A rejection or refusal by an insurer offering only stop-loss, excess-of-loss, or reinsurance coverage with respect to the applicant shall be sufficient evidence under this subsection.

(2) The board or administrator shall require verification of residency and shall require any additional

information or documentation or statements under oath, when necessary to determine residency upon initial application and for the entire term of the policy.

(3) The board shall promulgate a list of medical or health conditions for which a person is eligible for plan coverage without applying for health insurance pursuant to subsection (1). Persons who demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in subsection (1). The list shall be effective on the first day of the operation of the plan and may be amended as appropriate.

(4) Any resident dependent unmarried child of the insured is eligible from the moment of birth, provided that no other coverage is available. Subject to the provisions of s. 627.6041, such coverage shall terminate at the end of the premium period in which the child marries, ceases to be a dependent of the insured, or attains the age of 19, whichever occurs first. However, if the child is a full-time student at an accredited institution of higher learning, the coverage may continue while the child remains unmarried and a full-time student, but not beyond the premium period in which the child reaches age 23.

(5) A person is ineligible for coverage under the plan if:

(a) 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.

(b) The person is an inmate or resident of a public institution or correction facility; or

(c) 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 agency or health care provider.

(d) The person has received $500,000 in covered benefits that have been paid out pursuant to the plan.

(e) The person is eligible, on the date of issue of coverage under the plan, for substantially similar coverage under another contract or policy, unless such coverage is provided pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986) (COBRA), as amended, and scheduled to end at a time certain and the person meets all other requirements of eligibility. Coverage provided by the association shall be secondary to any coverage provided by an insurer pursuant to COBRA.

(f) The person is currently eligible for health care benefits under Florida's Medicaid program, unless he or she:

1. Has an illness or disease that requires supplies or medication that are covered by the plan but are not included in the benefits or coverage under Florida's Medicaid program; and

2. Is not receiving health care benefits or coverage under Florida's Medicaid program.

(5) Coverage shall cease:

(a) On the date a person is no longer a resident of this state;

(b) On the date a person requests coverage to end;

(c) Upon the death of the covered person;

(d) On the date state law requires cancellation of the policy; or

(e) At the option of the plan, 30 days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

(6) All eligible persons who are classified as high-risk individuals shall, upon application or renewal, agree to be placed in a case-management system when it is determined by the board and the plan case manager that such system will be cost-effective and provide quality care to the individual.

(7) The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated immediately. If such person again becomes eligible for subsequent coverage under the plan, any previous claims payments shall be applied towards the $500,000 lifetime maximum benefit and any limitation relating to preexisting conditions in effect at the time such person again becomes eligible shall apply to such person.

Section 4. Administrator.--

(1) The board shall select an administrator, through a competitive bidding process, to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board, which criteria must include:

(a) The administrator's proven ability to handle individual accident and health insurance.

(b) The extent to which the administrator has developed a network of health care providers for providing managed health care on a statewide basis.

(c) The efficiency of the administrator's claims-paying procedures.

(d) An estimate of total charges for administering the plan.

(2) The administrator shall serve for a period of 3 years. At least 1 year prior to the expiration of each 3-year period of service by an administrator, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administrator for the succeeding 3-year period. The selection of the administrator for the succeeding period must be made at least 6 months prior to the end of the current 3-year period.

(3) The administrator shall:

(a) Perform all eligibility and administrative claims-payment functions relating to the plan, as prescribed by the board.

(b) Pay an agent's referral fee as established by the board to each insurance agent who refers an applicant to the plan, if the applicant's application is accepted. The selling or marketing of plans is not limited to the administrator or its agents. However, any agent must be selected by the board and licensed by the Department of Insurance to sell health insurance in this state. The referral fees shall be paid by the administrator from moneys received as premiums for the plan.

(c) Establish a premium-billing procedure for collecting premiums from insured persons. Billings shall be made periodically as determined by the board.

(d) Perform all necessary functions to assure timely payment of benefits under the plan, including:

1. Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions are made.

2. Evaluating the eligibility of each claim for payment under the plan.

3. Notifying each claimant, within the time limits prescribed by law, as to insurers after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected, or compromised.

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

(f) Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expense allowance, and the expense of administration pertaining to the reinsurance operations of the association.

(g) Pay claims expenses from the premium payments received from or on behalf of covered persons under the plan. If the payments by the administrator for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide the administrator with additional funds for payment of claims expenses to the extent that such funds are available.

(4)(a) The administrator shall be paid, as provided in the contract of the association, for its direct and indirect expenses incurred in the performance of its services.

(b) As used in this subsection, the term "direct and indirect expenses" includes that portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses, and other actual operating and administrative expenses of the administering insurer which are approved by the board as

allocable to the administration of the plan and included in the bid specifications.

Section 5. Minimum benefits coverage; exclusions; premiums; deductibles.--

(1) COVERAGE OFFERED.--

(a) The plan shall offer in an annually renewable policy the coverage specified in this section for each eligible person.

(b) If an eligible person is also eligible for Medicare coverage, the plan may not pay or reimburse any person for expenses paid by Medicare.

(c) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

(d) Coverage provided to a person who is eligible for Medicare benefits may not be issued as a Medicare supplement policy as defined in section 627.672, Florida Statutes.

(2) BENEFITS.--

(a) The plan shall offer major medical expense coverage to every eligible person, subject to limitations set by the board. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under subsection (4), up to a lifetime limit of $500,000 per covered individual. The maximum limit under this paragraph may not be altered by the board, and no actuarially equivalent benefit may be substituted by the board.

(b) The plan shall provide that any policy issued to a person eligible for Medicare shall be separately rated to reflect differences in experience reasonably expected to occur as a result of Medicare payments.

(3) COVERED EXPENSES.--The coverage to be issued by the association shall, at a minimum, be patterned after the standard individual health insurance plan approved by the Department of Insurance.

(4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.--

(a) The plan shall provide for annual deductibles for major medical expense coverage in the amount of $1,000 or any higher amounts proposed by the board and approved by the department, plus the benefits payable under any other type of insurance coverage or workers' compensation. The schedule of premiums and deductibles shall be established by the association. With regard to any preferred provider arrangement used by the association, the deductibles provided in this paragraph shall be the minimum deductibles applicable to the preferred providers and higher deductibles, as approved by the department, may be applied to providers who are not preferred providers.

1. Separate schedules of premium rates based on age may apply for individual risks.

2. Rates are subject to approval by the department.

3. Standard risk rates for coverages issued by the association shall be established under section 627.6675(3), Florida Statutes.

4. The board shall establish separate premium schedules for low-risk individuals, medium-risk individuals, and high-risk individuals and shall revise premium schedules annually beginning January 2000. A rate may not exceed 150

percent of the standard risk rate for low-risk individuals, 200 percent of the standard risk rate for medium-risk individuals, or 250 percent of the standard risk rate for high-risk individuals. For the purpose of determining what constitutes a low-risk individual, medium-risk individual, or high-risk individual, the board shall consider the anticipated claims payment for individuals based upon an individual's health condition.

(b) If the covered costs incurred by the eligible person exceed the deductible for major medical expense coverage selected by the person in a policy year, the plan shall pay in the following manner:

1. For individuals placed under case management, after satisfaction of the deductible, the plan shall pay 90 percent of the additional covered costs incurred by the person during the policy year for the first $10,000, after which the plan shall pay 100 percent of the covered costs incurred by the person during the policy year.

2. For individuals using the preferred provider network, after satisfaction of the deductible, the plan shall pay 80 percent of the additional covered costs incurred by the person during the policy year for the first $10,000, after which the plan shall pay 90 percent of covered costs incurred by the person during the policy year.

3. If the person does not use the case management system or the preferred provider network, after satisfaction of the deductible, the plan shall pay 60 percent of the additional covered costs incurred by the person for the first $10,000, after which the plan shall pay 70 percent of the additional covered costs incurred by the person during the policy year.

4. For individuals placed under case management or individuals using the preferred provider network, the maximum out-of-pocket expense, after satisfaction of the deductible, is limited to $10,000 per calendar year.

(c) All premiums, deductibles, and coinsurance paid to the association shall be deposited with the Florida Health Endowment Association.

(d) Notwithstanding the provisions of section 624.509, Florida Statutes, premiums for coverage shall, as to the association and participating insurers, be exempt from premium taxation.

(5) PREEXISTING CONDITIONS.--An association policy may contain provisions under which coverage is excluded during a period of 12 months following the effective date of coverage with respect to a given covered individual for any preexisting condition, if:

(a) The condition manifested itself within 6 months before the effective date of coverage; or

(b) Medical advice or treatment was recommended or received within 6 months before the effective date of coverage.

(6) OTHER SOURCES PRIMARY.--

(a) Any amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may not be made or recognized as claims under such policy or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums or to reduce the limits of benefits available.

(b) The association has a cause of action against a participant for any benefits paid to the participant which

should not have been claimed or recognized as claims because of the provisions of this subsection or because the condition is not covered.

(7) NONENTITLEMENT.--This section does not provide an individual with an entitlement to health care services or health insurance. No cause of action shall arise against the state, the board, or a unit of local government for failure to make health services or health insurance available under this section.

(8) ISSUING OF POLICIES.--The coverage provided by this plan shall be directly insured by the Florida Health Endowment Association, and the policies shall be issued through the administrator.

Section 6. Disease management services.--

(1) The association may contract with insurers to provide disease management services for insurers that elect to participate in the association disease management program.

(2) An insurer that elects to contract for such services shall provide the association with all medical records and claims information necessary for the association to effectively manage the services.

(3) Moneys collected by the association for providing disease management services shall be used by the association to pay administrative expenses associated with the disease management program and any remaining moneys shall be deposited in the Florida Health Endowment Trust Fund.

Section 7. Tax credits.--

(1)(a) Any insurance company subject to premium tax liability pursuant to section 624.509, Florida Statutes, who makes a contribution to the Florida Health Endowment Association shall earn a vested credit against premium tax

liability equal to 100 percent of the contribution. Insurance companies may use not more than 25 percentage points of the vested premium tax credit, including any carryforward credits under this act, per year beginning with premium tax filings for calendar year 2001. Any premium tax credits not used in any single year may be carried forward and applied against the premium tax liabilities for subsequent calendar years.

(b) The credit to be applied against premium tax liability in any single year may not exceed the premium tax liability of the insurance company for that taxable year.

(c) An insurance company claiming a credit against premium tax liability earned through an investment in the Florida Health Endowment Association is not required to pay any additional retaliatory tax levied under section 624.5091, Florida Statutes, as a result of claiming such credit. Because credits under this section are available to an insurance company, section 624.5091, Florida Statutes, does not limit such credit in any manner.

(2) The claim of a transferee of an insurance company's unused premium tax credit shall be permitted in the same manner and subject to the same provisions and limitations of this act as the original insurance company. The term "transferee" means any person who:

(a) Through the voluntary sale, assignment, or other transfer of the business or control of the business of the insurance company, including the sale or other transfer of stock or assets by merger, consolidation, or dissolution, succeeds to all or substantially all of the business and property of the insurance company;

(b) Becomes by operation of law or otherwise the parent company or a wholly owned subsidiary of the insurance company; or

(c) Directly or indirectly owns, whether through rights, options, convertible interests, or otherwise, controls, or holds power to vote 10 percent or more of the outstanding voting securities or other ownership interest of the insurance company.

Section 8. Plan termination.--If the state determines the plan to be financially infeasible, the state may discontinue the plan. Any participants shall be entitled to exercise the complete benefits for which he or she has contracted. However, additional participants may not be permitted to enter the plan.

Section 9. Section 627.648, Florida Statutes; section 627.6482, Florida Statutes, as amended by sections 224 and 292 of chapter 98-166, Laws of Florida; sections 627.6484 and 627.6486, Florida Statutes; section 627.6487, Florida Statutes, as amended by section 5 of chapter 98-159, Laws of Florida; sections 627.64871, 627.6488, 627.6489, 627.649, and 627.6496, Florida Statutes; and section 627.6498, Florida Statutes, as amended by section 6 of chapter 98-159, Laws of Florida, are repealed effective upon the opening of the plan by the board. Sections 627.6492 and 627.6494, Florida Statutes, are repealed January 1, 2000. Effective upon the date of the opening of the plan, all individuals who have insurance coverage issued by the Florida Comprehensive Health Association on that date shall be issued insurance coverage under the plan. The association shall assume all assets and liabilities of the Florida Comprehensive Health Association.

Section 10. The sum of $50 million is appropriated from the General Revenue Fund to the Florida Health Endowment Trust Fund.

Section 11. This act shall take effect July 1, 1999, contingent upon the sum of $50 million being appropriated to the Florida Health Endowment Trust Fund.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 1800

1. Clarifies that the designee of the Secretary of Health be from the Department of Health and the designee of the Insurance Commissioner be from the Insurance Department. These members will serve on the board of the Florida Health Endowment Association (FHEA).

2. Adds "Definitions" and "Eligibility" sections. The "Definitions" section defines certain terms regarding the structure and operation of the FHEA. Clarifies that the Department of Health is the agency responsible for approving all the FHEA articles, bylaws, and operating rules.

   The "Eligibility" section provides that a Florida resident shall be eligible for the FHEA plan provided he or she receives a notice of rejection or refusal to issue substantially similar coverage for health reasons by an insurer licensed to issue coverage in Florida, or at rates higher than the FHEA plan rates. Verification of residency is required. The board is given the authority to provide exceptions to the eligibility criteria by promulgating a list of medical or health conditions which would guarantee eligibility for the plan without applying and being rejected for coverage in the standard market. Also, resident dependent unmarried children of the insured are eligible, provided that no other coverage is available.

   Restrictions for eligibility are included: persons who have or obtain substantially similar coverage (with the exception of COBRA); residents of public institutions or prisons, persons whose premiums are paid under any government sponsored program; persons who have reached the lifetime maximum of $500,000 in covered benefits; or persons who are eligible for Medicaid, unless their illness or disease requires supplies or medication which are covered under the FHEA plan, but not covered under Medicaid. The circumstances under which coverage will cease are specified as are provisions for the use of a case management system. Reentry into the FHEA is allowed, though currently prohibited under the Florida Comprehensive Health Association. However, a person reentering would be subject to any new pre-existing condition limitations in effect at the time and previous claim payments would be applied to the $500,000 lifetime maximum benefit limit.

3. Repeals all provisions under the Florida Comprehensive Health Association (FCHA) effective January 1, 2000. Provides that effective upon the opening of the comprehensive health insurance plan adopted by the FHEA, all individuals covered under FCHA shall be issued insurance coverage under FHEA. Provides that FHEA will assume all assets and liabilities of the FCHA. Deletes the provision allowing an assessment against insurers and health maintenance organizations for the operating

losses of the FHEA.

4. Provides that $50 million is appropriated from the General Revenue Fund to the Florida Health Endowment Trust Fund (created by CS/SB 1802) and that the act shall take effect contingent upon the $50 million being appropriated to the Trust Fund.