

By Senator Latvala

19-199A-00

1 A bill to be entitled
2 An act relating to health care; creating the
3 Florida Health Endowment Association; providing
4 for appointment of a board of directors;
5 providing a limitation on the liability of
6 members, employees of the association, and
7 representatives of the Department of Health
8 when performing responsibilities of the
9 association; providing for open meetings;
10 prescribing duties of the board; authorizing
11 the board to administer the Florida Health
12 Endowment Trust Fund; providing for the
13 adoption of a comprehensive health insurance
14 plan for state residents; providing for the
15 establishment of a plan of operation by the
16 board that includes the assumption of all
17 assets and liabilities of the Florida
18 Comprehensive Health Association and for the
19 transfer of its remaining policyholders into
20 the plan; providing rulemaking authority;
21 specifying mandatory and discretionary powers
22 of the board; requiring an audit and report;
23 providing definitions; providing eligibility
24 requirements for persons who seek to join the
25 new comprehensive health insurance plan;
26 specifying coverages and limitations on
27 coverages as a condition of a person's
28 eligibility; providing for the selection of,
29 term of service of, and duties of the
30 administrator of the plan; providing coverages,
31 benefits, expenses, premiums, and deductibles

1 under the plan; requiring coverage provided by
2 the plan to be directly insured by the Florida
3 Health Endowment Association and requiring
4 policies to be issued by the administrator;
5 authorizing the association to contract with
6 insurers to provide disease-management
7 services; providing a tax credit for certain
8 insurers that make a contribution to the
9 association; providing conditions; repealing s.
10 627.648, F.S., which provides for the Florida
11 Comprehensive Health Association Act; repealing
12 s. 627.6482, F.S., relating to definitions;
13 repealing s. 627.6484, F.S., relating to
14 termination of enrollment; repealing s.
15 627.6486, F.S., relating to eligibility;
16 repealing s. 627.6487, F.S., relating to
17 availability of individual health insurance
18 coverage; repealing s. 627.64871, F.S.,
19 relating to certification of coverage;
20 repealing s. 627.6488, F.S., relating to the
21 creation of the Florida Comprehensive Health
22 Association; repealing s. 627.6489, F.S.,
23 relating to the disease-management program;
24 repealing s. 627.649, F.S., relating to the
25 administrator of the program; repealing s.
26 627.6496, F.S., relating to issuance of
27 policies; repealing s. 627.6498, F.S., relating
28 to minimum benefits; repealing s. 627.6492,
29 F.S., relating to participation of insurers;
30 repealing s. 627.6494, F.S., relating to
31 assessments; providing that individuals having

1 coverage issued by the Florida Comprehensive
2 Health Association will be issued coverage
3 under the plan of the Florida Health Endowment
4 Association on the effective date of the plan;
5 requiring the Florida Health Endowment
6 Association to assume the assets and
7 liabilities of the Florida Comprehensive Health
8 Association; providing an appropriation to the
9 Florida Health Endowment Association Trust
10 Fund; providing a contingent effective date.

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

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14 Section 1. Florida Health Endowment Association.--

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

17 (2)(a) The association shall operate subject to the
18 supervision and approval of a five-member board of directors.

19 The board of directors shall consist of:

20 1. The Secretary of Health, or his or her designee
21 from the Department of Health, who shall serve as chairperson
22 of the board.

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

25 3. Three members appointed by the Governor as follows:

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

28 b. One representative of the health insurance
29 industry.

30 c. One member of the public.

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

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

8 (d) The board of directors may employ persons to
9 perform the administrative and financial transactions and
10 responsibilities of the association and to perform other
11 necessary functions not prohibited by law.

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

16 (f) There is no liability on the part of, and no cause
17 of action of any nature shall arise against, any employee of
18 the association, member of the board of directors of the
19 association, or representative of the Department of Health for
20 any act or omission taken by them in the performance of their
21 powers and duties under this act, unless that act or omission
22 is in intentional disregard of the rights of the claimant.

23 (g) Meetings of the board are subject to section
24 286.011, Florida Statutes.

25 (3) The board of directors of the association shall
26 adopt a plan pursuant to this act and submit its articles,
27 bylaws, and operating rules to the Department of Health for
28 approval. If the board of directors fails to adopt such plan
29 and suitable articles, bylaws, and operating rules within 180
30 days after the appointment of the board, the department shall
31 adopt rules to implement this act, and such rules shall remain

1 in effect until superseded by a plan and articles, bylaws, and
2 operating rules submitted by the board of directors and
3 approved by the department.

4 (4) The board of directors shall:

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

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

14 (c) Establish eligibility requirements for individuals
15 participating in the plan to ensure the viability of the
16 association.

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

20 (e) Select an administrator under section 4.

21 (f) Require that all policy forms issued by the
22 association conform to standard forms developed by the
23 association. The forms must be approved by the Department of
24 Insurance.

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

29 (h) Design and employ cost-containment measures and
30 requirements that shall include preadmission certification,
31 any out-of-state health care, home health care, hospice care,

1 negotiated purchase of medical and pharmaceutical supplies,
2 and individual case management.

3 (i) Contract with preferred provider organizations and
4 health maintenance organizations giving due consideration to
5 the preferred provider organizations. If cost-effective and
6 available in the county where the policyholder resides, the
7 board, upon application or renewal of a policy, shall place an
8 individual, as established under section 5, with the plan case
9 manager who shall determine the most cost-effective quality
10 care system or health care provider and shall place the
11 individual in such system or with such health care provider.
12 Prior to and during the implementation of case management, the
13 plan case manager shall obtain input from the policyholder,
14 parent, guardian, and health care providers.

15 (j) Use a case manager or managers to supervise and
16 manage the medical care or coordinate the supervision and
17 management of the medical care of specified individuals. The
18 case manager, with the approval of the board, has final
19 approval over the case management for any specific individual.

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

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

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1 (m) Establish a comprehensive investment plan with the
2 approval of the State Board of Administration. The
3 comprehensive investment plan must specify the investment
4 policies to be used by the board in administering the fund.
5 The board may place assets of the fund in savings accounts or
6 use the fund to purchase fixed or variable life insurance or
7 annuity contracts, securities, evidence of indebtedness, or
8 other investment products pursuant to the comprehensive
9 investment plan and in such proportions as are designated or
10 approved under the investment plan. Such insurance, annuity,
11 savings, or investment products must be underwritten and
12 offered in compliance with the applicable federal and state
13 laws and rules by persons who are authorized by applicable
14 federal and state authorities. Within the comprehensive
15 investment plan, the board may authorize investment vehicles,
16 or products incident thereto, that are available or offered by
17 qualified companies or persons.

18 (n) Solicit proposals and contract under section
19 287.057, Florida Statutes, for a trustee services firm to
20 select and supervise investment programs on behalf of the
21 board. The goal of the board in selecting a trustee services
22 firm is to obtain the highest standards of professional
23 trustee services, to allow all qualified firms interested in
24 providing such services equal consideration, and to provide
25 such services to the state at no cost and to the purchasers at
26 the lowest cost possible. The trustee services firm must agree
27 to meet the obligations of the board to qualified
28 beneficiaries if moneys in the fund fail to offset the
29 obligations of the board as a result of imprudent selection or
30 supervision of investment programs by such firm. Evaluations
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1 of proposals submitted under this paragraph must include the
2 following criteria:

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

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

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

11 4. The minimum purchaser participation assumed within
12 the proposal and any additional requirements of purchases.

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

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

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

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

22 (o) Make a report to the Governor, the President of
23 the Senate, the Speaker of the House of Representatives, and
24 the Minority Leaders of the Senate and the House of
25 Representatives not later than October 1 of each year. The
26 report must summarize the activities of the plan for the
27 12-month period ending December 31 of the previous year,
28 including then-current data and estimates as to net written
29 and earned premiums, the expense of administration, the paid
30 and incurred losses for the year, the financial status of the
31 Florida Health Endowment Trust Fund, and any recommendations

1 by the actuary and actions by the board for the opening or
2 closing of the plan. The report shall also include analysis
3 and recommendations for legislative changes regarding
4 utilization review, quality assurance, an evaluation of the
5 administrator of the plan, access to cost-effective health
6 care, and the cost-containment and case-management policy and
7 recommendations concerning the opening of enrollment.

8 (p) Establish a plan of operation which includes the
9 assumption of all assets and liabilities of the Florida
10 Comprehensive Health Association and the transition of its
11 remaining policyholders into the plan.

12 1. The plan must include directives for calculating,
13 issuing, and collecting the final assessment for operating
14 losses of the Florida Comprehensive Health Association as
15 defined in section 627.6488(4)(d), Florida Statutes.

16 2. The plan must ensure that remaining Florida
17 Comprehensive Health Association policyholders, including
18 those currently enrolled in Medicare, will not be subjected to
19 a new pre-existing condition waiting period. In addition,
20 those individuals will retain the remaining lifetime benefits
21 available under their prior Florida Comprehensive Health
22 Association policy, subject to the viability of the plan.

23 (5) The board may:

24 (a) Adopt articles and rules.

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

27 (c) Sue or be sued.

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

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

1 (f) Invest funds not required for immediate
2 disbursement.

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

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

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

13 (j) Contract for necessary goods and services; employ
14 necessary personnel; and engage the services of private
15 consultants, actuaries, managers, legal counsel, and auditors
16 for administrative or technical assistance.

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

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

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

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

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

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1 (6) The Auditor General shall conduct a performance
2 audit, including a review of the annual financial audit and
3 the annual report prepared by the board. The report shall
4 critique the affairs of the association and shall be submitted
5 to the President of the Senate and the Speaker of the House of
6 Representatives prior to the legislative session. The Auditor
7 General may require and receive from the association, its
8 administrator, and its independent auditor any detail or
9 supplemental data relative to the operation of the
10 association.

11 Section 2. Definitions.--As used in sections 1-8 of
12 this act, the term:

13 (1) "Association" means the Florida Health Endowment
14 Association.

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

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

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

23 (5) "Federal poverty level" means the level
24 established by the Economic Service Department of Children and
25 Families and in effect on the date of the policy and its
26 annual renewal.

27 (6) "Household" means a person or group of persons
28 living together in a room or group of rooms as a housing unit,
29 but the term does not include persons boarding in or renting a
30 portion of the dwelling.

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1 (7) "Household or family income" means the adjusted
2 gross income, as defined in s. 62 of the United States
3 Internal Revenue Code, of all members of a household.

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

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

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

15 (11) "Plan of operation" means the articles, bylaws,
16 and operating rules and procedures adopted by the board under
17 section 1.

18 (12) "Plan" means the comprehensive health insurance
19 plan adopted by the association.

20 (13) "Resident" means a person who is legally
21 domiciled in this state.

22 (14) "Transferee" means any person who:

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

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

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

6 Section 3. Eligibility.--

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

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

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

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

20 (2) The board or administrator shall require
21 verification of residency and shall require any additional
22 information or documentation or statements under oath when
23 necessary to determine residency upon initial application and
24 for the entire term of the policy.

25 (3) The board shall adopt a list of medical or health
26 conditions for which a person is eligible for plan coverage
27 without applying for health insurance under subsection (1).
28 Persons who demonstrate the existence or history of any
29 medical or health conditions on the list adopted by the board
30 are not required to provide the evidence specified in

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1 subsection (1). The list is effective on the first day of the
2 operation of the plan and may be amended as appropriate.

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

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

16 (a) The person has or obtains health insurance
17 coverage substantially similar to or more comprehensive than a
18 plan policy, or would be eligible to have coverage if the
19 person elected to obtain it.

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

22 (c) The person's premiums are paid for or reimbursed
23 under any government-sponsored program or by any government
24 agency or health care provider, except as an agency or health
25 care provider.

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

28 (e) The person is eligible, on the date of issue of
29 coverage under the plan, for substantially similar coverage
30 under another contract or policy, unless such coverage is
31 provided pursuant to the Consolidated Omnibus Budget

1 Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat.
2 82(1986)(COBRA), as amended, and scheduled to end at a time
3 certain and the person meets all other requirements of
4 eligibility. Coverage provided by the association shall be
5 secondary to any coverage provided by an insurer pursuant to
6 COBRA.

7 (f) The person is currently enrolled for health care
8 benefits under the Medicare programs.

9 (6) Coverage ceases:

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

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

13 (c) Upon the date of death of the covered person;

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

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

19 (7) All eligible persons must, upon application or
20 renewal, agree to be placed in a case-management system when
21 it is determined by the board and the plan case manager that
22 such system will be cost-effective and provide quality care to
23 the individual.

24 (8) The coverage of any person who ceases to meet the
25 eligibility requirements may be terminated immediately. If
26 such person again becomes eligible for subsequent coverage
27 under the plan, any previous claims payments must be applied
28 towards the \$500,000 lifetime maximum benefit, and any
29 limitation relating to preexisting conditions in effect at the
30 time such person again becomes eligible applies to such
31 person.

1 Section 4. Administrator.--

2 (1) The board shall select an administrator, through a
3 competitive bidding process, to administer the plan. The board
4 shall evaluate bids based on criteria established by the
5 board, which must include:

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

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

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

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

15 (2) The administrator serves for a period of 3 years
16 unless otherwise determined by the board. At least 1 year
17 prior to the expiration of each 3-year period of service by an
18 administrator, the board shall invite all insurers, including
19 the current administering insurer, to submit bids to serve as
20 the administrator for the succeeding 3-year period. The
21 selection of the administrator for the succeeding period must
22 be made at least 6 months prior to the end of the current
23 3-year period.

24 (3) The administrator may:

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

28 (b) Pay an agent's referral fee as established by the
29 board to each insurance agent who refers an applicant to the
30 plan, if the applicant's application is accepted. The selling
31 or marketing of plans is not limited to the administrator or

1 its agents. However, any agent must be selected by the board
2 and licensed by the Department of Insurance to sell health
3 insurance in this state. The referral fees must be paid by the
4 administrator from moneys received as premiums for the plan.

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

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

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

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

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

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

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

27 (g) Pay claims expenses from the premium payments
28 received from or on behalf of covered persons under the plan.
29 If the payments by the administrator for claims expenses
30 exceed the portion of premiums allocated by the board for
31 payment of claims expenses, the board must provide the

1 administrator with additional funds for payment of claims
2 expenses to the extent that such funds are available.

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

6 (b) As used in this subsection, the term "direct and
7 indirect expenses" includes that portion of the audited
8 administrative costs, printing expenses, claims administration
9 expenses, management expenses, building overhead expenses, and
10 other actual operating and administrative expenses of the
11 administering insurer which is approved by the board as
12 allocable to the administration of the plan and included in
13 the bid specifications.

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

16 (1) COVERAGE OFFERED.--

17 (a) The plan must offer in an annually renewable
18 policy the coverage specified in this section for each
19 eligible individual.

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

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

30 (2) BENEFITS.--The plan must offer major medical
31 expense coverage to every eligible person, subject to

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

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

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

14 (a) The plan may provide for annual deductibles for
15 major medical expense coverage in the amount of \$1,000 or any
16 higher amounts proposed by the board and approved by the
17 Department of Insurance, plus the benefits payable under any
18 other type of insurance coverage or workers' compensation. The
19 schedules of premiums and deductibles must be established by
20 the association.

21 1. Separate schedules of premium rates based on age,
22 gender, and geography may apply for individual risk.

23 2. Rates are subject to approval by the Department of
24 Insurance.

25 3. Standard risk rates for coverage issued by the
26 association must be established under section 627.6675(3),
27 Florida Statutes. Rates established by the board may not
28 exceed 200 percent of the standard risk rate.

29 4. The board shall establish three separate premium
30 schedules:

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1 a. Schedule A is applicable to an individual whose
2 family income exceeds the allowable amount for determining
3 eligibility under the Florida Medicaid program, up to and
4 including 200 percent of the Federal Poverty level. Premiums
5 for a person under this schedule may not exceed 5 percent of
6 the family income of an eligible person.

7 b. Schedule B will be applicable to a person whose
8 family income exceeds 200 percent of the Federal Poverty level
9 and whose combined premiums and deductible exceed 7.5 percent
10 of the family income of the person.

11 c. Schedule C will be applicable to a person whose
12 family income exceeds 200 percent of the Federal Poverty level
13 and whose combined premiums and deductible do not exceed 7.5
14 percent of the family income of the person.

15 (b) For persons eligible under Schedule A that uses
16 the preferred provider network, the plan shall pay 100 percent
17 of the covered cost incurred by the person during the policy
18 term. No cost will be covered for services provided by
19 non-network providers.

20 (c) For persons eligible under Schedule B, if covered
21 costs incurred by the eligible person exceed the deductible
22 for major medical expense coverage selected by the person in a
23 policy year, the plan must pay in the following manner:

24 1. For persons placed under case management, after
25 satisfaction of the deductible, the plan must pay 90 percent
26 of the additional covered cost incurred by the person during
27 the policy year for the first \$10,000, after which the plan
28 must pay 100 percent of the covered costs incurred by the
29 person during the policy year.

30 2. For persons using the preferred provider network,
31 after satisfaction of the deductible, the plan must pay 80

1 percent of the additional covered cost incurred by the person
2 during the policy year for the first \$10,000, after which the
3 plan must pay 90 percent of covered costs incurred by the
4 person during the policy year.

5 3. If the person does not use the case management
6 system or the preferred provider network, after satisfaction
7 of the deductible, the plan must pay 60 percent of the
8 additional covered costs incurred by the person for the first
9 \$10,000, after which the plan must pay 70 percent of the
10 additional cost incurred by the person during the policy year.

11 (d) For persons eligible under Schedule C, if covered
12 costs incurred by the eligible person exceed the deductible
13 for major medical expense coverage selected by the person in a
14 policy year, the plan must pay in the following manner:

15 1. For persons placed under case management, after
16 satisfaction of the deductible, the plan must pay 90 percent
17 of the additional covered cost incurred by the person during
18 the policy year.

19 2. For persons using the preferred provider network,
20 after satisfaction of the deductible, the plan must pay 80
21 percent of the additional covered cost incurred by the person
22 during the policy year.

23 3. If the person does not use the case management
24 system or the preferred provider network, after satisfaction
25 of the deductible, the plan must pay 60 percent of the
26 additional covered cost incurred by the person during the
27 policy year.

28 (e) All premiums paid to the association must be
29 deposited with the Florida Health Endowment Association.

30 (f) Notwithstanding the provisions of section 624.509,
31 Florida Statutes, premiums for coverage are, as to the

1 association and participating insurers, exempt from premium
2 taxation.

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

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

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

13 (6) OTHER SOURCES PRIMARY.--

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

21 (b) The association has a cause of action against a
22 participant for any benefits paid to the participant which
23 should not have been claimed or recognized as claims because
24 of the provisions of this subsection or because the condition
25 is not covered.

26 (7) NONENTITLEMENT.--This section does not provide an
27 individual with an entitlement to health care services or
28 health insurance. A cause of action does not arise against the
29 state, the board, or a unit of local government for failure to
30 make health services for health insurance available under this
31 section.

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

5 Section 6. Disease management services.--

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

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

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

18 Section 7. Tax Credits.--

19 (1)(a) Any insurance company subject to premium tax
20 liability under section 624.509, Florida Statutes, which makes
21 a contribution to the Florida Health Endowment Association
22 earns a vested credit against premium tax liability equal to
23 100 percent of the contribution. Insurance companies may use
24 not more than 25 percentage points of the vested premium tax
25 credit, including any carryforward credits under this act, per
26 year beginning with premium tax filings for calendar year
27 2002. Any premium tax credits not used in any single year may
28 be carried forward and applied against the premium tax
29 liabilities for subsequent calendar years.

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

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

12 (2) The claim of a transferee of an insurance
13 company's unused premium tax credit must be permitted in the
14 same manner and subject to the same provisions and limitations
15 of this act as is the original insurance company.

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

22 Section 9. Section 627.648, Florida Statutes, section
23 627.6482, Florida Statutes, sections 627.6484 and 627.6486,
24 Florida Statutes, section 627.6487, Florida Statutes, sections
25 627.64871, 627.6488, 627.6489, 627.649, and 627.6496, Florida
26 Statutes, and section 627.6498, Florida Statutes, are repealed
27 effective upon the opening of the plan by the board. Sections
28 627.6492 and 627.6494, Florida Statutes, are repealed January
29 1, 2001. Effective upon the date of the opening of the plan,
30 all individuals who have insurance coverage issued by the
31 Florida Comprehensive Health Association on that date must be

1 issued insurance coverage under the plan. The Florida Health
2 Endowment Association shall assume all assets and liabilities
3 of the Florida Comprehensive Health Association.

4 Section 10. The sum of \$50 million is appropriated
5 from the General Revenue Fund to the Florida Health Endowment
6 Trust Fund to carry out the provisions of this act during the
7 2000-2001 fiscal year.

8 Section 11. The act shall take effect July 1, 2000,
9 contingent upon the sum of \$50 million being appropriated to
10 the Florida Health Endowment Trust Fund.

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13 SENATE SUMMARY

14 Repeals the Florida Comprehensive Health Association Act.
15 Creates the Florida Health Endowment Association to adopt
16 a comprehensive health insurance plan for state
17 residents. Provides for appointment of a board of
18 directors of the association. Prescribes duties of the
19 board and limits members' liability for actions
20 undertaken while performing responsibilities of the
21 association under certain circumstances. Provides for
22 open board meetings. Authorizes the board to administer
23 the Florida Health Endowment Trust Fund. Provides for a
24 plan of operation by the board that includes the
25 assumption of assets and liabilities of the Florida
26 Comprehensive Health Association, and provides for the
27 transfer of its members into the new comprehensive plan.
28 Provides rulemaking authority and specifies mandatory and
29 discretionary powers of the Board. Provides eligibility
30 requirements for persons who want to join the new plan.
31 Specifies amounts of coverages and limitations on
coverages as a condition of eligibility. Provides for
selection and duties of the plan's administrator.
Provides coverages, benefits, expenses, premiums, and
deductibles under the plan. Requires coverage under the
plan to be insured by the association and to be issued by
the administrator. Authorizes the association to contract
with insurers to provide disease management services.
Provides a tax credit for certain insurers that
contribute to the association. Provides a \$50 million
appropriation to the Florida Health Endowment Trust Fund.
Provides a contingent effective date.