STORAGE NAME: h0645.hcs
DATE: January 20, 2000

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 645

RELATING TO: Health Care

SPONSOR(S): Representatives C. Green, Jones, and others

TIED BILL(S): HB 647

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES
(2) INSURANCE
(3) FINANCE & TAXATION
(4) HEALTH & HUMAN SERVICES APPROPRIATIONS
(5)

I. SUMMARY:

HB 645 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, 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 of $50 million from the General Revenue Fund to the Florida Health Endowment Trust Fund. (The trust fund is created by a tied bill, HB 647.)

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

Less Government: The bill requires additional duties for the Department of Health, as follows:

Section 1 requires the Secretary of the Department of Health, or his or her designee, to serve as the chairman of the Florida Health Endowment Association. As a member of the board, he or she is required to adopt a plan pursuant to this act and submit its articles, bylaws, and operating rules to the Department of Health for approval. If the department does not approve the rules, the department must adopt rules to implement the act. The rules remain in effect until the Association's rules are adopted, at which time the department's rules are "superseded." [Note: This section conflicts with s. 120.54(3), F.S., which provides a process for making and of repealing rules.]

B. 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 within 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), $1.9 million (1997), $4.9 million (1998), $4.5 million (1999). It is estimated that assessment/loss for fiscal year 2000 is similar to last year.

In 1997, 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 *Summary of Plan Activities, 1998-99,* the FCHA offered the following solutions to provide coverage for the uninsured:

1. Establish a State endowment;
2. Use the proceeds from the endowment to support coverage for risk pool policyholders;
3. Permit new enrollments only to the limits of the funding available from the endowment;
4. Eliminate the need to collect assessments from insurers and HMO's; and
5. Enable several thousand Floridians to obtain insurance coverage that was otherwise unavailable to them, thus improving their lives and reducing the need for taxpayers to subsidize their health care.

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) in its May 1999 report, *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards*, 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 December 1999, enrollment totaled 800 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 1991-99 is depicted in the following:

FY	Average Number of Enrollees	Avg. Cost to Insurers (Amt assessed per member)	Average Premium Paid by Enrollee	Average Total Expenses Per Enrollee
*1999	855	4634	3414	9336
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
1992	4528	1576	3355	5036
1991	5639	990	3824	4911

*Estimated based on financial information through September 1999.

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, 1998 totaled $4.6 million, and for 1999 are estimated to be approximately $4.5 million.

C. 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 percent of the vested premium tax credit, including carry-forward credits, per year.

The bill provides for $50 million from General Revenue.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates the "Florida Health Endowment Association."

Subsection (1) creates the association as a nonprofit legal entity.

Subsection (2) requires the association to operate subject to the supervision and approval of a five-member board of directors, consisting of:

- The Secretary of Health, or his or her designee from the Department of Health, who will serve as the chairperson;
- The Insurance Commissioner, or his or her designee from the Department of Insurance; and
- Three members appointed by the Governor, as follows:

    1. One representative of policyholders who is not associated with the medical profession or a hospital;
    2. One representative of the health insurance industry; and
    3. One member of the public.

Prohibits the administrator of the plan, or his or her affiliate, from serving as a member of the board. Provides that any appointed board member may be removed and replaced by his or her appointor at any time without cause. Requires that all appointed board members, including the chairperson, must be appointed to staggered 3-year terms, beginning on a date established in the plan of operation.

Authorizes, but does not require, the board of directors to employ persons to perform the administrative and financial transactions and responsibilities of the association and to perform other necessary functions not prohibited by law. Provides that board members may be reimbursed from moneys of the association for actual and necessary expenses incurred by them as members, but prohibits other compensation for their services. Provides that there is no liability on the part of, and specifies that no cause of action of any nature can arise against, any employee of the association, member of the board of directors of the association, or 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, except if that act or omission is in intentional disregard of the rights of the claimant. Provides that the meetings of the board are subject to s. 286.011, Florida Statutes.

Subsection (3) requires the board of directors of the association to adopt a plan in accordance with 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 a plan and suitable articles, bylaws, and operating rules within 180 days after the appointment of the board, the Department of Health must adopt rules to implement this act, and those rules must remain in effect until superseded by a plan and articles, bylaws, and operating rules submitted by the board of directors which have been approved by the Department of Health.

Subsection (4) requires the board of directors to: establish administrative and accounting procedures for the operation of the association; contract with an actuary which will evaluate the pool of insureds in the plan, monitor the financial status of the Trust Fund, recommend to the board the opening and closing of the plan based on an analysis of the trust fund, the income of the trust fund, and any premiums, deductibles, and coinsurance paid to the association.

Requires the board of directors to:

- Establish eligibility requirements for individuals participating in the plan to ensure the viability of the association;
- Establish procedures under which applicants in the plan may have grievances reviewed by an impartial body and reported to the board;
- Select an administrator under section 4;
- Require that all policy forms issued by the association conform to standard forms developed by the association and that all forms be approved by the Department of Insurance;
- 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; and
- Design and employ cost-containment measures and requirements that shall include preadmission certification, any out-of-state health care, home health care, hospice care, negotiated purchase of medical and pharmaceutical supplies, and individual case management.

Requires the plan to contract with preferred provider organizations and health maintenance organizations while giving due consideration to the preferred provider organizations. Provides that if it is cost-effective and available in the county where the policyholder resides, the board, upon application or renewal of a policy, must place the individual with the plan case manager. The plan case manager must determine the most cost-effective quality care system or health care provider and must place the individual in such system or with such health care provider. Requires that prior to and during the implementation of case management, the plan case manager must obtain input from the policyholder, parent, guardian, and health care providers. Requires the use of 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. Grants the case manager, with the approval of the board, final approval over the case management for any specific individual.

Requires the board of directors to 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.

Directs the board of directors to administer the Florida Health Endowment Trust Fund in a manner that is sufficiently actuarially sound to defray the obligations of the program. Requires the board of directors to annually evaluate or cause to be evaluated the actuarial soundness of the Trust Fund. Authorizes the board of directors, when it perceives a need for additional assets to preserve actuarial soundness, to adjust the benefits or restrict enrollment of the plan to ensure the soundness of the Trust Fund.

Requires the board of directors to establish a comprehensive investment plan with the approval of the State Board of Administration. Requires that the comprehensive investment plan must specify the investment policies to be used by the board in administering the fund. Authorizes the board to 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. Requires that any 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. Allows the board to, within the comprehensive investment plan, authorize investment vehicles, or products incident thereto, that are available or offered by qualified companies or persons.

Requires the board of directors to solicit proposals and contract under s. 287.057, F.S., for a trustee services firm to select and supervise investment programs on behalf of the board. Provides that the goal of the board in selecting a trustee services firm is to obtain the highest standards of professional trustee services, to allow all qualified firms interested in providing such services equal consideration, and to provide those services to the state at no cost and to the purchasers at the lowest cost possible. Requires the trustee services firm to 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. Provides that evaluations of trustee services proposals be reviewed based on specified criteria.

Requires the board of directors to 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 no later than October 1 of each year. Requires that 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 Trust Fund; any recommendations made by the actuary; and actions by the board for the opening or closing of the plan. Requires the report to also include the 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 along with the recommendations concerning the opening of enrollment.

Requires the board to establish a plan of operation which includes the assumption of all assets and liabilities of the Florida Comprehensive Health Association and the transition of its remaining policyholders into the plan. Requires the plan to also include directives for calculating, issuing, and collecting the final assessment for operating losses of the Florida Comprehensive Health Association as defined in s. 627.6488(4)(d), F.S. Requires the plan to ensure that remaining Florida Comprehensive Health Association policyholders, including those currently enrolled in Medicare, not be subjected to a new pre-existing condition waiting period. Requires that those policyholders will retain the remaining lifetime benefits available under their prior Florida Comprehensive Health Association policy, subject to the viability of the plan.

Subsection (5) allows the board to do the following:

- Adopt articles and rules;
- Exercise powers granted to insurers under the laws of this state;
- Sue or be sued;
- Make and execute contracts and other necessary instruments;
- Prepare or contract for a performance audit of the administrator of the association;
- Invest funds not required for immediate disbursement;
- Appear in its own behalf before boards, commissions, or other governmental agencies; and
- Hold, buy, and sell any instruments, obligations, securities, and property determined appropriate by the board.

Authorizes the board to restrict the number of participants in the plan based on actuarial estimates. Requires that any person denied participation solely on the basis of such restriction must be granted priority on a first-come, first-served basis for participation in the succeeding years in which the plan is reopened for participants.

Authorizes the board to:

- Contract for necessary goods and services;
- Employ necessary personnel;
- Engage the services of private consultants, actuaries, managers, legal counsel, and auditors for administrative or technical assistance;
- 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 act;
- 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;
- Procure insurance against any loss in connection with the property, assets, and activities of the fund or the board;
- Establish other policies, procedures, and criteria to implement and administer this section; and
- Adopt procedures to govern contract dispute proceedings between the board and its vendors.

Subsection (6) requires the Auditor General to conduct a performance audit, including a review of the annual financial audit and the annual report prepared by the board. The report must critique the affairs of the association and must be submitted to the President of the Senate and the Speaker of the House of Representatives prior to the legislative session. Authorizes the Auditor General to require and receive from the

association, its administrator, and its independent auditor any detail or supplemental data relative to the operation of the association.

Section 2. Provides definitions for 14 specific terms relating to the structure and operation of the Florida Health Endowment Association.

Section 3. Creates eligibility provisions for the Florida Health Endowment Association (FHEA).

Subsection (1) provides that specified Florida residents are eligible for the FHEA plan if he/she provides 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.

Subsection (2) authorizes verification of residency.

Subsection (3) authorizes the board to provide exceptions to the eligibility criteria by adopting 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.

Subsection (4) specifies that resident dependent unmarried children of the insured are eligible, provided that no other coverage is available until the child is married, ceases to be a dependent of the insured, or age 19, whichever occurs first. However, if the dependent 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.

Subsection (5) provides restrictions on eligibility:

- 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;
- The person is an inmate or resident of a public institution or correction facility;
- 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;
- The person has received $500,000 in covered benefits that have been paid out pursuant to the plan;
- 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;
- The person is currently enrolled for health care benefits under the Medicare programs.

Subsection (6) indicates that coverage ceases:

- On the date a person is no longer a resident of this state;
- On the date a person requests coverage to end;
- Upon the date of death of the covered person;

- On the date state law requires cancellation of the policy; or
- 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.

Subsection (7) requires all eligible persons, upon application or renewal, to 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.

Subsection (8) provides for immediate termination of coverage of any person who ceases to meet the eligibility requirements. Provides that if such person again becomes eligible for subsequent coverage under the plan, any previous claims payments are required to 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 applies to such person.

Section 4. Provides for administrator responsibilities under the FHEA.

Subsection (1) requires the board to competitively select an administrator to administer the plan. Administrator bids are to be reviewed based on specified criteria.

Subsection (2) indicates that the administrator serves for a period of 3 years, and specifies the timeframes and process for subsequent administrator selection, as well as who can be an administrator.

Subsection (3) authorizes the administrator to:

- Perform all eligibility and administrative claims-payment functions relating to the plan, as prescribed by the board;
- 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. Requires that any agent must be selected by the board and licensed by the Department of Insurance to sell health insurance in this state. Requires that the referral fees must be paid by the administrator from moneys received as premiums for the plan;
- Establish a premium-billing procedure for collecting premiums from insured persons. Billings must be made periodically as determined by the board;
- Perform all necessary functions to assure timely payment of benefits under the plan, including those relating to claims forms, claim eligibility, and claim acceptance, rejection, or compromise;
- Submit regular reports to the board regarding the operation of the plan. The frequency, content, and form of the reports must be determined by the board;
- 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; and
- Pay claims expenses from the premium payments received from or on behalf of covered persons under the plan. Provides that 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 is required to provide the administrator with additional funds for payment to the extent that such funds are available.

Subsection (4) requires that the administrator must be paid, as provided in the contract of the association, for its direct and indirect expenses incurred in the performance of its services. Specifically, defines the term "direct and indirect expenses" in this context.

Section 5. Provides for minimum benefits coverage, exclusions, premiums, and deductibles.

Subsection (1) specifies that the plan must offer an annual renewable policy for each eligible individual. Specifies that any person whose health insurance is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan subject to specified limitations. Prohibits coverage to be issued as a Medicare supplement policy, as defined in s. 627.672, F.S., to a person eligible for Medicare benefits.

Subsection (2) requires the plan to offer major medical expense coverage to every eligible individual, subject to limitations set by the board. Major medical expense coverage offered under the plan must pay the eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized. The maximum lifetime benefits allowed are $500,000, per covered individual. The maximum limit may not be altered by the board, and no actuarial equivalent benefit may be substituted by the board.

Subsection (3) requires that plan coverage, at a minimum, to be patterned after the standard individual health insurance plan approved by the Department of Insurance.

Subsection (4) authorizes the plan to provide for annual deductibles for major medical expenses in the amount of $1,000 or any higher amounts proposed by the board and approved by the Department of Insurance, plus benefits payable under any other type of insurance coverage or workers' compensation. Requires that separate schedules of premium rates and deductibles be established by the association based on: age, gender, and geography (for individual risk) subject to approval by the Department of Insurance; and established under s. 627.6675(3), F.S., relating to conversion or termination of eligibility.

Authorizes separate premium schedules as follows:

- Schedule A applies to an individual whose family income exceeds the allowable amount for determining eligibility under the Florida Medicaid program, up to and including 200 percent of the federal poverty level. Premiums for a person under this schedule may not exceed 5 percent of the family income of an eligible person. For persons using the preferred provider network, the plan pays 100 percent of the covered costs incurred by the person, during the policy term. The plan does not pay for services provided by non-network providers.

- Schedule B applies to a person whose family income exceeds 200 percent of the federal poverty level and whose combined premiums and deductible exceed 7.5 percent of the family income of the person. For persons placed under case management, after satisfaction of the deductible, the plan pays 90 percent of the additional covered cost incurred during the policy year up to the first $10,000, after which the plan pays 100 percent of the covered costs incurred by the person during the policy year. For persons using the preferred provider network and after satisfaction of the deductible, the plan pays 80 percent of the additional covered cost incurred by the person during the policy year for the first $10,000, after which

the plan pays 90 percent of the covered costs incurred by the person during the policy year. For persons not placed under case management or not utilizing the preferred provider network, after satisfaction of the deductible, the plan must pay 60 percent of the additional covered costs incurred by the person for the first $10,000, after which the plan pays 70 percent of the additional costs incurred by the person during the policy year.

- Schedule C will be applicable to a person whose family income exceeds 200 percent of the federal poverty level and whose combined premiums and deductible do not exceed 7.5 percent of the family income of the person. For persons placed under case management, after satisfaction of the deductible, the plan pays for 90 percent of the additional cost incurred by the person during the policy year. For persons using the preferred provider network, after satisfaction of the deductible, the plan must pay 80 percent of the additional covered cost incurred by the person during the policy year. For persons not placed under case management or not utilizing the preferred provider network, after satisfaction of the deductible, the plan pays for 60 percent of the additional covered costs incurred by the person during the policy year.

Requires that all premiums paid to the association must be deposited with the Florida Health Endowment Association. Provides an exception from premium taxation under s. 624.509, F.S., for FHEA premiums for coverage.

Subsection (5) authorizes a 12 month exclusion for preexisting conditions if the condition manifested itself within 6 months before the effective date of coverage or medical advice or treatment was recommended or received with 6 month before the effective date of coverage.

Subsection (6) grants the association a cause of action against a participant for any benefits paid to the participant which should not have been claimed. Specifies that any amounts paid or payable by Medicare, any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, is prohibited from being made or recognized as claims under the policy or recognized as or count towards satisfaction of applicable deductibles or out-of-pocket maximums or to reduce the limits of benefits available.

Subsection (7) specifies that this section does not create an entitlement to health care services or health insurance and that a cause of action does not arise against the state or board for failure to make health services for health insurance available under this section.

Subsection (8) specifies that coverage provided under this plan must be directly insured by the Florida Health Endowment Association and that policies must be issued by the administrator.

Section 6. Authorizes the Florida Health Endowment Association to contract with insurers to provide disease management services for insurers that elect to participate. Revenues collected by the association for this purpose are to be used to pay the administrative expenses of the disease management program.

Section 7. Relates to tax credits and allows any insurance company subject to premium tax liability pursuant to s. 624.509, F.S., who contributes to the Florida Health Endowment Association, to earn a vested credit against premium tax liability equal to 100 percent of the

contribution. However, this provision limits the annual use of the vested premium tax credit, including any carry-forward credits, to 25 percent, beginning with tax filings for calendar year 2001. This section 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 8. Allows the state to terminate the plan if it determines the plan is financially infeasible. Participants shall be entitled to exercise the complete benefits for which are contracted, but additional participants may not be permitted to enter the plan.

Section 9. Specifies certain sections of the Florida Statutes related to the current powers of the Florida Comprehensive Health Association) are to be repealed effective upon the date of the opening of the Florida Health Endowment plan or effective January 1, 2000. Provides that, effective upon the date of the opening of the plan, that all individuals who have insurance coverage issued by the Florida Comprehensive Health Association shall be issued insurance coverage under the plan. Also, provides that the Florida Health Endowment Association shall assume all assets and liabilities of the Florida Comprehensive Health Association

Section 10. Specifies that an appropriation of $50 million be made from the General Revenue Fund to the Florida Health Endowment Trust Fund. The Trust Fund is created under a tied bill (HB 647).

Section 11. Provides that the act will take effect July 1, 2000, contingent upon the $50 million being appropriated to the Florida Health Endowment Trust Fund.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Department of Insurance: The bill provides for tax credits which affect retaliatory taxes and premium tax credits would appear to impact General Revenue.

2. Expenditures:

The bill provides for an appropriation of $50 million from the General Revenue Fund. The July 1, 2000, effective date of the bill is contingent upon the $50 million being appropriated to the Florida Health Endowment Trust Fund.

Office of the Auditor General: The Office of the Auditor General estimates that the requirement for annual audits of the association would require two additional staff, assuming that the audits would be full operational, compliance, and performance audits.

Department of Health:

Non-Recurring or First Year Start-Up Effects:	Year 1 (25% Lapse)	Year 2

Expenses:		
SMA II Standard Package	$ 4,180	
SES Executive Aid	$ 4,180	
Sub Total Expense	$8,360	
OCO:		
SMA II Standard Package	$ 3,330	
SES Executive Aid	$ 3,330	
Sub Total OCO	$ 6,660	
Total Non-Recurring Costs	$ 15,020	
Recurring or Annualized Continuation Effects:		
Salaries/Benefits:		
SMAII (1.00 FTE)	$ 44,224	$ 58,965
SES Executive Aid (1.0 FTE)*	$ 73,125	$ 97,500
*Based on $75,000 annual salary and fringe benefits at 30% of salary		
Sub Total Salaries/Benefits	$117,349	$158,465
Expenses:		
SMAII	$ 8,354	$ 11,138
SES Executive AID	$ 8,354	$ 11,138
Sub Total Salaries/Benefits:	$ 16,708	$ 22,276
Total Recurring Costs	$149,077	$178,741

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill would allow individuals who are not able to obtain health insurance to benefit from the establishment of the association.

D. FISCAL COMMENTS:

According to the Department of Health, the department will need funds to create a position to assist the Secretary with his responsibilities as chairperson of the Board of Directors. The department will need to recruit an individual with expert knowledge of health insurance regulation. The department anticipates that a $75,000 annual salary will be necessary to recruit a qualified individual. In addition, funds will be needed to establish a position to manage the contract with the association. Given the technical and complex nature of the work of the association, a person with knowledge of insurance regulation or insurance company operations will be needed to manage the contract.

In addition, if the Board of Directors of the association fails to approve a plan, bylaws, and rules for the program within 180 days after it is appointed, the department will be required to develop articles, by-laws, and operating rules. If this occurs, funds will be needed to contract with an entity with expert knowledge in insurance regulation for the development of these products. These activities will be beyond the scope of one individual (the executive aid position) to do in a timely manner. The department estimates that up to $250,000 will be needed to purchase expert assistance to produce these products.

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 counties or municipalities 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 state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

According to the Joint Administrative Procedures Committee, the association, as a non-profit organization, is generally not considered to be an agency pursuant to the definition in s. 120.52(1), F.S., and therefore, is not subject to the administrative procedures requirements for rulemaking.

C. OTHER COMMENTS:

According to the Department of Health, the department's mission does not include a focus on regulating or brokering health insurance or providing oversight to corporations that offer health insurance. The regulatory oversight of private health insurance is a statutory function of the Department of Insurance, the Department of Management Services, and the Agency for Health Care Administration. There is little reference in the bill to any quality management or oversight of the plans or linkages with the Agency of Health Care Administration with respect to the quality of commercial plans.

The Department of Insurance has expressed the following concerns:

- The bill indicates that DOI will approve policy forms but does not also state that the plan's policy shall meet the requirements of the Insurance Code - i.e., policy benefits, rates, etc.
- The bill permits investments and authorizes the Board to contract with a trustee for investment services...it is unclear why the FHEA would have accumulated such funding as to be in a position to utilize a long term investment plan.
- It is not clear that the administrator chosen by the plan would also have to be a Third Party Administrator (TPA) licensed by the DOI.
- The 60 day break in coverage does not appear to comply with the "Health Insurance Portability and Accountability Act of 1996" (HIPAA).
- The $500,000 lifetime maximum is very low. Higher lifetime maximum would be more appropriate for this group of uninsurables and would not have a significant premium impact based on FCHA's current enrollment trends.
- In Covered Expenses, the coverage plan must, at a minimum, be patterned after the "standard individual health insurance plan" approved by the DOI. The correct reference should be "standard small group plan required pursuant to s. 627.6699."
- The bill indicates that premiums, deductibles, coinsurance, and rates will be DOI approved, while the Board sets premium schedules. Thus, approved rates would not comport with premium payments based on approved rates. This is a departure from the manner in which the DOI regulates private carriers.
- Pre-existing conditions do not comply with HIPAA and contain no credit for any prior coverage to offset pre-existing waiting periods.
- Tax credits appear to affect retaliatory taxes and premium tax credits with a general revenue impact. .

The State Board of Administration commented as follows:

- The State Board of Administration should be included in the exculpatory language of the bill.
- The State Board of Administration does not receive an appropriation and must be reimbursed for its services. It is recommended that language authorizing the cost of providing the review and approval by the State Board of Administration be paid by the association out of income of the Trust Fund.

The Office of the Auditor General commented as follows:

- The bill requires a "performance audit" to be conducted by the Auditor General to "critique the affairs" of the association. This language is not consistent with the Auditor General's responsibilities as set forth in s. 11.45, F.S, and is more consistent with the duties of the Office of Program Policy Analysis and Government Accountability. The term "performance audit" should be referred to as an "operational audit" as defined in s. 11.45, F.S.
- The bill is unclear as to whether the audit is intended to be an annual audit.
- The bill implies that there will be an independent audit; however, there is no specific requirement for an independent audit. The bill also provides that the Board may prepare or contract for a performance audit. It is not clear how this relates to the Auditor General's audit.

The Office of Program Policy Analysis and Governmental Accountability, in order to conduct a "performance audit" to "critique the affairs" of the association, would need language in the bill authorizing them to review the efficiency and effectiveness of the association's implementation of its responsibilities relative to this bill and suggests that such a report be submitted to the President of the Senate and the Speaker of the House prior to the 2002 Legislative Session.

In addition to the preceding comments, staff has identified aspects of the bill needing clarification which could be discussed a workshop of the bill.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Tonya Sue Chavis, Esq.	Phil E. Williams