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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: CS/HB 645

RELATING TO: Health Care

SPONSOR(S): Committee on Health Care Services, Representatives C. Green, Jones, and others

TIED BILL(S): HB 647

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

(1) HEALTH CARE SERVICES YEAS 12 NAYS 2
(2) INSURANCE
(3) FINANCE & TAXATION
(4) HEALTH & HUMAN SERVICES APPROPRIATIONS
(5)

I. SUMMARY:

CS/HB 645 creates the Florida Health Endowment Association as a nonprofit legal corporation to administer the Florida Health Endowment Trust Fund. The bill requires the association to be considered a health insurer for purposes of the Florida Insurance Code and exempts the association from the certificate-of-authority and financial requirements of the code. The bill creates a five-member board of directors, with the Executive Director of the Agency for Health Care Administration or his or her designee to serve as chairperson, and limits the liability of association members, association employees, and representatives of the agency. The bill requires an annual evaluation of actuarial soundness to determine the feasibility of enrolling new members, and establishes eligibility requirements for participants. The bill requires the establishment of an internal grievance system, but requires that individuals receiving care from HMOs must follow statutory grievance procedures.

The bill provides for the selection of an administrator via competitive bid, and provides duties and responsibilities of such. The bill requires that the association contract with the State Board of Administration to invest funds held in the trust fun. The bill requires an annual report summarizing the activities of the association to be submitted 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. The bill authorizes the restriction of participants based on actuarial estimates and provides for priority admission in succeeding years when the association is reopened. The bill provides for definitions, and minimal benefits coverage, including exclusions, premiums, and deductibles. The bill increases the lifetime limit to $1 million per covered individual. The bill repeals the statutory authority for the Florida Comprehensive Health Association is repealed, and assets, liabilities, and policyholders of the FCHA are transferred to the new association; and provides rulemaking authority.

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 Agency for Health Care Administration, as follows: Section 1 of CS/HB 645 requires the Director of the Agency for Health Care Administration, 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 of operation pursuant to this act and submit its articles, bylaws, and operating rules to the agency for approval.

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:

CS/HB 647 creates the Florida Health Endowment Association (FHEA) to replace the Florida Comprehensive Health Association (FCHA). FHEA provides individual health insurance coverage to individuals who are considered uninsurable in the standard market. The bill also allows existing FCHA policyholders to purchase FHEA health coverage.

Funding for the association is provided by premiums paid by policyholders and by earnings from the endowment created by General Revenue funds. This funding replaces 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.

The administrator for the association will be selected by competitive bid. The endowment will be invested by the State Board of Administration. The fund will be annually evaluated for actuarial soundness to determine the feasibility of enrolling new participants. The association is authorized to restrict the number of participants based on actuarial estimates and provides for priority admission in succeeding years when the association is reopened.

An annual report summarizing the activities of the association is to be submitted annually to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and House of Representatives.

The bill provides definitions, eligibility requirements, minimum benefits coverage, exclusions, premiums, and deductibles. The lifetime limit of coverage per covered individual is increased to $1 million. The statutory authorization for the Florida Comprehensive Health Association is repealed and assets, liabilities, and policyholders of the FCHA are transferred to the association. The bill provides the association rulemaking authority.

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 Florida Health Endowment Association (“association”), as a nonprofit legal entity, to be considered a health insurer for purposes of the Florida Insurance Code, but which is exempt from the certificate-of-authority and financial requirements of the Insurance Code.

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

Paragraph (a) requires the board of directors to consist of:

- The Director of the Agency for Health Care Administration (“agency”), or his or her designee, 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:
    - One representative of policyholders who is not associated with the medical profession or a hospital;
    - One representative of the health insurance industry; and
    - One member of the public.

Paragraph (b) prohibits the administrator of the plan, or his or her affiliate, from serving as a member of the board and provides that any appointed board member may be removed and replaced by his or her appointor at any time without cause.

Paragraph (c) 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.

Paragraph (d) 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.

Paragraph (e) provides that board members will serve without compensation but may be reimbursed by the association for actual and necessary expenses incurred by them as members, as provided in s. 112.061, F.S., relating to per diem and travel expenses of public officers, employees, and authorized persons.

Paragraph (f) 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 agency 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.

Paragraph (g) provides that the meetings of the board are subject to s. 286.011, F.S., relating to public meetings and records.

Subsection (3) specifies duties and responsibilities for the board of directors of the association.

Paragraph (a) requires the board to adopt a plan of operation, articles, bylaws, and operating rules in accordance with the act. The board must submit the plan of operation to the agency for approval. Until the agency approves the plan, the plan of operation, articles, bylaws, and operating rules of the Florida Comprehensive Health Association (“FCHA”), and any amendments thereto, remain in effect.

Paragraph (b) requires the board to direct the association in such a manner to ensure that the financial obligations of the association are adequate to meet the obligations of the program.

Paragraph (c) requires the board to establish administrative and accounting procedures for the operation of the association. The board must also provide for an annual audit of the financial statements by an independent certified public accountant.

Paragraph (d) requires the board to conduct an annual evaluation, or cause an annual evaluation, on the actuarial soundness of the association. The association must contract with an actuary to evaluate the pool of insured in the association and monitor the financial condition of the association’s trust fund. The actuary must determine the feasibility of enrolling new members in the association. The feasibility study must be based on projected revenues and expenses of the association.

Paragraph (e) requires the board to establish eligibility requirements for individuals participating in the association to ensure that the financial resources of the association are adequate to meet the obligations and are consistent with the annual actuarial feasibility determination and eligibility requirements.

Paragraph (f) requires the board to establish grievance procedures for members of the association. Grievances must be reviewed internally by an impartial body and reported to the association. However, individuals receiving care through the association under a contract from a health maintenance organization must follow the grievance procedures pursuant to s. 408,7056, F.S., relating to the Statewide Provider and Subscriber Assistance Program, and s. 641.31(5), F.S., relating to health maintenance contracts and resolving subscriber grievances.

Paragraph (g) requires the board to select an administrator.

Paragraph (h) requires the board to develop and implement a program to publicize the association, eligibility requirements, and procedures for enrollment.

Paragraph (i) requires the board to design and employ cost-containment measures and requirements that must 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.

Paragraph (j) requires the board to contract with authorized insurers, health maintenance organizations, or health care providers.

Paragraph (k) requires the board to use a case manager or managers to supervise and manage the medical care or coordinate the supervision and management of the medical care or coordinate the supervision and management of the medical care of specified individuals. Case managers must have final approval over the case management for any specific individual. At the time of application or upon renewal, where cost-effective and available in the county where a policyholder resides, the association may place an individual with a case manager who will determine the most cost-effective quality care system or health care provider and will place the individual in such system or with such provider. Before and during the implementation of case management, the case manager is required to obtain input from the policyholder, parent, guardian, and health care providers.

Paragraph (l) requires the board to appoint an executive director to serve as the chief administrative and operational officer of the association to perform other duties as assigned by the board.

Paragraph (m) requires the board to establish, in the plan of operation, procedures for the transition of policyholders from the FCHA to the association to include:

- Procedures for calculating, issuing, and collecting the final assessment for operating losses of the FCHA as specified in s. 627.6488(4)(d), F.S., relating to duties of the FCHA.

- Ensurances that remaining FCHA policyholders, including those currently enrolled in Medicare, will not be subjected to new preexisting conditions and that previous claims paid by the FCHA will apply towards the lifetime maximum benefit available in the association.

- A contract with the State Board of Administration for the investment of the funds held in the association's Trust Fund in accordance with a trust agreement entered into by the association and State Board of Administration, in accordance with, ss. 215.44-215.53, F.S., relating to the State Board of Administration.

Paragraph (o) requires the board to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, and the minority leaders in each body, not later than October 1 of each year. Requires the report to:

- Summarize the activities of the association for the previous 12-month period ending December 31 of the previous year;
- Include then-current data and estimates as to premiums, the expense of administration, the paid and incurred losses for the year, the financial status of the association's Trust Fund, and any recommendations by the actuary and actions by the association for the opening or closing of the association; and
- Include analysis and recommendations for legislative changes regarding utilization review, quality assurance, an evaluation of the administrator of the association, access to cost-effective health care, and cost containment or case management policy, and recommendations concerning enrollment.

Subsection (4) authorizes the association to do the following:

- Sue or be sued;
- Prepare or contract for an independent performance audit of the administrator of the association;
- Invest funds not required for immediate disbursement;
- Appear on its own behalf before boards, commissions, or other governmental agencies;
- Execute, hold, buy, and sell any instruments, obligations, securities, and property as determined appropriate by the board;
- Restrict the number of participants in the association based on actuarial estimates; however, persons denied participation based solely on actuarial restrictions must be granted priority on a first-come, first-served basis for participation when the association is reopened for participants;
- Contract for necessary goods and services; employ necessary personnel; and engage the services of private consultants, actuaries, managers, legal counsel, and independent certified public accountants for administrative or technical assistance;
- Solicit and accept gifts, grants, loans, and other aid 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 association on a fraudulent basis;
- Procure insurance against any loss in connection with the property, assets, and activities of the association 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 association and its vendors.

Subsection (5) requires the Auditor General to conduct an operational audit and an actuarial study of the association. The actuarial study must determine the projected revenues and expenses associated with providing continuing coverage to the current members of the FCHA and the feasibility of enrolling new members. The reports must be submitted to the President of the Senate and the Speaker of the House of Representatives on or before January 1, 2002.

Section 2. Provides definitions for 9 specific terms relating to the structure and operation of the association.

Section 3. Creates eligibility provisions for the association.

Subsection (1) provides that specified Florida residents are eligible for the association's 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.

Subsection (2) authorizes verification of residency.

Subsection (3) provides that a person is ineligible for coverage under the association if: the person:

- The person has or obtains health insurance coverage substantially similar to or more comprehensive than the association's policy, or would be eligible to have coverage if the person elected to obtain coverage;
- The person is an inmate or resident of a public institution or correctional 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 the lifetime maximum benefit under coverage issued by the association;
- The person Is eligible, on the date of issue of the coverage under the association, for substantially similar coverage under another contract or policy;
- The person is currently enrolled in or is eligible for health care benefits under:
  - The Medicare programs, except for those persons currently insured by the FCHA and currently enrolled under Medicare;
  - The Florida Medicaid program;
  - The Florida Kidcare program; or
  - Any other government-funded health care program.

Subsection (4) provides that coverage ceases:

- On the date a person is no long 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
- Sixty days after the person receives notice from the association making any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

Subsection (5) provides that all eligible persons must, at application or renewal, agree to be placed in a case-management system when the association and the case

manager determine that such system will be cost-effective and provide quality care to the individual.

Subsection (6) provides that coverage terminates immediately for any person who ceases to meet the eligibility requirements. If such person subsequently becomes eligible for coverage, any previous claims payments must be applied towards the lifetime maximum benefit and any limitation relating to preexisting conditions in effect at the time of re-eligibility.

Section 4. Provides for administrator responsibilities under the association.

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 association;
- 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 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 association;
- Perform all necessary functions to assure timely payment of benefits under the plan, including:

    - Making available information relating to the proper manner of submitting a claim for benefits and distributing submission forms;
    - Evaluating the eligibility of each claim for payment; and
    - Notifying each claimant, within statutory time limits, as to insurers and third-party administrators, after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected, or compromised.

- Submit required reports to the association, as determined by the association;
- After 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.

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. 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 association. 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 $1 million per covered individual. The maximum limit may not be altered by the association, and no actuarial equivalent benefit may be substituted by the association.

Subsection (3) requires that plan coverage, at a minimum, 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. 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 an association policy to contain provisions under which coverage is excluded during a period of 12 months following the effective date of coverage for a given individual for any preexisting condition, as long as the condition:

- Manifested itself within a period of 6 months before the effective date of the coverage; or
- Medical advice or treatment was recommended or received within a period of 6 months before the effective date of coverage.

The board is required to establish premium schedules and to revise the schedules in accordance with this section each 12-month policy period. Requires that the rate will be 200 percent of the standard risk rate, as established by the Department of Insurance.

Provides that if the covered costs incurred by the eligible person exceed the deductible for coverage selected by the person in a policy year, the association must pay in the following manner:

- For individuals in case management, the association must pay 90 percent of the additional covered costs incurred by the person during the policy year for the first $10,000, after which the association must pay 100 percent of the covered costs incurred by the person during the policy year;

- For individuals using a preferred provider network, the association must pay 80 percent of the additional covered costs incurred by the person during the policy year for the first $10,000, after which the association must pay 90 percent of the covered costs incurred by the person during the policy year.

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

Provides that all premiums paid to the association must be deposited with the association.

Provides that notwithstanding the provisions of s. 624.509, FS., relating to premium tax, premiums for coverage are, as to the association and participating insurers, exempt from premium taxation.

Subsection (5) provides that other payor sources are primary.

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

Paragraph (b) grants the association a cause of action against a participant for any benefits paid to the participant which should not have been claimed or recognized as claims.

Subsection (6) specifies that coverage under the association 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 or health insurance available under this section.

Section 6. Provides for disease management services.

Subsection (1) authorizes the association to contract with insurers to provide disease management services for insurers that elect to participate in the association's disease management program.

Subsection (2) requires that an insurer that chooses to contract for the disease management program services must provide the association with all medical records and claims information necessary for the association to effectively manage the services.

Subsection (3) provides that revenues collected by the association for this purpose are to be used to pay the administrative expenses of the disease management program, and any remining revenues are to be deposited in the association's trust fund.

Section 7. Provides that effective on the date of the opening of the association, all individuals who have insurance coverage issued by the FCHA must be issued insurance coverage under the association. The association must assume all assets and liabilities of the FCHA. The articles, bylaws, and operational rules of the FCHA**,** and any amendments thereto, will remain in effect until the Agency for Health Care Administration has approved the association's plan of operation, articles, bylaws, and operating rules.

Section 8. Specifies certain sections of the Florida Statutes related to the current powers of the FCHA are to be repealed effective upon the date of the opening of the association or effective January 1, 2000.

Section 9. 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 10. Provides that the act will take effect July 1, 2000.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

The bill provides for an appropriation of $50 million from the General Revenue Fund. The July 1, 2000.

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.

Depending on how involved with the association the Agency for Health Care Administration has to be, the bill may have some fiscal impacts on the agency.

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:

On February 15, 2000, the House Committee on Health Care Services held a workshop on this bill. At the workshop the issue was raised that the revenue generated from a $50 million endowment fund is unlikely to generate sufficient resources to maintain the current client caseload of the Florida Comprehensive Health Association. It was considered an extremely remote possibility that additional clients could be serviced by the new association.

On February 16, 2000, the Florida State Board of Administration issued a table containing the preliminary calculations of the Florida Health Endowment Trust Fund Projected Cash Flows. Based on these preliminary calculations, it appears that the end of year payout for year 1 is $2.2 million dollars (assuming the Chiles Endowment Annuity Provisions). The 1998 total expenses for the Florida Comprehensive Health Association were $8,743,711 ($4,892,503 of the total expenses were provided by assessments from all insurers to

provide for operating losses incurred or estimated to be incurred during the period for which the assessment is made).

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. The changes incorporated into the CS/HB are summarized as follows:

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On October 23, 2000, the Committee on Health Care Services approved a committee substitute for HB 645. The CS differs from the bill as introduced, as follows:

- Changes the composition of the association's board of directors, replacing the Department of Health with the Agency for Health Care Administration to appoint the chairman for the Florida Health Endowment Association board;
- Deletes the requirement for the Department of Health to adopt rules if the association fails to obtain departmental approval of rules within 180 days and specifies that the existing plan of operation, bylaws, articles, operational rules, and amendments thereto, will remain in effect until the agency approves the association's plan of operation, articles, bylaws, and operational rules;
- Specifies that the administrator be an authorized insurer or a third-party administrator licensed under chapter 626, F.S.;
- Clarifies residency requirements for eligibility to join the program;

- Increases lifetime maximum coverage limits to $1 million;
- Eliminates tax credit for certain insurers that make a contribution to the association and the transference of unused tax credits;
- Eliminates ambiguous definitions;
- Removes premium schedules based on income;
- Clarifies coverage limitations;
- Clarifies requirement governing annual independent audits; and
- Specifies the association is to contract with the State Board of Administration for the investment of the trust fund.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

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