By Representatives C. Green, Jones, Peaden, Fasano and Maygarden

A bill to be entitled

An act relating to health care; creating the Florida Health Endowment Association; providing for appointment of a board of directors; providing a limitation on the liability of members, employees of the association, and representatives of the Department of Health when performing responsibilities of the association; providing for open meetings; prescribing duties of the board; authorizing the board to administer the Florida Health Endowment Trust Fund; providing for the adoption of a comprehensive health insurance plan for state residents; providing for the establishment of a plan of operation by the board that includes the assumption of all assets and liabilities of the Florida Comprehensive Health Association and for the transfer of its remaining policyholders into the plan; providing rulemaking authority; specifying mandatory and discretionary powers of the board; requiring an audit and report; providing definitions; providing eligibility requirements for persons who seek to join the new comprehensive health insurance plan; specifying coverages and limitations on coverages as a condition of a person's eligibility; providing for the selection of, term of service of, and duties of the administrator of the plan; providing coverages, benefits, expenses, premiums, and deductibles

under the plan; requiring coverage provided by the plan to be directly insured by the Florida Health Endowment Association and requiring policies to be issued by the administrator; authorizing the association to contract with insurers to provide disease-management services; providing a tax credit for certain insurers that make a contribution to the association; providing conditions; repealing s. 627.648, F.S., which provides for the Florida Comprehensive Health Association Act; repealing s. 627.6482, F.S., relating to definitions; repealing s. 627.6484, F.S., relating to termination of enrollment; repealing s. 627.6486, F.S., relating to eligibility; repealing s. 627.6487, F.S., relating to availability of individual health insurance coverage; repealing s. 627.64871, F.S., relating to certification of coverage; repealing s. 627.6488, F.S., relating to the creation of the Florida Comprehensive Health Association; repealing s. 627.6489, F.S., relating to the disease-management program; repealing s. 627.649, F.S., relating to the administrator of the program; repealing s. 627.6496, F.S., relating to issuance of policies; repealing s. 627.6498, F.S., relating to minimum benefits; repealing s. 627.6492, F.S., relating to participation of insurers; repealing s. 627.6494, F.S., relating to assessments; providing that individuals having

coverage issued by the Florida Comprehensive Health Association will be issued coverage under the plan of the Florida Health Endowment Association on the effective date of the plan; requiring the Florida Health Endowment Association to assume the assets and liabilities of the Florida Comprehensive Health Association; providing an appropriation to the Florida Health Endowment Trust Fund; providing a contingent effective date.

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

Section 1. Florida Health Endowment Association.--

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

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

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

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

3. Three members appointed by the Governor as follows:

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

b. One representative of the health insurance industry.

c. One member of the public.

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

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

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

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

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

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

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

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

(4) The board of directors shall:

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

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

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

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

(e) Select an administrator under section 4.

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

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

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

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

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

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

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

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

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

(n) Solicit proposals and contract under section 287.057, Florida Statutes, for a trustee services firm to select and supervise investment programs on behalf of the board. 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 such services to the state at no cost and to the purchasers at the lowest cost possible. The trustee services firm must agree to meet the obligations of the board to qualified beneficiaries if moneys in the fund fail to offset the obligations of the board as a result of imprudent selection or supervision of investment programs by such firm. Evaluations

of proposals submitted under this paragraph must include the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) The board may:

(a) Adopt articles and rules.

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

(c) Sue or be sued.

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

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

(f) Invest funds not required for immediate disbursement.

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

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

(i) Restrict the number of participants in the plan based on actuarial estimates. However, any person denied participation solely on the basis of such restriction 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.

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

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

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

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

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

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

(6) The Auditor General shall conduct a performance audit, including a review of the annual financial audit and the annual report prepared by the board. The report shall critique the affairs of the association and shall be submitted to the President of the Senate and the Speaker of the House of Representatives prior to the legislative session. The Auditor General may 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. Definitions.--As used in sections 1-8 of this act, the term:

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) "Transferee" means any person who:

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

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

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

Section 3. Eligibility.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Coverage ceases:

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

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

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

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

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

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

(8) The coverage of any person who ceases to meet the eligibility requirements may be terminated immediately. If such person again becomes eligible for subsequent coverage under the plan, any previous claims payments must 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. Administrator.--

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

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

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

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

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

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

(3) The administrator may:

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

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

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

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

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

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

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

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

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

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

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

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

(4)(a) 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.

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

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

(1) COVERAGE OFFERED.--

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

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

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

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

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

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

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

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

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

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

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

4. The board shall establish three separate premium schedules:

a. Schedule A is applicable 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.

b. Schedule B will be applicable 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.

c. 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.

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

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

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

2. 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 the first $10,000, after which the plan must pay 90 percent of covered costs incurred by the person during the policy year.

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

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

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

2. 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.

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

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

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

association and participating insurers, exempt from premium taxation.

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

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

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

(6) OTHER SOURCES PRIMARY.--

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

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

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

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

Section 6. Disease management services.--

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

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

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

Section 7. Tax credits.--

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

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

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

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

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

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

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

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

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

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SENATE SUMMARY

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