SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1208

SPONSOR: Banking and Insurance Committee and Senator Latvala

SUBJECT: Health Insurance

DATE: March 20, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.			FT	
4.				
5.				
6.				

I. Summary:

Under current law, the Florida Comprehensive Health Association (FCHA) provides health insurance to individuals who, due to their health status or inability to afford coverage, are unable to obtain health insurance coverage in the private market. Throughout the early years of the program, enrollment and losses were low; however, in 1989, enrollment and losses increased substantially. Legislation was enacted to prohibit the FCHA from issuing policies to new applicants after July 1, 1991. The FCHA currently provides coverage for 702 individuals. According to representatives of FCHA, enrollment is declining at a rate of approximately 15 percent per year.

The committee substitute would reopen the FCHA for enrollment on January 1, 2002, and coverage would be effective on or after April 1, 2002. The bill caps new enrollment in the association at 500 for calendar year 2002 and allows an additional 1,500 members, effective January 1, 2003. If an individual is denied participation solely on the basis of such a determination, the individual must be granted priority for enrollment in the succeeding period in which the association is reopened for enrollment. Individuals that have been rejected for coverage by two insurers or have been offered coverage with a material underwriting restriction would be eligible for coverage. Also, individual with 18 months of creditable coverage, who do not have access to other specified health insurance, and who do not have more than a 63-day gap in coverage would automatically be eligible for coverage, unless the association ceased accepting new enrollees. An individual would be required to be a resident of Florida for previous 6 months to be eligible for enrollment.

The composition of the FCHA board of directors would be revised and expanded from three to five members, consisting of the Insurance Commissioner or his designee and four other members who must be residents of Florida. One of the members must be a representative of a health

insurer or health maintenance organization. The Insurance Commissioner, or his designee, would serve as the chairperson. The powers and duties of the board would include:

1. Appoint an executive director to serve as the chief administrative and operational officer of the association.
2. Adopt a plan of operation and submit it to the department for review and approval on an annual basis. The board would also be required to establish separate accounts and record keeping for policyholders issued coverage prior to January 1, 2002, and policyholders issued coverage on or after January 1, 2002.
3. Establish the coverage to be issued by the association. The lifetime benefit limit would be $500,000. However, policyholders of the association issued policies prior to 1992 are entitled to continued coverage at the benefit level established prior to January 1, 2002.
4. Implement a sliding fee schedule for premiums based upon an individual's income. The premium would be 150, 250, or 300 percent of the standard risk rate. The Department of Insurance would establish the standard risk rate. The premiums would be subject to approval by the department.
5. Administer the association in a fiscally responsible manner that would ensure that the expenses are reasonable in relationship with the services provided and that the financial resources are adequate to meet its obligations. The board is required to engage an actuary to conduct an annual evaluation of the actuarial soundness of the association. The actuary must determine the feasibility of enrolling new members, based upon the projected revenues and expenses of the association.
6. Restrict at any time the number of participants in the association, if it was determined that the revenues would not be adequate to fund new enrollees.

In addition to premiums, the funding for individuals provided coverage through the association on or after April 1, 2002, would be provided through a 25 cents per month assessment on insurers for each individual policy or covered group subscriber, not including dependents insured in Florida, as of December 31 of each year. The assessment would include plans administered by third-party administrators and insurers (administrative services only contracts). Supplemental policies and limited benefit policies would not be subject to the assessment. Self-insured, employee welfare benefit plans that are not regulated by the Employee Retirement Security Act of 1974 (ERISA) would be excluded from the assessment. Multiple employee welfare arrangements would be subject to the assessment.

The first payment would be due April 1, 2002, for the period of October 1, 2001, through December 31, 2001. Thereafter, payments for the prior calendar year would be due April 1 of the following year. Effective October 1, 2001, the insurer may charge the fee directly to each policyholder, insured member, or subscriber. Nonpayment of the fee would be considered nonpayment of the premium and would be grounds for cancellation of the policy or contract. The assessment would not be subject to the insurance premium tax.

The committee substitute substantially amends the following sections of the Florida Statutes: 627.6482, 627.6486, 627.6487, 627.88, 627.649, 627.6492, and 627.6498. Section 627.6484, F.S., is repealed.

II. Present Situation:

In recent years, many states have created health insurance risk pools to address the needs of the uninsured. In Florida, 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 was created as a nonprofit, legal entity 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. Presently, an independent agent serves as a representative of the insurers, as compared to a representative of an insurer selected in the past.

FCHA Eligibility, Benefits, and Premiums

Effective July 1, 1990, the FCHA was amended to require the FCHA to pattern its coverage after the state group health insurance program including benefits, exclusions, and other limitations, except as otherwise provided by law. The major medical expense coverage under FCHA includes a $500,000 lifetime limit per covered life. The FCHA provides for an annual deductible in the amount of $1,000 or more, as approved by the Department of Insurance. The FCHA provides for a 12-month exclusion of insurance 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, two insurers for coverage substantially similar to the FCHA's coverage must reject an individual 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 FCHA's rate. Therefore, the rejection may or may not be due to a determination that an applicant is 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 FCHA, 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.

Pursuant to s. 627.6498(4)(a), F.S., the Department of Insurance annually establishes the standard risk rate that is used for determining premiums for the FCHA. Under the provisions of s. 627.6675, F.S., the department uses reasonable actuarial techniques and standards adopted by rule. As currently provided, the maximum rates for the FCHA are 200 percent, 225 percent, and 250 percent of this standard risk rate for low, medium, and high-risk individuals, respectively.

According to the FCHA, the standard risk rate that is established by the department is compared to the rates approved by the FCHA and the FCHA actuary recommends whether adjustments are necessary. The FCHA currently has no rate filing pending with the department. In 2000, the

FCHA submitted its last rate filing with the department and that rate filing was effective January 1, 2001.

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 FCHA, 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.

Closure of the FCHA

Pursuant to law, on July 1, 1991, the FCHA ceased accepting applications due to the Legislature's concern 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 Uninsured In Florida

In the Summary of Plan Activities, 1997-98, the FCHA offered the following solutions to provide coverage for the uninsured:

1. Open enrollment for the state's high-risk pool, the FCHA;
2. Guarantee issue by individual insurers and health maintenance organizations
3. Expansion of the small group market guarantee-issue requirement;
4. Allow uninsurable individuals access to the State Employee Health Insurance Plan;
5. Allow access to Medicaid, regardless of income status; or
6. Allow alternative sources of funding for FCHA.

Reopening the FCHA: Anticipated Enrollment

High-risk pools may provide a safety net for otherwise uninsurable individuals; however, they enroll a relatively small number of individuals. Reasons for low enrollment include: limited funding, lack of public awareness, and the relative expense.

As of 2000, there are 28 states which have established high-risk pools, according to the *Comprehensive Health Insurance for High-Risk Individuals, 2000*, published by Communicating For Agriculture. Seven of these risk pools have created low- income premium subsidy programs for their state plans (Colorado, Connecticut, New Mexico, Oregon, Tennessee, Washington, and

Wisconsin). The premiums for these risk pools are range from 125 - 200 of the average premium for the particular state.

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 were 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 34 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 3,700 - 6,200 individuals might enroll.

Funding Options

The report "strongly recommended" that, if the FCHA was to be reopened, funding (assessment/tax) would need 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; or
9. Increase taxes on cigarettes, alcohol, or other products.

According to Communicating For Agriculture, 20 states fund risk pools by assessing association members. Other states provide funding through one or more sources, such as: state income tax, tobacco tax, general revenue, and tobacco settlement funds (California, Colorado, Louisiana, Kentucky, Utah, and Wisconsin). Louisiana appropriates funds from general revenue and imposes a service charge on hospital admissions and outpatient procedures.

Cost Analysis

According to the *Comprehensive Health Insurance for High-Risk Individuals, A State-by-State Analysis* (1997), issued by Communicating by 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." Typically, the FCHA premium as a percentage of total expenses ranged from 29 - 77 percent during the period of 1990 - 2000 (estimated). For 6 years of the 11-year period the average premium covered less than 50 percent of the average total expenses per enrollee. The average total assessment per enrollee, premium paid by enrollee, and average expense per enrollee for fiscal years 1990-98 is depicted in the following chart:

FY	Average Number of Enrollees	Total Assessments Against Insurers (millions)	Avg. Cost To Insurers (Amt. Assessed per member)	Average Premium Paid by Enrollee	Average Total Expenses Per Enrollee	Average Premium as a Percentage of Average Expenses
2000 (est.)	757	$5.4	$7145	$3400	$10714	31.7%
1999	856	4.0	4696	3473	8325	41.7%
1998	991	4.9	4937	3536	8823	40.0%
1997	1182	1.9	1637	3531	5653	62.5%
1996	1458	3.2	2211	3576	6016	59.4%
1995	1891	9.8	5193	3580	8880	40.3%
1994	2775	11.8	4258	3521	7814	45.1%
1993	3702	5.8	1566	3610	5064	71.3%
1992	4528	7.1	1576	3355	5036	66.6%
1991	5639	5.6	990	3824	4911	77.9%
1990	6402	33.9	5293	2324	7766	29.9%

Health Insurance Portability and Accountability Act (HIPAA)

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) which requires insurers issuing individual health insurance policies to guarantee the issuance of coverage to persons who previously were covered for at least 18 months and meet other eligibility criteria. The Act allowed each state to craft alternative methods of guaranteeing availability of coverage. The federal HIPAA law allows each state the option to enact and enforce the federal provisions or fall back to federal enforcement. HIPAA specifies that the federal provisions pertaining to health insurers in the individual market generally do not preempt state regulation of individual insurers. However, if the state's statutory provisions prevent the application of a federal requirement, HIPAA preempts the statutes and the federal requirements prevail. At a minimum, each state must ensure that its provisions comport with HIPAA and do not diminish the federal requirements. However, each state is permitted to adopt provisions that expand or provide more favorable treatment for the individual.

In 1997, Florida enacted legislation to conform state law to HIPAA, which included an alternative mechanism that was deemed to be acceptable by the federal Health Care Finance Administration (HCFA). In order to be eligible for guaranteed-issuance of individual coverage under HIPAA and Florida's conforming legislation, an individual must have had prior creditable coverage for at least 18 months, without a break in coverage of more than 63 days, and not be eligible for any other group coverage, Medicare or Medicaid. Under federal law, the individual's most recent prior coverage must have been under a group plan, a governmental plan, or church plan. However, in 1998, Florida expanded the eligibility criteria under state law to also include persons whose most recent coverage was under an individual plan if the prior insurance coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO. In 2000, this provision was limited to prior individual coverage issued in Florida.

The Florida law provides two mechanisms for guaranteeing access to individual coverage to persons who lose their eligibility for prior coverage. These mechanisms apply after exhaustion of the period of time that group coverage can be continued under the federal COBRA law or

Florida's "Mini-COBRA" law which, generally, is up to 18 months. One method requires the insurance company or HMO that issued the group health plan to offer an individual conversion policy to persons who lose their eligibility for group coverage. Florida law requires that the insurer or HMO offer at least two conversion policy options, one of which must be the standard benefit plan that Florida law requires small group carriers to offer small employers. The maximum premium that may be charged for any conversion policy is limited to 200 percent of the standard risk rate, which is a statewide average rate computed annually by the Department of Insurance, calculated separately for indemnity policies, exclusive/preferred provider policies, and HMO contracts.

Florida's second method of guaranteeing access to individual coverage is by allowing eligible individuals to purchase an individual policy from any insurance company or HMO issuing individual coverage in the state. The policy must be offered on a guaranteed-issue basis, that is, regardless of the health condition of the individual. The insurer or HMO must offer each of their two most popular policy forms, based on statewide premium volume. Under Florida law, this method applies to persons who meet the eligibility criteria but who are not entitled to a conversion policy under ss. 627.6675 or 641.3921, F.S. This generally includes persons who were previously covered under a self-insured employer's plan or who move outside of a service area of an HMO. It also applies to persons whose previous coverage was under an individual plan that was terminated for specified reasons.

The requirement under Florida law that insurers and HMOs offer conversion policies does not apply to self-insured employers. States may not impose any such requirement on self-insured employers due to federal ERISA preemption. However, a self-insured employer may offer conversion coverage which, under certain conditions, will disqualify a person from obtaining coverage from an individual carrier on a guaranteed-issue basis.

III. Effect of Proposed Changes:

Section 1. Amends s. 627.6482, F.S., to provide additional definitions and delete unnecessary, obsolete references.

The term, "Federal Poverty Level," is defined to mean the level established by Economic Services of the Department of Children and Families and in effect on the date of the policy and its annual renewal.

The term, "Family Income," is defined to mean the adjusted gross income, as defined in s. 62 of the United States Internal Revenue Code, of all members of a household.

Section 2. Amends s. 627.6486, F.S., to revise eligibility requirements for the FCHA, to require an individual to have been a resident of Florida for the prior 6 months and provides procedures for documenting residency, including purchasing a home that has been the primary residence for the prior 6 months and establishing domicile in accordance with the provisions of s. 222.17.

New applications would be taken, beginning January 1, 2002, for coverage effective April 1, 2002.

Presently, an individual is eligible to join the FCHA if two insurers in the voluntary market have rejected the person. However, the term, rejection also includes an offer of coverage at a rate greater than the association. The section eliminates coverage at a rate greater than the association from the definition of rejection. If coverage was available in the voluntary market, an individual would not be eligible for coverage.

The section also provides that an individual would be ineligible to join the association if such person is currently eligible for Medicare. Individuals who are currently members of the FCHA and are enrolled in Medicare, as of July 1, 2001, are exempt from this eligibility requirement.

Persons who are eligible for guaranteed-issuance of coverage under s. 627.6487, F.S., (the Florida law conforming to the federal HIPAA law), would be automatically eligible for coverage in the FCHA unless the association has ceased accepting new enrollees due to enrollment caps. If the FCHA has ceased accepting new enrollees, the eligible individual would revert to the coverage rights in s. 627.6487, F.S., which would entitle the person to obtain an individual policy from an individual health insurer. (See Section 3, below which changes the method for guaranteeing access to individual coverage for HIPAA-eligible individuals.)

Coverage would cease when: 1) The person is no longer a resident of Florida; 2) A person requests termination; 2) The covered person dies; 3) The state law required cancellation of the policy; 4) A covered person does not respond within 60 days to inquiries from the association regarding the person's eligibility or residence.

All eligible persons must, upon application or renewal, agree to be placed in a case-management system when the association and case manager find that such a system would be cost-effective and provide quality of care to the individual.

Section 3. Amends s. 627.6487, F.S., to revise the definition of HIPAA individuals eligible for guaranteed issuance in the voluntary market to exclude individuals who are eligible for coverage under the association, unless the association was not accepting new enrollees. If the association is accepting new enrollees, the 63-day period specified in s. 627.6561(6) would be tolled from the time the association receives the application from an individual until such time as the association notifies the individual that it is not accepting and issuing coverage to that individual.

Section 4. Amends s. 627.6488, F.S., to revise the composition of the Florida Comprehensive Health Association's board and to revise the powers and duties of the board. The board is expanded from three to five members, consisting of the Insurance Commissioner or his designee and four other members who must be residents of Florida. One of the members must be a representative of a health insurer or health maintenance organization. The Insurance Commissioner, or his designee, shall serve as the chairperson.

The board would appoint an executive director to serve as the chief administrative and operational officer of the association.

Members and employees of the board would be reimbursed, as provided in s. 112.061, F.S., for incurred expenses in carrying out their duties.

The board would be responsible for adopting a plan of operation and submitting it to the department for review and approval on an annual basis. The board would also be required to adopt internal controls for the operation of the association and for establishing procedures to establish separate accounts and record keeping for policyholders prior to January 1, 2002, and policyholders issued coverage on or after January 1, 2002.

The board is currently charged with adopting grievance procedures for applicants and participants in the plan. This provision is revised to require individuals receiving care from a health maintenance organization to follow the grievance procedures established in ss. 409.7056 and 641.31(5).

The section also eliminates the provision which requires the board to contract with preferred provider organizations and health maintenance organizations and to give consideration to the organizations that contract with the state group health insurance program.

Reporting requirements for the association are revised to coincide with the fiscal year of the association, which is a calendar year. Reports to the Legislature would be submitted on March 1 instead of October 1 of each year for the prior fiscal year.

The association is authorized to place an individual with a plan case manager, if it is cost-effective and available in the county where the policyholder resides.

The board is charged specifically with the responsibility of administering the association in a fiscally responsible manner that would ensure that the expenses are reasonable in relationship with the services provided and the financial resources are adequate to meet its obligations. To assist the board in meeting this objective, the board is required to engage an actuary to conduct an annual evaluation of the actuarial soundness of the association. If necessary, this evaluation would be conducted on a quarterly basis. The actuary must determine the feasibility of enrolling new members, based upon the projected revenues and expenses of the association.

The board would have the authority to restrict, at any time, the number of participants in the association, if it was determined that the revenues would not be adequate to fund new enrollees. If an individual is denied participation solely on the basis of such a determination, the individual must be granted priority for enrollment in the succeeding period in which the association is reopened for enrollment. For calendar year 2002, enrollment in the association is capped at 500. For calendar year 2003, the association may enroll an additional 1,500 persons. Except as provided in s. 627.6486(2)(j), applications for enrollment must be processed on a first-in, first-out basis.

The association would continue to levy assessments for costs and expenses associated with policyholders insured with the association prior to January 1, 2002. The board would be required to establish procedures to maintain separate accounts and record keeping for policyholders prior to January 1, 2002, and policyholders issued coverage on or after January 1, 2002.

The board is also granted the following powers: 1) appear on its own behalf before governmental agencies; 2) solicit and accept gifts, grants, loans, and other aid; 3) require and collect administrative fees and charges and penalties in connection with transactions; 4) obtain insurance against loss; and 5) contract for necessary goods and services.

Section 5. Amends s. 627.649, F.S., to require agents that sell health insurance in Florida to be licensed in Florida. Currently agents that refer applicants to the association that are ultimately accepted for enrollment are entitled to a referral fee. These agents would be required to be licensed in Florida.

Section 6. Amends section 627.6492, F.S., to provide that insurers are subject to the current law assessment only for those costs and expenses associated with policyholders insured with the association prior to January 1, 2002, including the renewal of coverage for such participants after that date. Obsolete language is eliminated.

For the costs and expenses associated with persons whose coverage begins after January 1, 2002, every insurer would be required to pay, 25 cents per month for each individual policy or covered group subscriber insured in this state, not including covered dependents, under a health insurance policy, certificate, or other evidence of coverage that is issued for a resident of Florida. The section defines insurer, for purposes of this provision, to exclude limited-benefit policies, or other types of supplemental policies designed to fill gaps in underlying coverage, personal injury protection coverage provided in a motor vehicle policy, and workers' compensation. The term, insurer, would include third-party administrators and any insurer who provides administrative services only.

The definition of insurer does not include self-insured employee welfare benefit plans that are not regulated by the Florida Insurance Code pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The definition of insurer would include multiple employer welfare arrangements as provided for in ERISA. Each covered group subscriber, without regard to covered dependents of the subscriber, would be counted only once with respect to any assessment.

The board is required to allow an insurer to exclude from its number of covered group subscribers those individuals that have been counted by any primary insurer providing coverage pursuant to s. 624.509, F.S.

The calculation of the fee shall be determined as of December 31 of each year and will include all polices and covered subscribers, excluding dependents, insured during any time of the year. The payment is due no later than April 1 of the subsequent year. The first payment would be due April 1, 2002, for the period of October 1, 2001, through December 31, 2001. Thereafter, the payment would be due April of the following year for the prior calendar year. The insurer is required to submit a form with the payment that identifies the number of covered lives for the different insurance products and the number of covered months.

Effective October 1, 2001, the fee may be charged directly by the insurer to each policyholder, insured member, or subscriber and is not part of the premium subject to the department's review and approval. Nonpayment of the fee would be considered nonpayment of premium for purposes

of s. 627.6043, F.S. Any insurer that neglects, fails, or refuses to collect the fee is liable for the payment of the fee. The fee would not be subject to the premium tax.

Section 7. Amends s. 627.6498, F.S., to require the association to offer an annual, rather than a semi-annual renewable policy. The section also provides that the plan must offer coverage to every eligible person, subject to limitations set by the association. The section provides the board with the flexibility of establishing the benefits and types of coverage. However, only the premium, deductible, and coinsurance amounts may be modified, as determined by the board. However, policyholders of association policies issued prior to 1992 are entitled to continued coverage at the benefit level established prior to January 1, 2002.

If the coverage is being offered to HIPPA eligible individual, as defined in s. 627.6487, F.S., the individual may select the standard or basic benefit plan, as established in s. 627.6699, F.S. The section eliminates the requirement that the coverage offered by the association must be patterned after the state group health insurance program.

Rates are subject to approval by the department, except as provided by this section. The board would be required to revise premium schedules annually, effective January 2002. The department would determine the standard risk rate. The rate would be adjusted for benefit differences.

The board would establish three premium schedules, based upon an individual's income. Schedule A would be applicable to an individual whose family income exceeds the allowable amount for determining eligibility under the Medicaid program, up to and including 200 percent of the Federal Poverty Level. Premiums for a person under this schedule may not exceed 150 percent of the standard risk rate. Schedule B is applicable to an individual whose family income exceeds 200 percent but is less than 300 percent of the Federal Poverty Level. Premiums for a person under this schedule may not exceed 250 percent of the standard risk rate. Schedule C is applicable to an individual whose income is equal to or greater than 300 percent of the Federal Poverty Level. Premiums for a person under this schedule may not exceed 300 percent of the standard risk rate.

The association would be required to include a provision in the policies that excludes coverage during a period of 12 months following the effective date of the policy for a condition for any preexisting condition that manifested itself within the a period of 6 months prior to the effective date of the policy or medical advice or treatment was recommended or received within that same 6 months. The preexisting condition provision would not apply to a HIPPA eligible individual.

Dependents would continue to be offered coverage in the association in the event of the death or divorce of a covered person.

The section also provides that this act 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 the association for failure to make health services or insurance.

Section 8. The Legislature finds that the provisions of this act fulfill an important state interest.

Section 9. The amendments in this act to s. 627.6487, F.S., would not take effect unless the Health Care Financing Administration of the U.S. Department of Health and Human Services approves this act as providing an acceptable alternative mechanism, as provided in the Public Health Services Act.

Section 10. Section 627.6484, F.S., relating to the closure of the FCHA and the Marketing Assistance Program, is repealed, effective January 1, 2002.

Section 11. Provides that this act is effective July 1, 2001, except as otherwise provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, s. 18 of the Florida Constitution provides that counties and municipalities are not bound by general laws that require them to spend funds or to take an action that requires the expenditure of funds unless the Legislature determines that the law fulfills an important state interest or meets other select exceptions, such as an insignificant fiscal impact. Section 8 provides that the provisions of the act fulfill an important state interest.

There will likely be a fiscal impact, although indeterminate, on cities and counties, unless a city or county administers their own self-insured plan.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

The bill would assess policyholders a monthly fee of 25 cents per month to fund the costs and expenses of the association. This assessment would fund the difference between premiums paid by policyholders and all costs of the association.

B. Private Sector Impact:

The opening of the FHCA would allow HIPPA eligibles and individuals who otherwise are not be able to obtain insurance coverage, due to a determination that they are medically uninsurable, an opportunity to obtain coverage, subject to funding limitations that would limit enrollment, as determined by the board. (See the chart, below, for the estimated number of enrollees.)

C. Government Sector Impact:

According to the Department of Insurance there are 8,572,000 individuals presently insured through employer-sponsored insurance, employer sponsored self-insurance, public sector (federal, state, local government) employer sponsored insurance, self-insurance (administered by a third-party administrator) or non-employer sponsored insurance in Florida. This number was adjusted (divided) by 2.5 percent to determine the estimated number of policies that would be subject to the assessment, to arrive at 3,428,800 policies that would be subject to the assessment. However, the department was unable to provide an estimate of the number of federal employer sponsored insurance or self-insured plans that would not be subject to this assessment.

The first payment of the assessment would be received by the FCHA in April 1, 2002, for the period of October 2001 through December 2001. This three-month period would generate an estimated $10.3 million (or $2.6 million per month) in revenues for the FCHA. On annual basis, it is estimated that the assessment would generate $10,286,400 for the association and provide coverage for an estimated 1,743 - 1,837 individuals.

Assuming that the current trends of the FCHA continue and the unfunded/assessed amount remains relatively stable, each additional member would require an estimated $5600 - $5900 in assessment funding per year. (This assessed amount would fund the difference between premium revenues received and the costs and expense of new enrollees of the FCHA.)

Number Of Enrollee	Estimated Costs (Assessment Funding) 3 Months	Estimated Costs (Assessment Funding) 1 Year	Estimated Revenues 3 Months	Estimated Revenues 1 Year
500	$700,000 - 737,500	$2,800,000- 2,950,000		
1500	$2,100,00- 2,212,500	$8,400,000- 8,850,000		
2000	$2,800,000 - 2,9500,000	$11,200,000 - 11,800,00	$2,571,600	$10,286,400

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.