By the Committees on Health, Aging and Long-Term Care; Banking and Insurance; and Senator Latvala

317-1731-01

A bill to be entitled

An act relating to health insurance; amending s. 627.6482, F.S.; amending definitions used in the Florida Comprehensive Health Association Act; amending s. 627.6486, F.S.; revising the criteria for eligibility for coverage from the association; providing for cessation of coverage; requiring all eligible persons to agree to be placed in a case-management system; amending s. 627.6487, F.S.; redefining the term "eligible individual" for purposes of guaranteed availability of individual health insurance coverage; providing that a person is not eligible if the person is eligible for coverage under the Florida Comprehensive Health Association; amending s. 627.6488, F.S.; revising the membership of the board of directors of the association; revising the reimbursement of board members and employees; requiring that the plan of the association be submitted to the department for approval on an annual basis; revising the duties of the association related to administrative and accounting procedures; requiring an annual financial audit; specifying grievance procedures; establishing a premium schedule based upon an individual's family income; deleting requirements for categorizing insureds as low-risk, medium-risk, and high-risk; authorizing the association to place an individual with a case manager who determines

the health care system or provider; requiring an annual review of the actuarial soundness of the association and the feasibility of enrolling new members; requiring a separate account for policyholders insured prior to a specified date; requiring appointment of an executive director with specified duties; authorizing the board to restrict the number of participants based on inadequate funding; limiting enrollment; specifying other powers of the board; amending s. 627.649, F.S.; revising the requirements for the association to use in selecting an administrator; amending s. 627.6492, F.S.; requiring insurers to be members of the association and to be subject to assessments for operating expenses; limiting assessments to specified maximum amounts; specifying when assessments are calculated and paid; allowing certain assessments to be charged by the health insurer directly to each insured, member, or subscriber and to not be subject to department review or approval; amending s. 627.6498, F.S.; revising the coverage, benefits, covered expenses, premiums, and deductibles of the association; requiring preexisting condition limitations; providing that the act does not provide an entitlement to health care services or health insurance and does not create a cause of action; limiting enrollment in the association; repealing s. 627.6484, F.S., relating to a prohibition on

the Florida Comprehensive Health Association from accepting applications for coverage after a certain date; making a legislative finding that the provisions of this act fulfill an important state interest; providing that the amendments to s. 627.6487, F.S., do not take effect unless approved by the U.S. Health Care Financing Administration; providing effective dates.

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

Section 1. Subsection (12) of section 627.6482, Florida Statutes, is amended, and subsections (15) and (16) are added to that section, to read:

627.6482 Definitions.--As used in ss. 627.648-627.6498, the term:

(12) "Premium" means the entire cost of an insurance plan, including the administrative fee, the risk assumption charge, and, in the instance of a minimum premium plan or stop-loss coverage, the incurred claims whether or not such claims are paid directly by the insurer. ~~"Premium" shall not include a health maintenance organization's annual earned premium revenue for Medicare and Medicaid contracts for any assessment due for calendar years 1990 and 1991. For assessments due for calendar year 1992 and subsequent years,~~A health maintenance organization's annual earned premium revenue for Medicare and Medicaid contracts is subject to assessments unless the department determines that the health maintenance organization has made a reasonable effort to amend its Medicare or Medicaid government contract ~~for 1992 and~~

~~subsequent years~~ to provide reimbursement for any assessment on Medicare or Medicaid premiums paid by the health maintenance organization and the contract does not provide for such reimbursement.

(15) "Federal poverty level" means the most current federal poverty guidelines, as established by the federal Department of Health and Human Services and published in the Federal Register, and in effect on the date of the policy and its annual renewal.

(16) "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.

Section 2. Section 627.6486, Florida Statutes, is amended to read:

627.6486 Eligibility.--

(1) Except as provided in subsection (2), any person who is a resident of this state and has been a resident of this state for the previous 6 months is ~~shall be~~ eligible for coverage under the plan, including:

(a) The insured's spouse.

(b) Any dependent ~~unmarried~~ child of the insured, from the moment of birth. Subject to the provisions of ss.~~s.~~ 627.6041 and 627.6562, such coverage shall 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~~.

(c) The former spouse of the insured whose coverage would otherwise terminate because of annulment or dissolution of marriage, if the former spouse is dependent upon the insured for financial support. The former spouse shall have continued coverage and shall not be subject to waiting periods because of the change in policyholder status.

(2)(a) The board or administrator shall require verification of residency <u>for the preceding 6 months</u> 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. <u>A person may demonstrate his or her residency by maintaining his or her residence in this state for the preceding 6 months, purchasing a home that has been occupied by him or her as his or her primary residence for the previous 6 months, or having established a domicile in this state pursuant to s. 222.17 for the preceding 6 months.</u>

(b) No person who is currently eligible for health care benefits under Florida's Medicaid program is eligible for coverage under the plan unless:

1. He or she has an illness or disease which requires supplies or medication which are covered by the association but are not included in the benefits provided under Florida's Medicaid program in any form or manner; and

2. He or she is not receiving health care benefits or coverage under Florida's Medicaid program.

(c) No person who is covered under the plan and terminates the coverage is again eligible for coverage.

(d) No person on whose behalf the plan has paid out <u>the lifetime maximum benefit currently being offered by the</u>

association of $500,000 in covered benefits is eligible for coverage under the plan.

(e) The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated immediately. If such person again becomes eligible for subsequent coverage under the plan, any previous claims payments shall 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 shall apply to such person. ~~However, no such person may again become eligible for coverage after June 30, 1991.~~

(f) No person is eligible for coverage under the plan unless such person has been rejected by two insurers for coverage substantially similar to the plan coverage and no insurer has been found through the market assistance plan pursuant to s. 627.6484 that is willing to accept the application. As used in this paragraph, "rejection" includes an offer of coverage with a material underwriting restriction ~~or an offer of coverage at a rate greater than the association plan rate~~.

(g) No person is eligible for coverage under the plan if such person has, or is eligible for, on the date of issue of coverage under the plan, 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, or such coverage is provided pursuant to s. 627.6692 and such coverage is 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 or pursuant to s. 627.6692.

(h) A person is ineligible for coverage under the plan if such person is currently eligible for health care benefits under the Medicare program, except for a person who is insured by the Florida Comprehensive Health Association and enrolled under Medicare on July 1, 2001. ~~All eligible persons who are classified as high-risk individuals pursuant to s. 627.6498(4)(a)4. shall, 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.~~

(i) A person is ineligible for coverage under the plan if such person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider.

(j) An eligible individual, as defined in s. 627.6487, and his or her dependents, as described in subsection (1), are automatically eligible for coverage in the association unless the association has ceased accepting new enrollees under s. 627.6488. If the association has ceased accepting new enrollees, the eligible individual is subject to the coverage rights set forth in s. 627.6487.

(3) A person's 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) Sixty days after the person receives notice from the association making any inquiry concerning the person's eligibility or place or residence to which the person does not reply.

(4) 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 system will be cost-effective and provide quality care to the individual.

(5) Except for persons who are insured by the association on December 31, 2001, and who renew such coverage, persons may apply for coverage beginning January 1, 2002, and coverage for such persons shall begin on or after April 1, 2002, as determined by the board pursuant to s. 627.6488(4)(n).

Section 3. Subsection (3) of section 627.6487, Florida Statutes, is amended to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.--

(3) For the purposes of this section, the term "eligible individual" means an individual:

(a)1. For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage, as defined in s. 627.6561(5) and (6), is 18 or more months; and

2.a. Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan; or

b. Whose most recent prior creditable coverage was under an individual plan issued in this state by a health insurer or health maintenance organization, which coverage is

terminated due to the insurer or health maintenance organization becoming insolvent or discontinuing the offering of all individual coverage in the State of Florida, or due to the insured no longer living in the service area in the State of Florida of the insurer or health maintenance organization that provides coverage through a network plan in the State of Florida;

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act;

2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured or self-insured employer plan;

3. Part A or part B of Title XVIII of the Social Security Act; ~~or~~

4. A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage; or

5. The Florida Comprehensive Health Association, if the association is accepting and issuing coverage to new enrollees, provided that the 63-day period specified in s. 627.6561(6) shall be tolled from the time the association receives an application from an individual until the association notifies the individual that it is not accepting and issuing coverage to that individual;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) was not terminated based on a factor described in s. 627.6571(2)(a) or (b), relating to nonpayment of premiums or fraud, unless such

nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

(d) Who, having been offered the option of continuation coverage under a COBRA continuation provision or under s. 627.6692, elected such coverage; and

(e) Who, if the individual elected such continuation provision, has exhausted such continuation coverage under such provision or program.

Section 4. Section 627.6488, Florida Statutes, is amended to read:

627.6488 Florida Comprehensive Health Association.--

(1) There is created a nonprofit legal entity to be known as the "Florida Comprehensive Health Association." All insurers, as a condition of doing business, shall be members of the association.

(2)(a) The association shall operate subject to the supervision and approval of a five-member ~~three-member~~ board of directors consisting of the Insurance Commissioner, or his or her designee, who shall serve as chairperson of the board, and four additional members who must be state residents. At least one member must be a representative of an authorized health insurer or health maintenance organization authorized to transact business in this state.The board of directors shall be appointed by the Insurance Commissioner ~~as follows:~~

~~1. The chair of the board shall be the Insurance Commissioner or his or her designee.~~

~~2. One representative of policyholders who is not associated with the medical profession, a hospital, or an insurer.~~

~~3. One representative of insurers~~.

The administrator or his or her affiliate shall not be a member of the board. Any board member appointed by the commissioner may be removed and replaced by him or her at any time without cause.

(b) All board members, including the chair, shall be appointed to serve for staggered 3-year terms beginning on a date as established in the plan of operation.

(c) The board of directors may ~~shall have the power to~~ employ or retain such persons as are necessary to perform the administrative and financial transactions and responsibilities of the association and to perform other necessary and proper functions not prohibited by law. Employees of the association shall be reimbursed as provided in s. 112.061 from moneys of the association for expenses incurred in carrying out their responsibilities under this act.

(d) Board members may be reimbursed as provided in s. 112.061 from moneys of the association for ~~actual and necessary~~ expenses incurred by them as members in carrying out their responsibilities under the Florida Comprehensive Health Association Act, but may not otherwise be compensated for their services.

(e) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, or its agents or employees, agents or employees of the association, members of the board of directors of the association, or the departmental representatives for any act or omission taken by them in the performance of their powers and duties under this act, unless such act or omission by such person is in intentional disregard of the rights of the claimant.

(f) Meetings of the board are subject to s. 286.011.

(3) The association shall adopt a plan pursuant to this act and submit its articles, bylaws, and operating rules to the department for approval. If the association 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 effectuate the provisions of this act; and such rules shall remain in effect until superseded by a plan and articles, bylaws, and operating rules submitted by the association and approved by the department. Such plan shall be reviewed, revised as necessary, and annually submitted to the department for approval.

(4) The association shall:

(a) Establish administrative and accounting procedures and internal controls for the operation of the association and provide for an annual financial audit of the association by an independent certified public accountant licensed pursuant to chapter 473.

(b) Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board. Individuals receiving care through the association under contract from a health maintenance organization must follow the grievance procedures established in ss. 408.7056 and 641.31(5).

(c) Select an administrator in accordance with s. 627.649.

(d) Collect assessments from all insurers to provide for operating losses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, as formulated in s. 627.6492(1). Annual assessment of the insurers for each calendar year shall occur as soon thereafter as the operating

results of the plan for the calendar year and the earned premiums of insurers being assessed for that year are known. Annual assessments are due and payable within 30 days of receipt of the assessment notice by the insurer.

(e) Require that all policy forms issued by the association conform to standard forms developed by the association. The forms shall be approved by the department.

(f) 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 to maintain public awareness of the plan.

(g) Design and employ cost containment measures and requirements which may include preadmission certification, home health care, hospice care, negotiated purchase of medical and pharmaceutical supplies, and individual case management.

~~(h) Contract with preferred provider organizations and health maintenance organizations giving due consideration to the preferred provider organizations and health maintenance organizations which have contracted with the state group health insurance program pursuant to s. 110.123. If cost-effective and available in the county where the policyholder resides, the board, upon application or renewal of a policy, shall place a high-risk individual, as established under s. 627.6498(4)(a)4., 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. If cost-effective and available in the county where the policyholder resides, the board, with the consent of the policyholder, may place a low-risk or medium-risk individual, as established under s. 627.6498(4)(a)4., with the plan case~~

~~manager who may 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, or guardian.~~

(h)~~(i)~~ 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 March 1 ~~October 1~~ of each year. The report shall summarize the activities of the plan for the prior fiscal ~~12-month period ending July 1 of that~~ year, including then-current data and estimates as to net written and earned premiums, the expense of administration, and the paid and incurred losses for the year. 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 cost containment/case management policy ~~and recommendations concerning the opening of enrollment to new entrants as of July 1, 1992~~.

(i)~~(j)~~ Make a report to the Governor, the Insurance Commissioner, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and House of Representatives, not later than 45 days after the close of each calendar quarter, which includes, for the prior quarter, current data and estimates of net written and earned premiums, the expenses of administration, and the paid and incurred losses. The report shall identify any statutorily mandated program that has not been fully implemented by the board.

(j)~~(k)~~ To facilitate preparation of assessments and for other purposes, the board shall engage an independent certified public account licensed pursuant to chapter 473 to conduct an annual financial audit of the association ~~direct preparation of annual audited financial statements~~ for each calendar year as soon as feasible following the conclusion of that calendar year, and shall, within 30 days after the issuance ~~rendition~~ of such statements, file with the department the annual report containing such information as required by the department to be filed on March 1 of each year.

(k)~~(l)~~ Employ a plan case manager or managers to supervise and manage the medical care or coordinate the supervision and management of the medical care, with the administrator, of specified individuals. The plan case manager, with the approval of the board, shall have final approval over the case management for any specific individual. If cost-effective and available in the county where the policyholder resides, the association, upon application or renewal of a policy, may place an individual 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 or guardian, and the health care providers.

(l) Administer the association in a fiscally responsible manner that ensures that its expenditures are reasonable in relation to the services provided and that the

financial resources of the association are adequate to meet its obligations.

(m) At least annually, but no more than quarterly, evaluate or cause to be evaluated the actuarial soundness of the association. The association shall contract with an actuary to evaluate the pool of insureds in the association and monitor the financial condition of the association. The actuary shall determine the feasibility of enrolling new members in the association, which must be based on the projected revenues and expenses of the association.

(n) Restrict at any time the number of participants in the association based on a determination by the board that the revenues will be inadequate to fund new participants. However, any person denied participation solely on the basis of such restriction must be granted priority for participation in the succeeding period in which the association is reopened for participants. Effective April 1, 2002, the association may provide coverage for up to 500 persons for the period ending December 31, 2002. On or after January 1, 2003, the association may enroll an additional 1,500 persons. At no time may the association provide coverage for more than 2,000 persons. Except as provided in s. 627.6486(2)(j), applications for enrollment must be processed on a first-in, first-out basis.

(o) Establish procedures to maintain separate accounts and recordkeeping for policyholders prior to January 1, 2002, and policyholders issued coverage on and after January 1, 2002.

(p) Appoint an executive director to serve as the chief administrative and operational officer of the association and operate within the specifications of the plan

of operation and perform other duties assigned to him or her by the board.

(5) The association may:

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

(b) Sue or be sued.

(c) In addition to imposing annual assessments under paragraph (4)(d), levy interim assessments against insurers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for a calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment shall be due and payable within 30 days after ~~of~~ receipt by an insurer of an interim assessment notice. Interim assessment payments shall be credited against the insurer's annual assessment. Such assessments may be levied only for costs and expenses associated with policyholders insured with the association prior to January 1, 2002.

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

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

(f) Solicit and accept gifts, grants, loans, and other aid from any source or participate in any way in any government program to carry out the purposes of the Florida Comprehensive Health Association Act.

(g) 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.

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

(i) 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.

(6) The department shall examine and investigate the association in the manner provided in part II of chapter 624.

Section 5. Paragraph (b) of subsection (3) of section 627.649, Florida Statutes, is amended to read:

627.649 Administrator.--

(3) The administrator shall:

(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 shall not be limited to the administrator or its agents. Any agent must be licensed by the department to sell health insurance in this state.The referral fees shall be paid by the administrator from moneys received as premiums for the plan.

Section 6. Section 627.6492, Florida Statutes, is amended to read:

627.6492 Participation of insurers.--

(1)(a) As a condition of doing business in this state an insurer shall pay an assessment to the board, in the amount prescribed by this section. Subsections (1), (2), and (3) apply only to the costs and expenses associated with

policyholders insured with the association prior to January 1, 2002, including renewal of coverage for such policyholders after that date. For operating losses incurred in any calendar year ~~on July 1, 1991, and thereafter~~, each insurer shall annually be assessed by the board in the following calendar year a portion of such incurred operating losses of the plan; such portion shall be determined by multiplying such operating losses by a fraction, the numerator of which equals the insurer's earned premium pertaining to direct writings of health insurance in the state during the calendar year preceding that for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by participating insurers in the state during such calendar year.

(b) ~~For operating losses incurred from July 1, 1991, through December 31, 1991, the total of all assessments upon a participating insurer shall not exceed .375 percent of such insurer's health insurance premiums earned in this state during 1990. For operating losses incurred in 1992 and thereafter,~~The total of all assessments upon a participating insurer shall not exceed 1 percent of such insurer's health insurance premium earned in this state during the calendar year preceding the year for which the assessments were levied.

~~(c) For operating losses incurred from October 1, 1990, through June 30, 1991, the board shall assess each insurer in the amount and manner prescribed by chapter 90-334, Laws of Florida. The maximum assessment against an insurer, as provided in such act, shall apply separately to the claims incurred in 1990 (October 1 through December 31) and the claims incurred in 1991 (January 1 through June 30). For operating losses incurred on January 1, 1991, through June 30,~~

~~1991, the maximum assessment against an insurer shall be one-half of the amount of the maximum assessment specified for such insurer in former s. 627.6492(1)(b), 1990 Supplement, as amended by chapter 90-334, Laws of Florida.~~

(c)~~(d)~~ All rights, title, and interest in the assessment funds collected shall vest in this state. However, all of such funds and interest earned shall be used by the association to pay claims and administrative expenses.

(2) If assessments and other receipts by the association, board, or administrator exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses. As used in this subsection, the term "future losses" includes reserves for claims incurred but not reported.

(3) Each insurer's assessment shall be determined annually by the association based on annual statements and other reports deemed necessary by the association and filed with it by the insurer. Any deficit incurred under the plan shall be recouped by assessments against participating insurers by the board in the manner provided in subsection (1); and the insurers may recover the assessment in the normal course of their respective businesses without time limitation.

(4)(a) This subsection applies only to those costs and expenses of the association related to persons whose coverage begins after January 1, 2002. As a condition of doing business in this state, every insurer shall pay an amount determined by the board of up to 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 this state and shall file the information with

the association as required pursuant to paragraph (d). Any insurer who neglects, fails, or refuses to collect the fee shall be liable for and pay the fee. The fee shall not be subject to the provisions of s. 624.509.

(b) For purposes of this subsection, health insurance does not include accident only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, nursing home care, home health care, community-based care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; any policy covering medical-payment coverage or personal injury protection coverage in a motor vehicle policy; coverage issued as a supplement to liability insurance; or workers' compensation insurance. For the purposes of this subsection, the term "insurer" as defined in s. 627.6482(7) also includes administrators licensed pursuant to s. 626.8805, and any insurer defined in s. 627.6482(7) from whom any person providing health insurance to Florida residents procures insurance for itself in the insurer, with respect to all or part of the health insurance risk of the person, or provides administrative services only. This definition of insurer excludes 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, Pub. L. No. 93-406, as amended. However, this definition of insurer includes multiple employer welfare arrangements as provided for in the Employee Retirement Income Security Act of 1974,

Pub. L. No. 93-406, as amended. Each covered group subscriber, without regard to covered dependents of the subscriber, shall be counted only once with respect to any assessment. For that purpose, the board shall allow an insurer as defined by this subsection to exclude from its number of covered group subscribers those who have been counted by any primary insurer providing health insurance coverage pursuant to s. 624.603.

(c) The calculation shall be determined as of December 31 of each year and shall include all policies and covered subscribers, not including covered dependents of the subscribers, insured at any time during the year, calculated for each month of coverage. The payment is payable to the association no later than April 1 of the subsequent year. The first payment shall be forwarded to the association no later than April 1, 2002, covering the period of October 1, 2001, through December 31, 2001.

(d) The payment of such funds shall be submitted to the association accompanied by a form prescribed by the association and adopted in the plan of operation. The form shall identify the number of covered lives for different types of health insurance products and the number of months of coverage.

(e) Beginning October 1, 2001, the fee paid to the association may be charged by the health insurer directly 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 shall be considered nonpayment of premium for purposes of s. 627.6043.

Section 7. Section 627.6498, Florida Statutes, is amended to read:

627.6498 Minimum benefits coverage; exclusions; premiums; deductibles.--

(1) COVERAGE OFFERED.--

(a) The plan shall offer in an annually ~~a semiannually~~ renewable policy the coverage specified in this section for each eligible person. ~~For applications accepted on or after June 7, 1991, but before July 1, 1991, coverage shall be effective on July 1, 1991, and shall be renewable on January 1, 1992, and every 6 months thereafter. Policies in existence on June 7, 1991, shall, upon renewal, be for a term of less than 6 months that terminates and becomes subject to subsequent renewal on the next succeeding January 1 or July 1, whichever is sooner.~~

~~(b) If an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.~~

~~(c) 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 shall be the date of termination of the previous coverage.~~

(b)~~(d)~~ The plan shall provide that, upon the death or divorce of the individual in whose name the contract was issued, every other person then covered in the contract may elect within 60 days to continue under the same or a different contract.

(c)~~(e)~~ No coverage provided to a person who is eligible for Medicare benefits shall be issued as a Medicare supplement policy as defined in s. 627.672.

(2) BENEFITS.--

(a) The plan must offer coverage to every eligible person subject to limitations set by the association. The coverage offered must pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under subsection (4). The lifetime benefits limit for such coverage shall be $500,000. However, policyholders of association policies issued prior to 1992 are entitled to continued coverage at the benefit level established prior to January 1, 2002. Only the premium, deductible, and coinsurance amounts may be modified as determined necessary by the board.~~The plan shall offer major medical expense coverage similar to that provided by the state group health insurance program as defined in s. 110.123 except as specified in subsection (3) to every eligible person who is not eligible for Medicare. Major medical expense coverage offered under the plan shall 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 paragraph shall not be altered by the board, and no actuarially equivalent benefit may be substituted by the board.~~

(b) The plan shall provide that any policy issued to a person eligible for Medicare shall be separately rated to reflect differences in experience reasonably expected to occur as a result of Medicare payments.

(3) COVERED EXPENSES.--

(a) The board shall establish the coverage to be issued by the association.

(b) If the coverage is being issued to an eligible individual as defined in s. 627.6487, the individual shall be offered, at the option of the individual, the basic and the standard health benefit plan as established in s. 627.6699. ~~The coverage to be issued by the association shall be patterned after the state group health insurance program as defined in s. 110.123, including its benefits, exclusions, and other limitations, except as otherwise provided in this act. The plan may cover the cost of experimental drugs which have been approved for use by the Food and Drug Administration on an experimental basis if the cost is less than the usual and customary treatment. Such coverage shall only apply to those insureds who are in the case management system upon the approval of the insured, the case manager, and the board.~~

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

~~(a)~~ The plan shall 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, plus the benefits payable under any other type of insurance coverage or workers' compensation. The schedule of premiums and deductibles shall be established by the board ~~association~~. ~~With regard to any preferred provider arrangement utilized by the association, the deductibles provided in this paragraph shall be the minimum deductibles applicable to the preferred providers and higher deductibles, as approved by the department, may be applied to providers who are not preferred providers.~~

1. Separate schedules of premium rates based on age may apply for individual risks.

2. Rates are subject to approval by the department pursuant to ss. 627.410 and 627.411, except as provided by

this section. The board shall revise premium schedules annually, beginning January 2002.

~~3. Standard risk rates for coverages issued by the association shall be established by the department, pursuant to s. 627.6675(3).~~

3.~~4.~~ The board shall establish three premium schedules based upon an individual's family income:

a. Schedule A is 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.

b. 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.

c. Schedule C is applicable to an individual whose family 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.

~~establish separate premium schedules for low-risk individuals, medium-risk individuals, and high-risk individuals and shall revise premium schedules annually beginning January 1999.~~

4. The standard risk rate shall be determined by the department pursuant to s. 627.6675(3). The rate shall be adjusted for benefit differences.~~No rate shall exceed 200 percent of the standard risk rate for low-risk individuals, 225 percent of the standard risk rate for medium-risk individuals, or 250 percent of the standard risk rate for high-risk individuals. For the purpose of determining what~~

~~constitutes a low-risk individual, medium-risk individual, or high-risk individual, the board shall consider the anticipated claims payment for individuals based upon an individual's health condition.~~

~~(b) If the 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 shall pay in the following manner:~~

~~1. For individuals placed under case management, the plan shall pay 90 percent of the additional covered costs incurred by the person during the policy year for the first $10,000, after which the plan shall pay 100 percent of the covered costs incurred by the person during the policy year.~~

~~2. For individuals utilizing the preferred provider network, the plan shall pay 80 percent of the additional covered costs incurred by the person during the policy year for the first $10,000, after which the plan shall pay 90 percent of covered costs incurred by the person during the policy year.~~

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

(5) PREEXISTING CONDITIONS.--An association policy shall ~~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, as long as:

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

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

This subsection does not apply to an eligible individual as defined in s. 627.6487.

(6) OTHER SOURCES PRIMARY.--

(a) No 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 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 otherwise not covered.

(7) NONENTITLEMENT.--The Florida Comprehensive Health Association 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 health insurance available under the Florida Comprehensive Health Association Act.

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

Section 9. The amendments in this act to section 627.6487, Florida Statutes, shall 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 Service Act.

Section 10. Effective January 1, 2002, section 627.6484, Florida Statutes, is repealed.

Section 11. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2001.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR CS for SB 1208

CS/CS/SB 1208 amends the bill to correct the definition of the term "Federal Poverty Level" to be the most current poverty guidelines established by the federal Department of Health and Human Services, published in the Federal Register, and in effect on the date of the policy and annual renewal. The term "Medicare programs" is corrected to "Medicare program." A mis-citation relating to enrollee eligibility of "s. 627.6488(5)(e)" is corrected to "s. 627.6488(4)(n)." Grammatical errors are edited out of the term "policyholder, parent or guardian, and the health care provider" as related to enrollee case management.