

Bill No. CS for SB 1210

Amendment No. Barcode 712174

<u>Senate</u>	CHAMBER ACTION	<u>House</u>
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11 Senator Latvala moved the following amendment:

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13 **Senate Amendment (with title amendment)**

14 On page 17, line 18, delete that line

15
16 and insert:

17 Section 9. Subsection (12) of section 627.6482,
18 Florida Statutes, is amended, and subsections (15) and (16)
19 are added to that section, to read:

20 627.6482 Definitions.--As used in ss.
21 627.648-627.6498, the term:

22 (12) "Premium" means the entire cost of an insurance
 23 plan, including the administrative fee, the risk assumption
 24 charge, and, in the instance of a minimum premium plan or
 25 stop-loss coverage, the incurred claims whether or not such
 26 claims are paid directly by the insurer. ~~"Premium" shall not
 27 include a health maintenance organization's annual earned
 28 premium revenue for Medicare and Medicaid contracts for any
 29 assessment due for calendar years 1990 and 1991. For
 30 assessments due for calendar year 1992 and subsequent years, A~~
 31 health maintenance organization's annual earned premium

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1 revenue for Medicare and Medicaid contracts is subject to
2 assessments unless the department determines that the health
3 maintenance organization has made a reasonable effort to amend
4 its Medicare or Medicaid government contract ~~for 1992 and~~
5 ~~subsequent years~~ to provide reimbursement for any assessment
6 on Medicare or Medicaid premiums paid by the health
7 maintenance organization and the contract does not provide for
8 such reimbursement.

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

14 (16) "Family income" means the adjusted gross income,
15 as defined in s. 62 of the United States Internal Revenue
16 Code, of all members of a household.

17 Section 10. Section 627.6486, Florida Statutes, is
18 amended to read:

19 627.6486 Eligibility.--

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

24 (a) The insured's spouse.

25 (b) Any dependent ~~unmarried~~ child of the insured, from
26 the moment of birth. Subject to the provisions of ~~ss. s.~~
27 627.6041 and 627.6562, such coverage shall terminate at the
28 end of the premium period in which the child ~~marries,~~ ceases
29 to be a dependent of the insured, ~~or attains the age of 19,~~
30 ~~whichever occurs first. However, if the child is a full-time~~
31 ~~student at an accredited institution of higher learning, the~~

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1 ~~coverage may continue while the child remains unmarried and a~~
2 ~~full-time student, but not beyond the premium period in which~~
3 ~~the child reaches age 23.~~

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

10 (2)(a) The board or administrator shall require
11 verification of residency for the preceding 6 months and shall
12 require any additional information or documentation, or
13 statements under oath, when necessary to determine residency
14 upon initial application and for the entire term of the
15 policy. A person may demonstrate his or her residency by
16 maintaining his or her residence in this state for the
17 preceding 6 months, purchasing a home that has been occupied
18 by him or her as his or her primary residence for the previous
19 6 months, or having established a domicile in this state
20 pursuant to s. 222.17 for the preceding 6 months.

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

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

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

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

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1 (d) No person on whose behalf the plan has paid out
2 the lifetime maximum benefit currently being offered by the
3 association of \$500,000 in covered benefits is eligible for
4 coverage under the plan.

5 (e) The coverage of any person who ceases to meet the
6 eligibility requirements of this section may be terminated
7 immediately. If such person again becomes eligible for
8 subsequent coverage under the plan, any previous claims
9 payments shall be applied towards the \$500,000 lifetime
10 maximum benefit and any limitation relating to preexisting
11 conditions in effect at the time such person again becomes
12 eligible shall apply to such person. ~~However, no such person~~
13 ~~may again become eligible for coverage after June 30, 1991.~~

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

23 (g) No person is eligible for coverage under the plan
24 if such person has, or is eligible for, on the date of issue
25 of coverage under the plan, substantially similar coverage
26 under another contract or policy, unless such coverage is
27 provided pursuant to the Consolidated Omnibus Budget
28 Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82
29 (1986) (COBRA), as amended, or such coverage is provided
30 pursuant to s. 627.6692 and such coverage is scheduled to end
31 at a time certain and the person meets all other requirements

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1 of eligibility. Coverage provided by the association shall be
2 secondary to any coverage provided by an insurer pursuant to
3 COBRA or pursuant to s. 627.6692.

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

10 ~~627.6498(4)(a)4. shall, upon application or renewal, agree to~~
11 ~~be placed in a case management system when it is determined by~~
12 ~~the board and the plan case manager that such system will be~~
13 ~~cost-effective and provide quality care to the individual.~~

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

18 (j) An eligible individual, as defined in s. 627.6487,
19 and his or her dependents, as described in subsection (1), are
20 automatically eligible for coverage in the association unless
21 the association has ceased accepting new enrollees under s.
22 627.6488. If the association has ceased accepting new
23 enrollees, the eligible individual is subject to the coverage
24 rights set forth in s. 627.6487.

25 (3) A person's coverage ceases:

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

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

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

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

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

5 (4) All eligible persons must, upon application or
6 renewal, agree to be placed in a case-management system when
7 the association and case manager find that such system will be
8 cost-effective and provide quality care to the individual.

9 (5) Except for persons who are insured by the
10 association on December 31, 2001, and who renew such coverage,
11 persons may apply for coverage beginning January 1, 2002, and
12 coverage for such persons shall begin on or after April 1,
13 2002, as determined by the board pursuant to s.
14 627.6488(4)(n).

15 Section 11. Subsection (3) of section 627.6487,
16 Florida Statutes, is amended to read:

17 627.6487 Guaranteed availability of individual health
18 insurance coverage to eligible individuals.--

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

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

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

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

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

8 (b) Who is not eligible for coverage under:

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

11 2. A conversion policy or contract issued by an
12 authorized insurer or health maintenance organization under s.
13 627.6675 or s. 641.3921, respectively, offered to an
14 individual who is no longer eligible for coverage under either
15 an insured or self-insured employer plan;

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

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

21 5. The Florida Comprehensive Health Association, if
22 the association is accepting and issuing coverage to new
23 enrollees, provided that the 63-day period specified in s.
24 627.6561(6) shall be tolled from the time the association
25 receives an application from an individual until the
26 association notifies the individual that it is not accepting
27 and issuing coverage to that individual;

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

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

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

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

9 Section 12. Section 627.6488, Florida Statutes, is
10 amended to read:

11 627.6488 Florida Comprehensive Health Association.--

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

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

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

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

30 ~~3. One representative of insurers.~~

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

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

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

16 (d) Board members may be reimbursed as provided in s.
17 112.061 from moneys of the association for ~~actual and~~
18 necessary expenses incurred by them as members in carrying out
19 their responsibilities under the Florida Comprehensive Health
20 Association Act, but may not otherwise be compensated for
21 their services.

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

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

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

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

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

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

16 ~~(h) Contract with preferred provider organizations and~~
17 ~~health maintenance organizations giving due consideration to~~
18 ~~the preferred provider organizations and health maintenance~~
19 ~~organizations which have contracted with the state group~~
20 ~~health insurance program pursuant to s. 110.123. If~~
21 ~~cost-effective and available in the county where the~~
22 ~~policyholder resides, the board, upon application or renewal~~
23 ~~of a policy, shall place a high-risk individual, as~~
24 ~~established under s. 627.6498(4)(a)4., with the plan case~~
25 ~~manager who shall determine the most cost-effective quality~~
26 ~~care system or health care provider and shall place the~~
27 ~~individual in such system or with such health care provider.~~
28 ~~If cost-effective and available in the county where the~~
29 ~~policyholder resides, the board, with the consent of the~~
30 ~~policyholder, may place a low-risk or medium-risk individual,~~
31 ~~as established under s. 627.6498(4)(a)4., with the plan case~~

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1 ~~manager who may determine the most cost-effective quality care~~
2 ~~system or health care provider and shall place the individual~~
3 ~~in such system or with such health care provider. Prior to and~~
4 ~~during the implementation of case management, the plan case~~
5 ~~manager shall obtain input from the policyholder, parent, or~~
6 ~~guardian.~~

7 (h)(i) Make a report to the Governor, the President of
8 the Senate, the Speaker of the House of Representatives, and
9 the Minority Leaders of the Senate and the House of
10 Representatives not later than March 1 ~~October 1~~ of each year.
11 The report shall summarize the activities of the plan for the
12 prior fiscal 12-month period ending July 1 of that year,
13 including then-current data and estimates as to net written
14 and earned premiums, the expense of administration, and the
15 paid and incurred losses for the year. The report shall also
16 include analysis and recommendations for legislative changes
17 regarding utilization review, quality assurance, an evaluation
18 of the administrator of the plan, access to cost-effective
19 health care, and cost containment/case management policy ~~and~~
20 ~~recommendations concerning the opening of enrollment to new~~
21 ~~entrants as of July 1, 1992.~~

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

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1 its obligations.

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

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

24 (o) Establish procedures to maintain separate accounts
25 and recordkeeping for policyholders prior to January 1, 2002,
26 and policyholders issued coverage on and after January 1,
27 2002.

28 (p) Appoint an executive director to serve as the
29 chief administrative and operational officer of the
30 association and operate within the specifications of the plan
31 of operation and perform other duties assigned to him or her

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1 by the board.

2 (5) The association may:

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

5 (b) Sue or be sued.

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

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

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

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

27 (g) Require and collect administrative fees and
28 charges in connection with any transaction and impose
29 reasonable penalties, including default, for delinquent
30 payments or for entering into the association on a fraudulent
31 basis.

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

4 (i) Contract for necessary goods and services; employ
5 necessary personnel; and engage the services of private
6 consultants, actuaries, managers, legal counsel, and
7 independent certified public accountants for administrative or
8 technical assistance.

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

11 Section 13. Paragraph (b) of subsection (3) of section
12 627.649, Florida Statutes, is amended to read:

13 627.649 Administrator.--

14 (3) The administrator shall:

15 (b) Pay an agent's referral fee as established by the
16 board to each insurance agent who refers an applicant to the
17 plan, if the applicant's application is accepted. The selling
18 or marketing of plans shall not be limited to the
19 administrator or its agents. Any agent must be licensed by the
20 department to sell health insurance in this state.The
21 referral fees shall be paid by the administrator from moneys
22 received as premiums for the plan.

23 Section 14. Section 627.6492, Florida Statutes, is
24 amended to read:

25 627.6492 Participation of insurers.--

26 (1)(a) As a condition of doing business in this state
27 an insurer shall pay an assessment to the board, in the amount
28 prescribed by this section. Subsections (1), (2), and (3)
29 apply only to the costs and expenses associated with
30 policyholders insured with the association prior to January 1,
31 2002, including renewal of coverage for such policyholders

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1 after that date. For operating losses incurred in any
2 calendar year ~~on July 1, 1991, and thereafter,~~ each insurer
3 shall annually be assessed by the board in the following
4 calendar year a portion of such incurred operating losses of
5 the plan; such portion shall be determined by multiplying such
6 operating losses by a fraction, the numerator of which equals
7 the insurer's earned premium pertaining to direct writings of
8 health insurance in the state during the calendar year
9 preceding that for which the assessment is levied, and the
10 denominator of which equals the total of all such premiums
11 earned by participating insurers in the state during such
12 calendar year.

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

22 (c) ~~For operating losses incurred from October 1,~~
23 ~~1990, through June 30, 1991, the board shall assess each~~
24 ~~insurer in the amount and manner prescribed by chapter 90-334,~~
25 ~~Laws of Florida. The maximum assessment against an insurer, as~~
26 ~~provided in such act, shall apply separately to the claims~~
27 ~~incurred in 1990 (October 1 through December 31) and the~~
28 ~~claims incurred in 1991 (January 1 through June 30). For~~
29 ~~operating losses incurred on January 1, 1991, through June 30,~~
30 ~~1991, the maximum assessment against an insurer shall be~~
31 ~~one-half of the amount of the maximum assessment specified for~~

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1 ~~such insurer in former s. 627.6492(1)(b), 1990 Supplement, as~~
2 ~~amended by chapter 90-334, Laws of Florida.~~

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

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

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

21 (4)(a) This subsection applies only to those costs and
22 expenses of the association related to persons whose coverage
23 begins after January 1, 2002. As a condition of doing business
24 in this state, every insurer shall pay an amount determined by
25 the board of up to 25 cents per month for each individual
26 policy or covered group subscriber insured in this state, not
27 including covered dependents, under a health insurance policy,
28 certificate, or other evidence of coverage that is issued for
29 a resident of this state and shall file the information with
30 the association as required pursuant to paragraph (d). Any
31 insurer who neglects, fails, or refuses to collect the fee

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1 shall be liable for and pay the fee. The fee shall not be
2 subject to the provisions of s. 624.509.

3 (b) For purposes of this subsection, health insurance
4 does not include accident only, specified disease, individual
5 hospital indemnity, credit, dental-only, vision-only, Medicare
6 supplement, long-term care, nursing home care, home health
7 care, community-based care, or disability income insurance;
8 similar supplemental plans provided under a separate policy,
9 certificate, or contract of insurance, which cannot duplicate
10 coverage under an underlying health plan and are specifically
11 designed to fill gaps in the underlying health plan,
12 coinsurance, or deductibles; any policy covering
13 medical-payment coverage or personal injury protection
14 coverage in a motor vehicle policy; coverage issued as a
15 supplement to liability insurance; or workers' compensation
16 insurance. For the purposes of this subsection, the term
17 "insurer" as defined in s. 627.6482(7) also includes
18 administrators licensed pursuant to s. 626.8805, and any
19 insurer defined in s. 627.6482(7) from whom any person
20 providing health insurance to Florida residents procures
21 insurance for itself in the insurer, with respect to all or
22 part of the health insurance risk of the person, or provides
23 administrative services only. This definition of insurer
24 excludes self-insured, employee welfare benefit plans that are
25 not regulated by the Florida Insurance Code pursuant to the
26 Employee Retirement Income Security Act of 1974, Pub. L. No.
27 93-406, as amended. However, this definition of insurer
28 includes multiple employer welfare arrangements as provided
29 for in the Employee Retirement Income Security Act of 1974,
30 Pub. L. No. 93-406, as amended. Each covered group subscriber,
31 without regard to covered dependents of the subscriber, shall

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1 be counted only once with respect to any assessment. For that
2 purpose, the board shall allow an insurer as defined by this
3 subsection to exclude from its number of covered group
4 subscribers those who have been counted by any primary insurer
5 providing health insurance coverage pursuant to s. 624.603.

6 (c) The calculation shall be determined as of December
7 31 of each year and shall include all policies and covered
8 subscribers, not including covered dependents of the
9 subscribers, insured at any time during the year, calculated
10 for each month of coverage. The payment is payable to the
11 association no later than April 1 of the subsequent year. The
12 first payment shall be forwarded to the association no later
13 than April 1, 2002, covering the period of October 1, 2001,
14 through December 31, 2001.

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

21 (e) Beginning October 1, 2001, the fee paid to the
22 association may be charged by the health insurer directly to
23 each policyholder, insured member, or subscriber and is not
24 part of the premium subject to the department's review and
25 approval. Nonpayment of the fee shall be considered nonpayment
26 of premium for purposes of s. 627.6043.

27 Section 15. Section 627.6498, Florida Statutes, is
28 amended to read:

29 627.6498 Minimum benefits coverage; exclusions;
30 premiums; deductibles.--

31 (1) COVERAGE OFFERED.--

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

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

14 ~~(c) Any person whose health insurance coverage is~~
15 ~~involuntarily terminated for any reason other than nonpayment~~
16 ~~of premium may apply for coverage under the plan. If such~~
17 ~~coverage is applied for within 60 days after the involuntary~~
18 ~~termination and if premiums are paid for the entire period of~~
19 ~~coverage, the effective date of the coverage shall be the date~~
20 ~~of termination of the previous coverage.~~

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

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

29 (2) BENEFITS.--

30 (a) The plan must offer coverage to every eligible
31 person subject to limitations set by the association. The

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

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

25 (3) COVERED EXPENSES.--

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

28 (b) If the coverage is being issued to an eligible
29 individual as defined in s. 627.6487, the individual shall be
30 offered, at the option of the individual, the basic and the
31 standard health benefit plan as established in s. 627.6699.

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1 ~~The coverage to be issued by the association shall be~~
2 ~~patterned after the state group health insurance program as~~
3 ~~defined in s. 110.123, including its benefits, exclusions, and~~
4 ~~other limitations, except as otherwise provided in this act.~~
5 ~~The plan may cover the cost of experimental drugs which have~~
6 ~~been approved for use by the Food and Drug Administration on~~
7 ~~an experimental basis if the cost is less than the usual and~~
8 ~~customary treatment. Such coverage shall only apply to those~~
9 ~~insureds who are in the case management system upon the~~
10 ~~approval of the insured, the case manager, and the board.~~

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

12 (a) The plan shall provide for annual deductibles for
13 major medical expense coverage in the amount of \$1,000 or any
14 higher amounts proposed by the board and approved by the
15 department, plus the benefits payable under any other type of
16 insurance coverage or workers' compensation. The schedule of
17 premiums and deductibles shall be established by the board
18 ~~association. With regard to any preferred provider arrangement~~
19 ~~utilized by the association, the deductibles provided in this~~
20 ~~paragraph shall be the minimum deductibles applicable to the~~
21 ~~preferred providers and higher deductibles, as approved by the~~
22 ~~department, may be applied to providers who are not preferred~~
23 ~~providers.~~

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

26 2. Rates are subject to approval by the department
27 pursuant to ss. 627.410 and 627.411, except as provided by
28 this section. The board shall revise premium schedules
29 annually, beginning January 2002.

30 3. ~~Standard risk rates for coverages issued by the~~
31 ~~association shall be established by the department, pursuant~~

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1 ~~to s. 627.6675(3).~~

2 3.4. The board shall establish three premium schedules
3 based upon an individual's family income:

4 a. Schedule A is applicable to an individual whose
5 family income exceeds the allowable amount for determining
6 eligibility under the Medicaid program, up to and including
7 200 percent of the Federal Poverty Level. Premiums for a
8 person under this schedule may not exceed 150 percent of the
9 standard risk rate.

10 b. Schedule B is applicable to an individual whose
11 family income exceeds 200 percent but is less than 300 percent
12 of the Federal Poverty Level. Premiums for a person under this
13 schedule may not exceed 250 percent of the standard risk rate.

14 c. Schedule C is applicable to an individual whose
15 family income is equal to or greater than 300 percent of the
16 Federal Poverty Level. Premiums for a person under this
17 schedule may not exceed 300 percent of the standard risk rate.

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

21 4. The standard risk rate shall be determined by the
22 department pursuant to s. 627.6675(3). The rate shall be
23 adjusted for benefit differences.~~No rate shall exceed 200~~
24 ~~percent of the standard risk rate for low-risk individuals,~~
25 ~~225 percent of the standard risk rate for medium-risk~~
26 ~~individuals, or 250 percent of the standard risk rate for~~
27 ~~high-risk individuals. For the purpose of determining what~~
28 ~~constitutes a low-risk individual, medium-risk individual, or~~
29 ~~high-risk individual, the board shall consider the anticipated~~
30 ~~claims payment for individuals based upon an individual's~~
31 ~~health condition.~~

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1 ~~(b) If the covered costs incurred by the eligible~~
2 ~~person exceed the deductible for major medical expense~~
3 ~~coverage selected by the person in a policy year, the plan~~
4 ~~shall pay in the following manner:~~

5 ~~1. For individuals placed under case management, the~~
6 ~~plan shall pay 90 percent of the additional covered costs~~
7 ~~incurred by the person during the policy year for the first~~
8 ~~\$10,000, after which the plan shall pay 100 percent of the~~
9 ~~covered costs incurred by the person during the policy year.~~

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

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

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

27 (a) The condition manifested itself within a period of
28 6 months before the effective date of coverage; or

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

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

Section 17. The amendments in this act to section 627.6487(3), 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.

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1 Section 18. Effective January 1, 2002, section
2 627.6484, Florida Statutes, is repealed.

3 Section 19. Except as otherwise expressly provided in
4 this act, this act shall take effect July 1, 2001.

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6

7 ===== T I T L E A M E N D M E N T =====

8 And the title is amended as follows:

9 On page 2, line 25, delete that line

10

11 and insert:

12 of subscribers; amending s. 627.6482, F.S.;

13 amending definitions used in the Florida

14 Comprehensive Health Association Act; amending

15 s. 627.6486, F.S.; revising the criteria for

16 eligibility for coverage from the association;

17 providing for cessation of coverage; requiring

18 all eligible persons to agree to be placed in a

19 case-management system; amending s. 627.6487,

20 F.S.; redefining the term "eligible individual"

21 for purposes of guaranteed availability of

22 individual health insurance coverage; providing

23 that a person is not eligible if the person is

24 eligible for coverage under the Florida

25 Comprehensive Health Association; amending s.

26 627.6488, F.S.; revising the membership of the

27 board of directors of the association; revising

28 the reimbursement of board members and

29 employees; requiring that the plan of the

30 association be submitted to the department for

31 approval on an annual basis; revising the

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1 duties of the association related to
2 administrative and accounting procedures;
3 requiring an annual financial audit; specifying
4 grievance procedures; establishing a premium
5 schedule based upon an individual's family
6 income; deleting requirements for categorizing
7 insureds as low-risk, medium-risk, and
8 high-risk; authorizing the association to place
9 an individual with a case manager who
10 determines the health care system or provider;
11 requiring an annual review of the actuarial
12 soundness of the association and the
13 feasibility of enrolling new members; requiring
14 a separate account for policyholders insured
15 prior to a specified date; requiring
16 appointment of an executive director with
17 specified duties; authorizing the board to
18 restrict the number of participants based on
19 inadequate funding; limiting enrollment;
20 specifying other powers of the board; amending
21 s. 627.649, F.S.; revising the requirements for
22 the association to use in selecting an
23 administrator; amending s. 627.6492, F.S.;

24 requiring insurers to be members of the
25 association and to be subject to assessments
26 for operating expenses; limiting assessments to
27 specified maximum amounts; specifying when
28 assessments are calculated and paid; allowing
29 certain assessments to be charged by the health
30 insurer directly to each insured, member, or
31 subscriber and to not be subject to department

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1 review or approval; amending s. 627.6498, F.S.;

2 revising the coverage, benefits, covered

3 expenses, premiums, and deductibles of the

4 association; requiring preexisting condition

5 limitations; providing that the act does not

6 provide an entitlement to health care services

7 or health insurance and does not create a cause

8 of action; limiting enrollment in the

9 association; repealing s. 627.6484, F.S.,

10 relating to a prohibition on the Florida

11 Comprehensive Health Association from accepting

12 applications for coverage after a certain date;

13 making a legislative finding that the

14 provisions of this act fulfill an important

15 state interest; providing that the amendments

16 to s. 627.6487(3), F.S., do not take effect

17 unless approved by the U.S. Health Care

18 Financing Administration; providing effective

19 dates.

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