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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH PROMOTION
ANALYSIS

BILL #: HB 1373

RELATING TO: Health Insurance

SPONSOR(S): Representative Green

TIED BILL(S):

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

(1) HEALTH PROMOTION YEAS 11 NAYS 0
(2) INSURANCE
(3) HEALTH & HUMAN SERVICES APPROPRIATIONS
(4) COUNCIL FOR HEALTHY COMMUNITIES
(5)

I. SUMMARY:

HB 1373 revises various provisions of the statute relating to the Florida Comprehensive Health Association (FCHA). The bill:

- Modifies criteria for eligibility for coverage from the association and provides for cessation of coverage;
- Requires all eligible persons to agree to be placed in a case-management system and redefines the term "eligible individual," provides that a person is not eligible if they are eligible for health care benefits under the Medicare programs, with certain exceptions;
- Revises the membership of the board of directors of the association, revises the reimbursement of board members, specifies other powers of the board, requires that the plan of the association be submitted to the Department of Insurance for approval on an annual basis, and revises the duties of the association related to administrative/accounting procedures, and requires an annual audit;
- Specifies grievance procedures and deletes requirements for categorizing insureds as low-risk/medium-risk/high-risk;
- Requires an annual review of the actuarial soundness of the association, the feasibility of enrolling new members, and requires a separate account for policyholders insured prior to a specified date;
- Requires appointment of an executive director with specified duties, authorizes the board to restrict the number of participants based on inadequate funding, and revises the requirements for association use in selecting an administrator;
- Requires insurers to be members of the association and to be subject to assessments for operating expenses, limits assessments to specified maximum amounts ($1 per covered insured, member, or subscriber per month), specifies when assessments are calculated and paid, and allows certain assessments to be charged by the health insurer directly to each insured, member, or subscriber;
- Revises the coverage/benefits/covered expenses, premiums, and deductibles of the association and requires preexisting condition limitations, and provides that the act does not provide an entitlement to health care services or health insurance and does not create a cause of action; and
- Repeals current law relating to a prohibition on the association from accepting applications for coverage after a certain date.

The bill's effective date is July 1, 2001.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No [x]	N/A []
3.	Individual Freedom	Yes [x]	No []	N/A []
4.	Personal Responsibility	Yes [x]	No []	N/A []
5.	Family Empowerment	Yes [x]	No []	N/A []

Less Government: The bill authorizes the re-opening of the Florida Comprehensive Health Association, a health insurance high risk pool. The bill expands the board, the duties of the board, and opens enrollment for certain eligible individuals based on the actuarial soundness of the association.

Lower Taxes: The bill authorizes a $1 per month assessment per each individual policy, insured group member, self-insured individual, or subscriber, as of December 31 of each year. The insurer or third-party administrator would be liable for the payment of the assessment to the association. The first payment would be due April 1, 2002, for the period of October 1, 2001 through December 31, 2001. Thereafter, payments for the prior calendar year would be due April 1 of the following year. Effective October 1, 2001, the insurer may charge the fee directly to each policyholder, insured member, or subscriber.

B. PRESENT SITUATION:

Florida Comprehensive Health Association

Under current law, the FCHA provides health insurance to individuals who, due to their health status or inability to afford coverage, are unable to obtain health insurance coverage in the private market. Throughout the early years of the program, enrollment and losses were low; however, in 1989, enrollment and losses increased substantially. Legislation was enacted to prohibit the FCHA from issuing new policies to new applicants after July 1, 1991, s. 627.6484, F.S. Established under ss. 627.648-627.6498, F.S, the FCHA currently provides coverage for 702 individuals. According to the representatives of FCHA, enrollment is declining at a rate of 15 percent per year.

In Florida, the State Comprehensive Health Association (the predecessor of the FCHA) was created in 1983 to offer residents of the state, through the participation of health insurance companies, a program of health insurance. The FCHA was created as a nonprofit, legal entity subject to the supervision of a three-member board of directors, appointed by the Insurance Commissioner. The board includes the chairman, who is the Insurance Commissioner or his designee, one representative of policyholders, and one representative of insurers. Presently, an independent agent serves as a representative of the insurers, as compared to a representative of an insurer selected in the past.

FCHA Eligibility, Benefits, and Premiums

Effective July 1, 1990, the FCHA was amended to require the FCHA to pattern its coverage after the state group health insurance program including benefits, exclusions, and other limitations,

except as otherwise provided by law. The major medical expense coverage under FCHA includes a $500,000 lifetime limit per covered life. The FCHA provides for an annual deductible in the amount of $1,000 or more, as approved by the Department of Insurance. The FCHA provides for a 12-month exclusion of insurance coverage with respect to a condition that manifested itself within 6 months of the effective date of the coverage, or medical advice or treatment recommended or received within a period of 6 months before the effective date of the coverage.

As a condition for being considered eligible for enrollment in the FCHA, two insurers offering coverage substantially similar to the FCHA's coverage must reject an individual and no insurer has been found through the market assistance plan that is willing to accept the application. Rejection is defined to mean an offer of coverage with a material underwriting restriction or an offer of coverage at a rate greater than the FCHA's rate. Therefore, the rejection may or may not be due to a determination that an applicant is medically uninsurable.

Legislative changes in 1990 required the FCHA board or administrator to verify the residency of an applicant and to prohibit the enrollment of a person who is eligible for Medicaid from receiving benefits from the FCHA unless: 1) such person has an illness or disease which requires supplies or services which are covered by the FCHA, but not under Florida's Medicaid program, and 2) the person is not receiving benefits under Medicaid. In addition, the law was clarified to allow FCHA to terminate an enrollee immediately if a person ceases to meet the eligibility requirements.

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

According to the FCHA, the standard risk rate that is established by the department is compared to the rates approved by the FCHA and the FCHA actuary recommends whether adjustments are necessary. The FCHA currently has no rate filing pending with the department. In 2000, the FCHA submitted its last rate filing with the department and that rate filing was effective January 1, 2001.

Assessments

As a condition of doing business in Florida, health insurers are required to pay assessments to fund the deficits of the FCHA. Companies subject to the assessment include all health insurance companies, health maintenance organizations, fraternal benefit societies, multiple employer welfare arrangements, and prepaid health clinics. Self-funded employers and governmental entities are not subject to the assessment.

Each insurer is assessed annually by the board a portion of incurred operating losses of the FCHA, based on the insurer's market share in Florida as measured by premium volume. The total of all assessments upon a participating insurer is capped at 1 percent of such insurer's health insurance premium earned in Florida during the calendar year preceding the year for which the assessment is levied.

Closure of the FCHA

Pursuant to law, on July 1, 1991, the FCHA ceased accepting applications due to the Legislature's concern over mounting financial losses. At that time, two actuarial firms estimated the 1992 deficit of the FCHA to be between $48 - $56 million, as compared to the maximum $27 million that could be assessed against insurers under the funding formula enacted in 1990. In 1991, legislation

revised the funding formula providing for maximum assessments against the insurers of 1 percent of health insurance premiums written in Florida.

The Uninsurable In Florida

In the Summary of Plan Activities, 1997-98, the FCHA offered the following solutions to provide coverage for those unable to obtain insurance in the private market:

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

Reopening the FCHA: Anticipated Enrollment

Some uninsured individuals in Florida choose not to purchase insurance coverage; however, there is a segment of medically uninsured that may purchase insurance, if it were available. According to the FCHA, a portion of the uninsured population would be willing to pay higher premiums if they were allowed to purchase health insurance coverage. The FCHA noted that 34 percent of the current enrollees have a household income of $40,000 or more.

The FCHA report estimated the number of individuals (based on 1990 FCHA enrollment data) that would enroll, if FCHA was reopened. The report estimated that 3,700 - 6,200 individuals might enroll. [Source: William M. Mercer, Inc., *"Florida's Uninsured Population in the Post-Health Care Reform Environment: A Study"*, September 1997.]

Funding Options

The report "strongly recommended" that, if the FCHA was to be reopened, funding (assessment/tax) would need to be addressed to effectively finance the high-risk pool. The report suggested the following funding options:

1. Appropriate General Revenue monies;
2. Creation of another business tax;
3. Increase sales tax;
4. Provide premium tax offset for assessment;
5. Raise risk-pool premiums;
6. Tax hospital revenues;
7. Place service charge on hospitals and surgical centers;
8. Assess health insurance policyholders; or
9. Increase taxes on cigarettes, alcohol, or other products.

Cost Analysis

According to the Comprehensive Health Insurance for High-Risk Individuals, A State-by-State Analysis (1997), issued by Communicating by Agriculture, "The key to financing a state plan is to realize that premiums collected from the enrollees probably will only cover 50 percent of the cost to operate the plan." Typically, the FCHA premium as a percentage of total expenses ranged from 29 - 77 percent during the period of 1990 - 2000 (estimated). For 6 years of the 11-year period the average premium covered less than 50 percent of the average total expenses per enrollee.

The average total assessment per enrollee, premium paid by enrollee, and average expense per enrollee for fiscal years 1990-98 is depicted in the following chart:

FY	Average Number of Enrollees	Total Assessments Against Insurers (millions)	Ave. cost To Insurers (Amt. Assessed per member)	Average premium Paid by Enrollee	Average Total Expenses Per Enrollee	Average Premium as a Percentage of Average Expenses
2000(est)	757	$ 5.4	$7,145	$3,400	$10,714	31.7%
1999	856	4.0	4,696	3,473	8,325	41.7%
1998	991	4.8	4,937	3,536	8,823	40.0%
1997	1,182	1.9	1,637	3,531	5,653	62.5%
1996	1,458	3.2	2,211	3,576	6,016	59.4%
1995	1,891	9.8	5,193	3,580	8,880	40.3%
1994	2,775	11.8	4,258	3,521	7,814	45.1%
1993	3,702	5.8	1,566	3,610	5,064	71.3%
1992	4,528	7.1	1,576	3,355	5,036	66.6%
1991	5,639	5.6	990	3,824	4,911	77.9%
1990	6,402	33.9	5,293	2,324	7,766	29.9%

State High-Risk Pools

In recent years, many states have created health insurance risk pools to address the needs of the uninsured. High-risk pools may provide a safety net for otherwise uninsurable individuals; however, they enroll a relatively small number of individuals. Reasons for low enrollment include: limited funding, lack of public awareness, and the relative expense.

As of 2000, there are 28 states which have established high-risk pools, according to the Comprehensive Health Insurance for High-Risk Individuals, 2000, published by Communicating For Agriculture. Seven of these risk pools have created low-income premium subsidy programs for their state plans (Colorado, Connecticut, New Mexico, Oregon, Tennessee, Washington, and Wisconsin). The premiums for these risk pools range from 125 - 200 of the average premium for the particular state.

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

Health Insurance Portability and Accountability Act (HIPAA)

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

minimum, each state must ensure that its provisions comport with HIPAA and do not diminish the federal requirements. However, each state is permitted to adopt provisions that expand or provide more favorable treatment for the individual.

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

The Florida law provides two mechanisms for guaranteeing access to individual coverage to persons who lose their eligibility for prior coverage. These mechanisms apply after exhaustion of the period of time that group coverage can be continued under the federal COBRA law or Florida's "mini-COBRA" law, s. 627.6692, F.S., which, generally, is up to 18 months. One method requires the insurance company or HMO that issued the group health plan to offer an individual conversion policy to persons who lose their eligibility for group coverage. Florida law requires that the insurer or HMO offer at least two conversion policy options, one of which must be the standard benefit plan that Florida law requires small group carriers to offer small employers. The maximum premium that may be charged for any conversion policy is limited to 200 percent of the standard risk rate, which is a statewide average rate computed annually by the Department of Insurance, calculated separately for indemnity policies, exclusive/preferred provider policies, and HMO contracts.

[**Note:** The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted in 1986. The law requires that most employers who sponsor group health insurance plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. Section 627.6692, F.S., known as the "Florida Health Insurance Coverage Continuation Act, became effective on January 1, 1997. The act requires that employers with fewer than 20 eligible employees, offer eligible employees and the families the opportunity for a temporary extension of health coverage in certain instances where coverage under the plan would otherwise end.]

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

The requirement under Florida law that insurers and HMOs offer conversion policies does not apply to self-insured employers. States may not impose any such requirement on self-insured employers due to federal ERISA preemption. However, a self-insured employer may offer conversion

coverage which, under certain conditions, will disqualify a person from obtaining coverage from an individual carrier on a guaranteed-issue basis.

Employee Retirement Income Security Act of 1974

Employer group plans are regulated, in part, by the federal government, under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code, and to the extent the plans purchase insurance, in part, by the states under state insurance laws and regulations. Policies sold in the individual market are regulated by the individual states.

Federal Poverty Level

The federal Department of Health and Human Services annually updates the federal poverty guidelines used as the basis for eligibility for a variety of federal and state programs. These data, generally referred to as the "federal poverty level," are published in the Federal Register. As published on February 16, 2001, the federal poverty level for the year 2001 are as follows:

Size of Family Unit	100% of FPL	200% of FPL
1	$ 8,590	$21,475
2	$11,610	$29,025
3	$14,630	$36,575
4	$17,650	$44,125

C. EFFECT OF PROPOSED CHANGES:

HB 1373 revises provisions relating to the Florida Comprehensive Health Association Act, as follows:

- Modifies criteria for eligibility for coverage from the association;
- Provides for cessation of coverage;
- Requires all eligible persons to agree to be placed in a case-management system;
- Redefines the term "eligible individual" for purposes of guaranteed availability of individual health insurance coverage;
- Provides that a person is not eligible if they are eligible for health care benefits under the Medicare programs, except for a person who is insured by the association and enrolled under Medicare on July 1, 2001;
- Revises the membership of the board of directors of the association;
- Revises the reimbursement of board members;
- Requires that the plan of the association be submitted to the Department of Insurance for approval on an annual basis;
- Revises the duties of the association related to administrative and accounting procedures;
- Requires an annual audit;
- Specifies grievance procedures;
- Deletes requirements for categorizing insureds as low-risk, medium-risk, and high-risk;
- Authorizes the association to place an individual with a case manager who determines the health care system or provider;
- Requires an annual review of the actuarial soundness of the association and the feasibility of enrolling new members;
- Requires a separate account for policyholders insured prior to a specified date;
- Requires appointment of an executive director with specified duties;
- Authorizes the board to restrict the number of participants based on inadequate funding;

- Modifies the other powers of the board;
- Revises the requirements used in selecting an association administrator;
- Requires insurers to be members of the association and to be subject to assessments for operating expenses;
- Limits assessments to specified maximum amounts;
- Specifies when assessments are calculated and paid;
- Allows certain assessments to be charged by the health insurer directly to each insured, member, or subscriber and not to be subject to Department of Insurance review or approval;
- Revises the coverage, benefits, covered expenses, premiums, and deductibles of the association;
- Requires preexisting condition limitations;
- Provides that the act does not provide an entitlement to health care services or health insurance and does not create a cause of action;
- Repeals current law relating to a prohibition on the association from accepting applications for coverage after a certain date; and
- Deletes obsolete language.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 627.6482(12), F.S., relating to the definition of "premium" in the context of FCHA, to delete unnecessary, obsolete language.

Section 2. Amends s. 627.6486, F.S., relating to FCHA eligibility, as follows:

Subsection (1) is amended to revise eligibility requirements for the FCHA, to require an individual to have been a resident of Florida for the prior 12 months and provides procedures for documenting residency, including purchasing a home that has been occupied by him or her as his or her primary residence for the previous 12 months. Deletes unnecessary language relating to the marital status of a dependent child and provides statutory cross-reference to s. 627.6562, F.S., relating to dependent coverage.

Subsection (2) is amended, as follows:

Paragraph (a) is amended to specify that the board or administrator shall require verification of residency for the preceding 12 months. Authorizes a person to demonstrate his or her residency by maintaining his or her residence in this state for the preceding 12 months, purchasing a home that has been occupied by him or her as his or her primary residence for the previous 12 months, or having established a domicile in this state pursuant to s. 222.17, F.S., relating to manifesting evidence of domicile in Florida.

Paragraph (d) is amended to delete the current $500,000 cap on benefits and specify that no person on whose behalf the plan has paid out the lifetime maximum benefit currently being offered by the association in covered benefits is eligible for coverage under the plan.

Paragraph (e) is amended to delete the $500,000 lifetime maximum benefit cap and delete noneligibilty language for certain terminated persons qualifying for re-eligibility after June 30, 1991.

Paragraph (f) is amended to delete the alternative definition of "rejection" relating to an offer of coverage at a rate greater than the association plan rate.

Paragraph (g) is amended to make ineligible for coverage under this plan those persons who are eligible for substantially similar coverage under another contract or policy, unless such coverage is provided pursuant to the Consolidated Omnibus Budge Reconciliation Act (COBRA) of 1985. Provides that no person eligible for the plan or eligible for substantially similar coverage under another contract or plan is eligible unless such coverage is provided pursuant to COBRA or such coverage is provide pursuant to s. 627.6692, F.S., relating to the Florida Health Insurance Coverage Continuation Act and that such coverage is scheduled to end at a time certain and the person meets all other requirements of eligibility.

Paragraph (h) is amended to delete existing language requiring all eligible persons who are classified as high-risk to be placed in a plan or case management system. Provides that a person is ineligible for coverage under the plan if he or she is eligible for health care benefits under Medicare programs, except for a person who is insured by the FCHA and enrolled in Medicare on July 1, 2001.

Paragraph (i) is added to provide that a person is ineligible for coverage under the plan if the person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider.

Paragraph (j) is added to provide that an eligible individual, as defined in s. 627.6487, F.S., relating to guaranteed availability of individual health insurance coverage to eligible individuals, is automatically eligible for coverage in the association unless the association has ceased accepting new enrollees under s. 627.6488, F.S., relating to the Florida Comprehensive Health Association. Provides that if the association has ceased accepting new enrollees, the eligible individual is subject to the coverage rights set forth in s. 627.6487, F.S.

Subsection (3), relating to cessation of coverage is added, as follows:

Paragraph (a) provides that coverage ceases on the date a person is no longer a resident of this state.

Paragraph (b) provides that coverage ceases on the date a person requests the coverage to end.

Paragraph (c) provides that coverage ceases on the date of death of the covered person.

Paragraph (d) provides that coverage ceases on the date state law requires cancellation of the policy.

Paragraph (e) provides that coverage ceases sixty days after the person receives notice from the association making any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

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

Subsection (5) is added to provide that 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, 2001, and coverage shall begin on or after April 1, 2001, as determined by the board pursuant to s. 627.6488(5)(e), F.S., relating to the powers of the association.

Section 3. Amends subsection (3) of s. 627.6487, F.S., to revise the definition of HIPPA individuals eligible for guaranteed issuance in the voluntary market to exclude individuals who are eligible for coverage under the association, unless the association was not accepting new enrollees.

Section 4. Amends s. 627.6488, F.S., relating to the creation and administration of the Florida Comprehensive Health Association.

Subsection (2) is amended as follows:

Paragraph (a) is amended to increase the number of board members from three to five. Provides that the board of directors shall consist of the Insurance Commissioner, or his or her designee, who shall serve as the chairperson of the board; and four additional members who must be state residents. Provides that at least one of the four members must be a representative of an authorized health insurer or HMO authorized to transact business in this state. Deletes requirement that one of the board members be a representative of policyholders who is not associated with the medical profession, hospital, or an insurer. Deletes requirement that one member be a representative of insurers.

Paragraph (c) is amended to make permissive the ability of the board of directors 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.

Paragraph (d) is amended to clarify language relating to reimbursement of board members and provides a statutory cross-reference to s. 112.061, F.S., relating to per diem and travel expenses of public officers, employees, and authorized persons.

Subsection (3), relating to the adoption of a plan by the FCHA, is amended to provide that such plan shall be reviewed, revised as necessary, and annually submitted to the department for approval.

Subsection (4), relating to FCHA responsibilities, is amended as follows:

Paragraph (a) is amended to require the association to establish competitive administrative and accounting procedures. Requires internal controls for the operation of the association. Requires an annual audit of the financial statements by an independent certified public accountant.

Paragraph (b) is amended to require individuals receiving care through the association under contract from an HMO to follow the grievance procedures established in s. 408.7056, F.S., relating to the Statewide Provider and Subscriber Assistance Program, and s. 641.31(5), F.S., relating to health maintenance contracts and internal grievance procedures.

Paragraph (h), relating to contracts with preferred provider organizations and HMOs and placement of high-risk individuals, is deleted.

Paragraph (i) is designated as (h), and obsolete language is deleted.

Paragraphs (j) and (k) are designated as paragraphs (i) and (j).

Paragraph (l) is designated as (k) and amended to require case management if cost-effective and available in the county where the policyholder resides and to authorize the case manager to

determine the most cost-effective quality care system or health care provider and to place the individual in such system or with such health care provider. Requires the case manager, before and during implementation of case management, to obtain input from the policyholder, parent, or guardian and health care providers.

A new paragraph (l) is added to require the association to be administered 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 obligation.

Paragraph (m) is added to require, at a minimum, an annual and at a maximum, a quarterly, evaluation of the actuarial soundness of the association. Requires the association to contract with an actuary to evaluate the pool of insureds in the association and to 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.

Paragraph (n) is added to 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.

Paragraph (o) is added to require FCHA to 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.

Paragraph (p) is added to require FCHA to 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.

Paragraph (q) is added to require the association to develop and promote one or more pilot programs to expand health care options for lower-income, uninsured state residents. Requires the association, in administering the pilot program to:

- Limit eligibility to state residents who are: age 64 or younger; have a family income of less than 200 percent of the federal poverty level; are not covered by any other private coverage or public health care plan and have not been covered at any time for the past 6 months; have requested to obtain the affordable health-care option; and agree to make payments required for participation or payments due at the time the health care services are provided.
- Emphasize basic and preventive health care services and consider cost-containment measures and coverages to make the program affordable by eligible state residents.

Allows the association to:

- Integrate the pilot program with other governmental or community-based programs in a manner that is consistent with the objectives and requirements of the pilot program.
- Limit or exclude benefits otherwise required by law for insurers offering coverage in this state.
- Contract with community-based programs, provider-sponsored organizations, health insurers, or HMOs to provide or administer all or portion of a pilot program.

Requires the association to:

- Include the pilot program in the association's operating plan by 2003.
- Submit forms, rates, and program structure of the pilot program for approval by the department.
- Design the pilot program to be financially self-sufficient.

Subsection (5), relating to FCHA powers and duties, is amended as follows:

Paragraph (c) is amended to clarify that any interim assessment shall be due and payable within 30 days after receipt by an insurer of an interim assessment notice. Provides that such assessments may be levied only for costs and expenses associated with policyholders prior to January 1, 2002.

Paragraph (e) is added to allow the association to appear in its own behalf before boards, commissions, or other governmental agencies.

Paragraph (f) is added to allow the association to solicit and accept gifts, grants, loans, and other aid from any source or participate in any way in any government program to carry out its purposes.

Paragraph (g) is added to allow the association to 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.

Paragraph (h) is added to allow the association to procure insurance against any loss in connection with the property, assets, and activities of the association or the board.

Paragraph (i) is added to allow the association to: 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.

Section 5. Amends s. 627.649, F.S., relating to the FCHA administrator, to specify that agents that sell health insurance in Florida must be licensed in Florida.

Section 6. Amends s. 627.6492, F.S., relating to participation of insurers in FCHA, as follows:

Subsection (1) is amended as follows:

Paragraph (a) is amended to provide that insurers are only subject to the assessment for costs and expenses associated with policyholders insured with the association prior to January 2, 2002, including the renewal of coverage for such participants after that date. Eliminates obsolete language.

Paragraphs (b) and (d) are amended to delete obsolete language.

Paragraph (d) is redesignated as paragraph (c).

Subsection (4) is created, as follows:

Paragraph (a) is added to limit the applicability of this subsection to persons whose coverage begins after January 1, 2002. Provides that, as a condition of doing business in this state, every insurer shall pay an amount determined by the board of up to $1 per month for each individual policy or insured group member or subscriber insured in this state under a health insurance policy or certificate that is issued for a resident in this state.

Paragraph (b) is added to provide that for this subsection, insurer does not include limited-benefit policies, or other types of supplemental policies designed to fill gaps in underlying coverage, personal injury protection coverage provided in a motor vehicle policy, and workers' compensation. The term does include third-party administrators from whom any person providing health insurance procures coverage. The board is required to allow an insurer to exclude from its number of covered group subscribers those individuals that have been counted by any primary insurer or third-party administrator for the purpose of determining its assessment under this subsection.

Paragraph (c) is added to provide that the calculation of the fee shall be determined as of December 31 of each year and shall include all policies and covered subscribers insured during any time of the year. The payment is due no later than April 1 of the subsequent year. The first payment is due April 1, 2002, for the period of October 1, 2001, though December 31, 2001.

Paragraph (d) is added to provide that the insurer is required to submit a form with the payment that identifies the number of covered lives for the different health insurance types, and number of covered months.

Paragraph (e) is added to provide that effective October 1, 2001, the fee may be charged directly by the insurer to each policyholder, insured member, or subscriber, and is not part of the premium subject to the department's review and approval.

Section 7. Amends s. 627.6498, F.S., relating to minimum benefits coverage, as follows:

Section (1), relating to coverage offered, is amended as follows:

Paragraph (a) requires the association to offer an annual, rather than semi-annual renewable policy. Deletes obsolete language related to the semi-annual renewable policy.

Paragraph (b), relating to Medicare coverage, is deleted.

Paragraph (c), relating to involuntary termination of coverage for reasons other than nonpayment, is deleted.

Paragraphs (d) and (e) are redesignated as paragraphs (b) and (c).

Paragraph (a) of subsection (2), relating to benefits, is amended to require that the plan offer coverage to every eligible person subject to limitations set by the association. Requires that the coverage offered must pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under subsection (4). Provides that policyholders of association policies prior to 1992 are entitled to continued coverage at the benefit level established prior to January 1, 2002. Provides that only the premium, deductible, and coinsurance amounts may be modified as determined necessary by the board. Deletes language relating to persons eligible for Medicare coverage, limitations on major medical expense coverage, individual lifetime limits, and the prohibition of the board to substitute an actuarially equivalent lifetime benefit amount.

Subsection (3), relating to covered expenses, is amended as follows:

Paragraph (a) is added to require the board to establish the coverage to be issued by the association.

Paragraph (b) is added to provide that if the coverage is being issued to an eligible individual as defined in s. 627.6487, F.S., relating to guaranteed availability of individual health insurance coverage to eligible individuals, the individual shall be offered, at the option to the individual, the basic and the standard health benefit plan as established in s. 627.6699, F.S., relating to the Employee Health Care Access Act.

Deletes language requiring coverage to be patterned after the state group health insurance program. Deletes language allowing the plan to cover the cost of certain experimental drugs and limitations to such coverage.

Subsection (4), relating to premiums, deductibles, and coinsurance, is amended.

Paragraph (a) is redesignated as introductory language, and is amended to delete coinsurance and further amended to clarify that the schedule of premiums and deductibles shall be established by the board. Deletes language relating to preferred provider arrangements utilized by the association and related deductibles.

Subparagraphs (a)1. and 2. are redesignated as paragraphs (a) and (b) and paragraph (b) is amended to specify that rates are subject to approval by the department under filing and approval of forms, and under s. 627.411, F.S., relating to grounds for disapproval, except as provided by this section.

Subparagraph (a)3., relating to standard risk rates for coverages, is deleted.

Subparagraph (a)4. is redesignated as paragraph (c) and language to require separate premium schedules for low-risk, medium-risk, and high-risk individuals to be revised annually by January 1999 is deleted. Requires the board to revise premium schedules annually beginning January 2002.

Existing language is redesignated as paragraph (d) and is amended to prohibit any rate from exceeding 200 percent of the standard risk rate and provides a statutory cross-reference to s. 627.6675(3), F.S., relating to conversion on termination of eligibility. Provides for rate adjustments based on benefit differences. Deletes language relating to low-risk, medium-risk, and high-risk rates.

Existing paragraph (b) is deleted, relating to covered costs incurred by eligible persons who exceed the deductible for major medical expense coverage.

Subsection (5), relating to preexisting conditions, is amended to make permissive the association's policy to contain provisions under which coverage is excluded during a period of 12 months following the effective date of the coverage. Provides that this subsection does not apply to an eligible individual as defined in s. 627.6487, F.S., relating to guaranteed availability of individual health insurance coverage to eligible individuals.

Subsection (7) is added to provide that the Florida Comprehensive Health Association Act does not provide an individual with an entitlement to health care services or health insurance. Provides that

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. Repeals s. 627.6484, F.S., relating to the closure of the FCHA and the Marketing Assistance Program, effective January 1, 2002.

Section 9. Provides an effective date of July 1, 2001, except as otherwise expressly provided.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

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

The first payment of the assessment would be received by the FCHA on April 1, 2002, for the period of October 2001 through December 2001. This three-month period would generate an estimated $10.3 million (or $3.4 million per month) in revenues for the FCHA. On an annual basis, it is estimated that the assessment would generate $41,145,600 for the association and provide coverage for an estimated 6,974 – 7,347 individuals.

Assuming that the current trends of the FCHA continue and the unfunded/assessed amount remains relatively stable, each additional member would require an estimated $5,600 - $5,900 in assessment per year. This assessed amount would fund the difference between premium revenues received and the costs and expense of new enrollees of the FCHA.

Number of Enrollees	Estimated Costs (Assessment Funding) 3-months	Estimated Costs (Assessment Funding) 1-Year	Estimated Revenues 3-Months	Estimated Revenues 1-Year
500	$ 700,000 - $ 737,500	$ 2,800,000 - $ 2,950,000		
1,500	$2,100,000 - $ 2,212,500	$ 8,400,000 - $ 8,850,000		
2,000	$2,800,000 - $ 2,950,000	$11,200,000 - $11,800,000	$10,286,400	$41,145,600
6,900	$9,660,000 - $10,177,500	$38,640,000 - $40,710,000		

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

See IV.A., APPLICABILITY OF THE MADATES PROVISION, below.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The opening of the FCHA would allow HIPPA eligibles and individuals who otherwise are not able to obtain insurance coverage, due to a determination that they are medically uninsurable, an opportunity to obtain coverage, subject to funding limitations that would limit enrollment, as determined by the board.

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

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

There will likely be a fiscal impact on counties and cities, unless a county or city administers their own self-insurance plan. The amount is indeterminate and it is unknown whether the amount is significant enough to trigger the protection of Article VII, s. 18.

The bill is silent as to the fulfillment of an important state interest.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

N/A

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 3, 2001, the Committee on Health Promotion unanimously adopted a "strike-everything" amendment. The amendment:

- Caps new enrollment in the association at 500 for calendar year 2002 and allows for an additional 1,500 members, effective January 1, 2003.
- Provides that the assessment on insurers, for new enrollment, would be reduced from up to $1 to 25 cents per month for each individual policy or covered group subscriber insured in Florida, not including dependents, including plans administered by third-party administrator and insurers (administrative services only contracts). The definition of insurer would not include self-insured employee welfare benefit plans that are not regulated by the Florida Insurance Code pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The definition of insurer would include multiple employer welfare arrangements as provided for in ERISA.
- Specifies that the insurer would be liable for the payment of the fee to the association. Nonpayment of the fee would be considered nonpayment of premium and would be grounds for cancellation of the policy or contract. The assessment would be exempt from the insurance premium tax.
- Reduces the Florida residency requirement from 12 months to 6 months.
- Reinstates the $500,000 lifetime benefit maximum for coverage under the plan.
- Implements a sliding fee schedule for premiums based upon an individual's income. The premium would be 150, 250, or 300 percent of the standard risk rate, contingent upon an individual's income level.
- Provides a hold-harmless provision for individuals eligible for guaranteed-issuance of coverage, as provided in s. 627.648, F.S., to specify that the 63-day period specified in s. 627.6561(6), F.S., would be tolled from the time the association receives an application for an individual until such time as the association notifies the individual that it is not accepting and issuing coverage to that individual. In addition, if the federal Health Care Financing Administration does not authorize the association to be an acceptable alternative mechanism to provide coverage to those individuals who are guaranteed the issuance of coverage under s. 627.6487, F.S., these individuals could continue to obtain coverage in the voluntary market.
- Requires employees of the association to be reimbursed for expenses, as provided in s. 112.061, F.S., incurred in carrying out their duties.
- Provides that the act fulfills an important state interest.
- Eliminates the pilot program to expand health care options to lower-income, uninsured state residents.

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

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