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HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
INSURANCE
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 YEAS 12 NAYS 0
(3) HEALTH & HUMAN SERVICES APPROPRIATIONS
(4) COUNCIL FOR HEALTHY COMMUNITIES
(5)

I. SUMMARY:

The Legislature established the Florida Comprehensive Health Association (FCHA) in 1982, and closed it to new enrollees after July 1, 1991. The FCHA provides health insurance to individuals unable to obtain it due to health status or inability to afford coverage. It covers 702 individuals, down from over 5,600 in 1991. Thirty-four percent of enrollees have a household income of $40,000 or more.

The bill would reopen the FCHA for new enrollees beginning January 1, 2002, with coverage beginning on or after April 1, 2002. The FCHA would be required to restrict the number of participants when the board found available revenues inadequate to fund the plan.

Insurers would be required to pay an assessment of up to $1 per month per individual policy, insured group member, or subscriber to fund premium shortfalls for coverage extended to new enrollees. Insurers, in turn, could recoup these directly from their policyholders, members, and subscribers. Assessments collected from policyholders, members, and subscribers, in the aggregate, could total $41 million if the full $1 is levied.

The board of directors for the FCHA would be increased in size and changed in composition. Eligibility requirements for prospective enrollees would be revised to exclude eligibility based on inability to obtain coverage at a rate less than that charged by the FCHA.

The FCHA would have the flexibility to offer coverage subject to limitations it imposes. The plan would no longer be required to offer major medical coverage similar to that provided to state employees under the state group health insurance plan. Rates for individuals at all risk levels could not exceed 200 percent of the standard risk rate now applicable only to those low-risk individuals. Those individuals considered medium or high risk would no longer be capped at a rate of 225 or 250 percent, respectively.

The FCHA would be required to develop pilot programs to expand health care options for certain lower-income, uninsured state residents with a family income below 200 percent of the federal poverty level.

The bill would take effect July 1, 2001, except as otherwise provided.

There is a "remove everything" amendment adopted by the Health Promotion Committee traveling with the bill and an amendment to the amendment adopted by the Committee on Insurance. See Section VI. of this analysis for an explanation of these amendments.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1. Less Government Yes [] No [x] N/A []

The bill would authorize the re-opening of the Florida Comprehensive Health Association, a health insurance high-risk pool closed to new enrollees by the Legislature in 1991.

2. Lower Taxes Yes [] No [x] N/A []

The bill would authorize up to a $1 per month assessment per individual policy, insured group member, or subscriber. The insurer would be permitted to recoup the assessment directly from each policyholder, insured member, or subscriber. Assessments in the aggregate could total $41 million if the full $1 is levied.

3. Individual Freedom Yes [x] No [] N/A []

4. Personal Responsibility Yes [x] No [] N/A []

5. Family Empowerment Yes [x] No [] N/A []

B. PRESENT SITUATION:

Florida Comprehensive Health Association

The Legislature established the FCHA[1] in 1982 and closed it to new enrollees after July 1, 1991.[2] The FCHA provides health insurance coverage to individuals unable to obtain coverage due to their health status or inability to afford coverage. It currently covers 702 individuals, down from over 5600 in 1991. Enrollment is declining at a rate of 15 percent per year. Thirty-four percent of current enrollees have a household income of $40,000 or more.

The FCHA is a nonprofit legal entity supervised by a three-member board of directors appointed by the Insurance Commissioner. The Insurance Commissioner or designee chairs the board. The other two members are a policyholder representative and an insurer representative.

Enrollment Eligibility

To qualify for coverage through the FCHA, an individual must be rejected by two insurers offering coverage substantially similar to that offered by the FCHA and be unable to procure coverage through the market assistance plan. An individual has been "rejected" when the offer of coverage includes a material underwriting restriction or is at a rate greater than the rate charged by the FCHA.

[1] Originally created as the State Comprehensive Health Association
[2] Section 627.6484, F.S. At that time, two actuarial firms estimated a 1992 FCHA deficit of between $48 and $56 million, nearly twice that of the potential assessment revenues of $27 million. In 1991, the Legislature authorized maximum assessments against insurers of 1 percent of health insurance premiums written in Florida.

Medicaid-eligible individuals may not receive FCHA benefits unless they have an illness or disease requiring supplies or services covered by the FCHA but not by Medicaid, or the individuals are not receiving Medicaid benefits.

Benefits

FCHA coverage, including benefits, exclusions and other limitations, must be patterned after the state group health insurance program, 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 does not cover for a 12-month period 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.

Funding

Premiums

Based on the industry standard, premiums collected from the enrollees generally will only cover 50 percent of the cost to operate the plan.[3] Typically, the FCHA premium as a percentage of total expenses has ranged from between 29 and 77 percent during the period of 1990 to 2000. In six of these years, the average premium covered less than 50 percent of the average total expenses per enrollee.

The Department approves FCHA premium rates. The Department establishes the standard risk rate used to determine these premium rates.[4] These premium rates cannot exceed 200, 225, and 250 percent of this standard risk rate for low, medium, and high-risk individuals, respectively. Distinctions among the risk classifications are based in part on the anticipated claims payments for individuals based on their health condition.

The most recent FCHA rate filing took effect January 1, 2001.

Assessments

As a condition of doing business in Florida, "health insurers" are required to pay assessments to fund FCHA deficits. These assessments are based on each insurer's relative share of the Florida market measured by premium volume. Total assessments levied upon a participating insurer are capped at 1 percent of the insurer's health insurance premium earned in Florida during the calendar year preceding the year for which the assessment is levied. Assessments in 2000 totalled an estimated $5.4 million.

"Health insurers" include any insurance company authorized to transact health insurance in Florida, any insurance company authorized to transact health or casualty insurance in Florida which is offering a minimum premium plan or stop-loss coverage, health maintenance organizations, prepaid health clinics, multiple employer welfare arrangements, and fraternal benefit societies.[5] Self-funded employers and governmental entities are not subject to assessments.

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[3] *Comprehensive Health Insurance for High-Risk Individuals, 2000, Communicating by Agriculture*.
[4] Section 627.6498(4)(a), F.S.
[5] Section 627.6482(7), F.S.

Table 1. Per enrollee assessment per enrollee, premium paid by enrollee, and average expense per enrollee for fiscal years 1990-98 is depicted in the following chart:

		Assessments ($M)		Premium and Expenses		
FY	Avg. # Enrollees	Total	Per member	Avg. Premium Paid by Enrollee	Avg. Total Expenses Per Enrollee	Average Premium as Percentage of Average Expenses
2000*	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%

*estimated

High-Risk Pools in Other States

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.

As of 2000, twenty-eight states have established a high-risk pool.[6] Seven of these risk pools have created low-income premium subsidy programs for their state plans.[7] Premiums for risk pools in these states range from 125 to 200 percent. Twenty states fund risk pools by assessing association members.[8] Other states provide funding through one or more sources, including a state income tax, tobacco tax, general revenue,[9] or tobacco settlement funds.[10]

Health Insurance Portability and Accountability Act (HIPAA)

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA requires insurers issuing individual health insurance policies to guarantee issuance of coverage to persons previously covered for at least 18 months, if they meet certain other eligibility criteria. Each state could craft alternative methods of guaranteeing availability of coverage. Each state is permitted to provide for more favorable treatment for the individual.

In 1997, Florida enacted legislation to conform state law to HIPAA. The Legislature enacted an alternative mechanism deemed acceptable by the federal Health Care Financing Administration (HCFA). To qualify 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,

[6] *Comprehensive Health Insurance for High-Risk Individuals, 2000, Communicating For Agriculture.*
[7] Colorado, Connecticut, New Mexico, Oregon, Tennessee, Washington, and Wisconsin
[8] See note 6.
[9] Louisiana appropriates funds from general revenue and imposes a service charge on hospital admissions and outpatient procedures.
[10] California, Colorado, Louisiana, Kentucky, Utah, and Wisconsin use tobacco settlement funds.

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. 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 was 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 derivative[11] 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 the insurer or HMO to 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.[12]

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.

Self-insured employers are not subject to the requirement under Florida law to offer conversion policies.[13]

C. EFFECT OF PROPOSED CHANGES:

The bill would reopen the FCHA for new enrollees beginning January 1, 2002, with coverage beginning on or after April 1, 2002. A 1997 report prepared for the FCHA estimated between 3,700 and 6,200 individuals would enroll if the Legislature re-opened the FCHA.[14]

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[11] Section 627.6692, F.S. The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted in 1986. The law requires most employers who sponsor group health insurance plans to 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," took effect on January 1, 1997. It requires employers with fewer than twenty eligible employees to offer eligible employees and their families the opportunity for a temporary extension of health coverage in instances where coverage under the plan would otherwise end.

[12] Standard risk rate is a statewide average rate computed annually by the Department of Insurance, calculated separately for indemnity policies, exclusive/preferred provider policies, and HMO contracts.

[13] 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.

[14] William M. Mercer, Inc., *"Florida's Uninsured Population in the Post-Health Care Reform Environment: A Study,"* September 1997. This estimate was based on 1990 FCHA enrollment data.

The FCHA would be required to restrict the number of participants when the board found available revenues inadequate to fund the plan. The plan would be renewable annually, rather than semi-annually, as under current law.

Insurers would be required to pay an assessment of up to $1 per month per individual policy, insured group member, or subscriber to fund coverage for new enrollees. Insurance not subject to the assessment would include workers' compensation, personal injury protection or medical payment coverage in a motor vehicle insurance policy, long-term care, dental-only and vision-only, credit, and several other types.[15]

Beginning October 1, 2001, insurers could recoup the assessment from their policyholders, members, and subscribers. Insurers must submit their first payment by April 1, 2002, covering the period October-December 2001. Aggregate fees collected from policyholders, members, and subscribers subject to the assessment could total $41 million.

The board of directors for the FCHA would be increased in size and changed in composition.

Eligibility requirements for prospective enrollees would be revised to require prospective enrollees to be state residents for the preceding 12 months and replace the $500,000 cap on benefit payouts as a basis for denial of participation with the benefit cap "currently being offered by the FCHA." Eligibility could not be established based on an inability to obtain coverage at a rate less than that charged by the FCHA as opposed to an inability stemming from a "material underwriting restriction."

The FCHA, through the board of directors, would have the flexibility to offer coverage subject to limitations set by the FCHA. The FCHA could set limits on deductibles and coinsurance payments. Those existing policyholders would continue coverage at their current benefit level. The plan would no longer be required to offer major medical coverage similar to that provided to state employees under the state group health insurance plan. For those individuals eligible for continued group coverage under the federal COBRA law or Florida's COBRA derivative, the FCHA shall offer, at the individual's option, the basic and standard health benefit plans under the Employee Health Care Access Act.

Rates for individuals at all risk levels could not exceed 200 percent of the standard risk rate now applicable only to those low-risk individuals. Those individuals considered medium or high risk would no longer be capped at a rate of 225 or 250 percent, respectively.

The FCHA, as part of case management services, would be authorized to have the plan case manager place an individual in the most cost effective quality care system or with the most cost effective health care provider.

The FCHA would be required to evaluate the actuarial soundness of the FCHA no less frequently than annually. The FCHA also would be required to develop and promote one or more pilot programs to expand health care options for lower-income, uninsured state residents younger than 65 and with a family income below 200 percent of the federal poverty level.[16]

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[15] The Mercer report identified the following funding options: appropriate General Revenue monies; create another business tax; increase the sales tax; provide a premium tax offset for assessments; raise risk-pool premiums; tax hospital revenues; place a service charge on hospitals and surgical centers; assess health insurance policyholders; or increase taxes on cigarettes, alcohol, or other products.

[16] 200% of the Federal Poverty Level for a family of 1 is $21, 475 and for a family of 4 is $44,125.

D. SECTION-BY-SECTION ANALYSIS:

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

Section 2. Amends s. 627.6486, F.S., to revise eligibility requirements. Would require an individual to have been a resident of Florida for the prior 12 months and provides procedures for documenting residency. The current lifetime maximum benefit cap of $500,000 would be replaced with a cap based on an unspecified "current lifetime maximum benefit." Previously terminated persons could now qualify for re-eligibility and re-enrollment after June 30, 1991. The definition of "rejection" would be amended to exclude offers of coverage at a rate greater than the FCHA plan rate. Would make ineligible for coverage under this plan not only those with substantially similar coverage under another contract or policy, but those eligible for such unless the coverage is provided pursuant to the federal COBRA law or such coverage is provided pursuant to the Florida Health Insurance Coverage Continuation Act.[17]

Except for those insured by the FCHA on December 31, 2001, and who renew their 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.

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

Section 4. Amends s. 627.6488, F.S., relating to the creation and administration of the Florida Comprehensive Health Association. The board of directors for the FCHA would be increased in size and changed in composition. Would require individuals receiving care through the FCHA 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. Would require the FCHA to evaluate the actuarial soundness of the FCHA, at least annually. Would restrict the number of FCHA participants based on a determination by the board that the revenues will be inadequate to fund new participants. Would require the 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.

The FCHA would be required to develop and promote one or more pilot programs to expand health care options for lower-income, uninsured state residents with eligibility limited to state residents who are age 64 or younger, have a family income of less than 200 percent of the federal poverty level and are not covered by any other private coverage or public health care plan.

The bill would revise FCHA powers and duties.

Section 5. Amends s. 627.649, F.S., relating to the FCHA administrator, to specify any agent must be licensed by the department to sell health insurance in Florida.

Section 6. Amends s. 627.6492, F.S., relating to participation of insurers in the FCHA. Would require every insurer, as a condition of doing business in this state, to 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. Limited-benefit policies or other types of supplemental policies designed to fill gaps in

[17] Section 627.6692, F.S.

underlying coverage, personal injury protection coverage provided in a motor vehicle policy, and workers' compensation coverage would not be subject to the per policy charge. Third-party administrators from whom any person providing health insurance procures coverage would be subject to the charge. Insurers could exclude from its number of covered group subscribers those individuals counted by any primary insurer or third-party administrator. The assessment would be determined as of December 31 of each year and include all policies and covered subscribers insured during any time of the year. The first payment would be due April 1, 2002, for the period of October 1, 2001, through December 31, 2001. Insurers subject to the assessment would be required to submit a form with the payment identifying the number of covered lives for the different health insurance types, and number of covered months. Effective October 1, 2001, the insurer would be permitted to collect the fee directly from each policyholder, insured member, or subscriber, separate from the premium.

Section 7. Amends s. 627.6498, F.S., relating to minimum benefits coverage, to require the FCHA to offer an annual, rather than semi-annual, renewable policy; replace the requirement that the plan offer major medical expense coverage similar to that provided under the state group health insurance program with a requirement that the plan offer coverage to every eligible person subject to limitations on deductibles and copayments set by the FCHA. Would permit those FCHA policyholders issued policies prior to 1992, to continue coverage at the benefit level established prior to January 1, 2002. Only the premium, deductible, and coinsurance amounts could 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. The board would be required to establish the coverage to be issued by the FCHA.

References to the department approval of standard risk rates for coverages would be deleted. Separate premium schedules for low-risk, medium-risk, and high-risk individuals would no longer be specified. The 200 percent of standard risk rate cap for low-risk individuals would be applied to medium and high-risk individuals. This would be a reduction from 225 and 250 percent, respectively. The board would be required to revise premium schedules annually beginning January 2002.

Relating to preexisting conditions, the bill would require the FCHA policies to contain provisions under which coverage would be excluded during a period of 12 months following the effective date of the coverage in certain instances. This exclusion would not apply to eligible individuals as defined in s. 627.6487, F.S., relating to guaranteed availability of individual health insurance coverage to eligible individuals.

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:

The impact on the state depends in part on the extent to which the assessments would apply to state group health insurance policyholders. See Fiscal Comments section, Section III.D., of this analysis.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

See Section IV.A., of this analysis.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Assessments paid by the private sector, whether directly by insurers or indirectly through recoupments from their policyholders, members, or subscribers, could total approximately $41 million, based on an assumption that approximately 3.4 million policies will be subject to the assessment and the full $1 is levied. See Section III.D., of this analysis.

D. FISCAL COMMENTS:

According to the Department, over 8.5 million individuals are insured through employer-sponsored insurance, employer-sponsored self-insurance, public sector (e.g., federal, state, and local government) employer-sponsored insurance, self-insurance (administered by a third-party administrator) or non-employer sponsored insurance in Florida. Dividing this number by a factor of 2.5, the Department generated an estimate of approximately 3.4 million policies. The Department could not estimate the number of federal employer-sponsored insurance or self-insurance plans not subject to this assessment.

The FCHA would receive its first assessment payment on April 1, 2002, for the period of October 2001 through December 2001. For this three-month period, the assessment would generate an estimated $10.3 million (or $3.4 million per month). On an annual basis, an assessment of the full $1 would generate an estimated $41.1 million to use along with premium revenues to fund coverage for an estimated 6,974 to 7,347 individuals.

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	$10,286,400	$41,145,600
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		
6,900	$9,660,000 - $10,177,500	$38,640,000 - $40,710,000		

Assuming present trends continue and the unfunded/assessed amount remains relatively stable, each new enrollee would require an estimated $5,600 to $5,900 in assessments per year.

The opening of the FCHA would allow HIPAA-eligibles and individuals otherwise unable to obtain insurance coverage, due to a determination they are medically uninsurable, an opportunity to obtain coverage, subject to funding limitations limiting enrollment, as determined by the board.

Health insurers would be subject to an assessment of up to $1 per month per policy, group member, or subscriber. Insurers could then recoup these assessments directly from policyholders, group members, and subscribers.

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.

Except for those with their own self-insurance plan, municipalities or counties could be subject to payment of assessments. It is unknown whether or not 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 adopted a “remove-everything” amendment.

Amendment by the Committee on Health Promotion (“remove everything”): The “remove-everything” amendment would replace the substance of the bill, rewriting it to include the following changes:

- Cap new enrollment in the FCHA at 500 for calendar year 2002, and allow for an additional 1,500 members, effective January 1, 2003.

- Reduce the assessment on insurers, for new enrollment, from up to $1 to up to 25 cents per month for each policy, member or subscriber.

- Reduce the Florida residency requirement for establishing eligibility for FCHA coverage from 12 months to 6 months.

- Reinstate the $500,000 lifetime benefit maximum for coverage under the plan.

- Implement a sliding schedule for premiums of 150, 250, or 300 percent of the standard risk rate, contingent upon an individual's income level.

- Include a hold-harmless provision for individuals eligible for guaranteed-issuance of coverage, as provided in s. 627.648, F.S.

- Specify that the act fulfills an important state interest.

- Eliminate the pilot program to expand health care options to lower-income, uninsured state residents.

On April 20, the Committee on Insurance adopted an amendment by Rep. Green to the amendment traveling with the bill by the Committee on Health Promotion:

Amendment 1 by Rep. Green to the Traveling Amendment by the Committee on Health Promotion (page 18, line 21, through page 20, line 26): This amendment would replace the source for funding the re-opening of the Florida Comprehensive Health Association (FCHA) to new enrollees. The amendment would propose to fund the FCHA through the use of $10 million of the revenues from the supplemental permit fee on cigarettes proposed in SB 2214 or similar legislation, rather than through a per policy assessment of up to $1 levied against insurers and recouped from policyholders. The supplemental permit fee would be a fee paid by those that have not entered into the 1997 Tobacco Settlement Agreement with the state.]

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

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

AS REVISED BY THE COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Stephen T. Hogge	Stephen T. Hogge