SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Date: April 7, 1998 Revised: _____ _____ _____ _____

Subject: Health Insurance

	Analyst	Staff Director	Reference	Action
1.	Johnson	Deffenbaugh	BI	Favorable/CS
2.			WM	
3.				
4.				
5.				

I. Summary:

The bill would open the Florida Comprehensive Health Association (FCHA) for enrollment for health insurance coverage for up to 500 persons for a 1-year period.

The bill also revises the eligibility criteria to deem a person eligible only if the person has been rejected by two insurers for similar coverage or has received an offer of coverage with a material underwriting restriction. Current law defines rejection to also include an offer of coverage at a rate greater than the FCHA plan rate.

At the end of the 1-year enrollment, the Department of Insurance is required to review the impact of the new enrollment on the standard market rates and to study the effectiveness of the association or other means of providing access to health insurance to the medically uninsurable.

The Department of Insurance is required to develop and issue a request for proposal to privatize the administration of the FCHA's claims or, as an alternative, issue a request for proposal and enter into a contract with an authorized insurer to assume all the risks in the FCHA. Premiums would be established pursuant to s. 627.6498, F.S, (the current law that specifies how FCHA rates are determined). The department is required to assess and collect from insurers any deficits and reimburse such assessments to the insurer administering the program. This provision would be effective July 1, 1998, and would be implemented by July 1, 1999.

This bill substantially amends the following sections of the Florida Statutes: 627.6484, 627.6486, and 627.649.

II. Present Situation:

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

FCHA Eligibility, Benefits, and Premiums

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

Policyholders pay premiums that are up to 250 percent of standard rates. The FCHA is authorized to establish a separate premium schedule for low, moderate, or high risk individuals. The FCHA is authorized to charge up to a maximum of 200 percent of the standard risk rate for individuals classified as low-risk, 225 percent for moderate risk enrollees, and 250 percent for high-risk enrollees.

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 plan, 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 concerns 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 following assessments/losses were incurred for fiscal years 1994 - 1996: $11.8 million, $9.8 million, and $3.2 million, respectively.

Effective October 1, 1990, the Department of Insurance was required to create a market assistance plan (MAP) for the purpose of finding coverage for FCHA applicants in the standard market. The association was required to set guidelines for the use of MAP in the Association's plan of operation. The guidelines were intended to describe what types of applications are exempt from submission to MAP and how MAP and periodic reviews to depopulate the FCHA were to be conducted.

The Uninsured In Florida
Recently, the Florida Comprehensive Health Association released a report (conducted by William M. Mercer, Inc.) entitled, *Florida's Uninsured Population in the Post-Health Care Reform Environment* (September 1997), which evaluated the characteristics of the uninsured in Florida and offered recommendations to provide coverage for the uninsured. The report noted anecdotal examples of uninsured individuals, including: workers without access to group coverage who are medically uninsurable, workers who lost access to group coverage prior to the enactment of HIPAA, disabled individuals, and Medicare-eligible retirees who do not currently have supplemental coverage.

In the FCHA report, disabled individuals were identified as a significant percentage of the uninsured. The report noted that disabled children, in particular, present a coverage concern. According to the report, "If employers provide dependent coverage, it typically lasts until the dependent reaches age 19, or age 23, if a full-time student." Pursuant to s. 627.6615, F.S., a

group health insurance policy or health maintenance organization contract delivered or issued in Florida that provides coverage of a dependent child of an employee or other member of a covered group will not terminate coverage of the dependent child upon attaining the limiting age while the child continues to be both: (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (2) chiefly dependent upon the employee or member for support and maintenance.

Individuals eligible for Medicare who did not purchase coverage when they first qualified were identified as a significant group of the uninsured. According to the FCHA report, the federal OBRA Act of 1990 prohibits carriers from denying coverage based " . . . of health status, claims experience, or medical condition during the 6 months a Medicare beneficiary age 65 or older enrolls in Part B of Medicare." However, based on an informal survey of carriers, some large carriers offer certain Medigap policies on a guaranteed-issue basis, regardless of age.

In the *Summary of Plan Activities, 1996-97*, the FCHA offered the following solutions to provide coverage for the uninsured:

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

Reopening the FCHA: Anticipated Enrollment

High-risk pools may provide a safety net for otherwise uninsurable individuals; however, they enroll a relatively small number of individuals. In the majority of states that have risk pools (22 of 25), the General Accounting Office (GAO) noted that less than 5 percent of the nonelderly, with individual coverage, obtain coverage through a risk pool (November 1996). GAO noted reasons for low enrollment including: limited funding, lack of public awareness, and the relative expense.

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 was 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 43 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 between 3,700 - 6,200 individuals might enroll.

Funding Options

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

Premiums

Pursuant to s. 627.6498(4)(a), F.S., the standard risk rate for coverage issued by the FCHA is established by the association, subject to approval by the Department of Insurance, using reasonable actuarial techniques, and reflecting anticipated experience and expenses of such coverages for standard risks. The FCHA policy has characteristics of a preferred provider organization and an exclusive provider organization.

According to the FCHA, the actuaries compare the weighted average premium to FCHA's average rate for a low-risk enrollee (200 percent standard risk). The FCHA Board uses the actuary's recommendation as a benchmark in determining whether a rate increase is warranted.

Section 627.6498(4), F.S., requires the board to establish separate premium schedules for low-risk, medium-risk, and high-risk individuals and revise the schedules for each 6-month policy period beginning after January 1992. Documentation provided by the FCHA indicates that the actuaries typically conduct a rate review on an annual basis.

In recent years, as a basis for determining the adequacy of the premiums, FCHA engaged an independent actuary to evaluate and derive a weighted individual health insurance premium for each of the four designated market areas in Florida. Premiums for indemnity policies of four insurers writing or previously writing individual or association policies were used in this evaluation to derive the weighted premium for the four areas.

In December 1997, the actuaries implemented a different methodology to evaluate the FCHA rates and to make recommendations to the FCHA regarding the adequacy of the rates. A weighted average based on the estimated 1996 earned premium for each carrier was used (In previous years, a straight average of the four carriers was used.) According to the actuaries, this has a significant effect in that the rates are weighted heavily toward the larger (by premium volume) indemnity and PPO plans which have the lowest rates of the non-HMO plans. Five health maintenance organizations were included in the survey. In addition, the actuaries included one individual, preferred provider organization plan for the first time that was noted as having the largest earned premium of any of the plans in the survey. Three indemnity plans (writing individual policies) and one association plan were also included in the survey. The ratio of 200 percent of premium, weighted benefits adjusted market average to current FCHA rates for the four areas ranged between 0.86-0.94 (based on indemnity, HMO, and PPO plans).

During the last several years when the Board has recommended a rate increase, the FCHA rate filing with the Department of Insurance has produced a premium that is generally less than the 200 percent standard risk, as depicted in the following table:

Year	Actuary Recommendation for FCHA to meet 200% of Average Market Rate	FCHA Board Recommendation	Rate Adjustment?
1994	6 - 42 percent	Not Available	Deferred until 1995
1995	4 - 36 percent in 3 areas. FCHA rates in Area 1 were approximately 3-6% higher than the market average.	Maximum rate increase for any policyholder at 20% and cap the maximum decrease at 10%	Yes, effective 7/95.
1996	On 6/13/96, indicated that rates in Areas 1 & 2 would need to increase by approximately 21% and about 35% in Areas 3 & 4 to meet 200% of the average	No action.	
1997	On 5/12/97, recommended 27% increase in Areas 1 & 2 and approximately 40% increase in Areas 3 & 4.	On 5/21/97, Board recommended no adjustment due to the uncertainty of the future of the FCHA.	
1998	On 12/2/97, the ratio of 200% of premium weighted benefits, adjusted market average to current FCHA rates was reported in the range of 0.86-0.94 in the four areas (based on indemnity, HMO, PPO).	No official Board action to date. (According to the FCHA Executive Director, the Board intends to accept the report and recommend no action.)	

The premium for conversion policies offered by carriers is tied to the rate established by the FCHA for individual policies. Pursuant to s. 627.6675, F.S., the premium for a converted policy may not exceed 200 percent of the standard risk rate as established by the Florida Comprehensive Health Association (FCHA), adjusted for differences in benefit levels and structure between the converted policy and the policy offered by the FCHA. Therefore, the rates established by the FCHA effect and limit the premiums for the 3,300 conversions policies in force in Florida.

Cost Analysis

Based on an analysis of FCHA audited financial statements, the average assessment per member for the period of 1990-95 experienced a slight decline/stabilization through 1993 and increased significantly during the next two years. In 1996, the average assessment per enrollee was $2,211. In contrast, the average assessment for 1995 was $5,193. Since 1991, average premiums has declined slightly and has stabilized around $3,500. In 1995 and 1996, the average annual premium for an FCHA policyholder was approximately $3,600. The average total expense per enrollee has increased significantly since 1991, appearing to be stabilizing. As of October 1997, enrollment totaled 1,150.

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 -1996. For 3 out of the 7 years the average premium covered less than 50 percent of the average total expenses per enrollee.

The average assessment per enrollee, premium paid by enrollee, and average expense per enrollee for fiscal years 1990-96 is depicted in the following chart:

FY	Average Number of Enrollees	Avg. Cost To Insurers (Amt. assessed per member)	Average Premium Paid by Enrollee	Average Total Expenses Per Enrollee	Average Premium as a Percentage of Average Expenses
1996	1458	2211	3576	6016	59.4%
1995	1891	5193	3580	8880	40.3%
1994	2775	4258	3521	7814	45.1%
1993	3702	1566	3610	5064	71.3%
1992	4528	1576	3355	5036	66.6%
1991	5639	990	3824	4911	77.9%
1990	6402	5293	2324	7766	29.9%

Net losses (assessments) declined from a high of $33.9 million in 1990 to $5.8 million at the end of 1993, before increasing to $11.8 million in 1994 and $9.8 million for 1995. For the calendar year ended 1996, net losses totaled $3.2 million. For the period of 1994-1996, the average premium paid by enrollees has shown a slight decrease.

III. Effect of Proposed Changes:

Section 1. Amends s. 627.6464, F.S., to reopen enrollment in FCHA for a 1-year period, beginning January 1, 1999, with new enrollment limited to 500 applicants. Procedures are delineated for processing applications. At the end of the 1-year enrollment, the Department of Insurance is required to review the impact of the new enrollment on the standard market rates and to study the effectiveness of the association or other means of providing access to health insurance to the medically uninsurable.

Section 2. Amends s. 627.6486, F.S, to revise the eligibility requirements for the FCHA to eliminate eligibility to the FCHA based on the fact the individual received an offer of coverage at a rate greater than the association plan rate. As a result, an individual would be eligible for the FCHA, if the person has been rejected by two insurers for similar coverage or has received an offer of coverage with a material underwriting restriction.

Section 3. Section 627.649, F.S., is added to require the Department of Insurance to develop and issue a request for proposal to privatize the administration of the FCHA's claims or, as an alternative, issue a request for proposal and enter into a contract with an authorized insurer to

assume all the risks in the FCHA. Premiums would be established pursuant to s. 627.6498, F.S., which is the current law that specifies how FCHA rates are set. The department is required to assess and collect from insurers any deficits and reimburse such assessments to the insurer administering the program. This provision would be effective July 1, 1998, and would be implemented by July 1, 1999.

Section 4. Provides an effective date of October 1, 1998, unless otherwise specified.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

See Private Sector section, below, for estimates based on actual FCHA experiences for fiscal years 1994-96.

B. Private Sector Impact:

The primary beneficiaries of this legislation would be the maximum 500 individuals who are currently unable to purchase a policy in the private sector. The cost of this policy would limit the availability to only middle and upper income individuals.

Expanding health insurance coverage through the FCHA will increase assessments against health insurers. These increased assessments would be passed through to individuals and companies (who purchase health insurance) in the form of increased rates and premiums. If the current FCHA rates are maintained, the average insurers' assessment per enrollee would be approximately $3,900 per year (based on an average of 1994-96 data) or a total of approximately $1,950,000 in additional assessments per year (500 enrollees at $3,900 per year).

Based on the average premium per enrollee for fiscal years 1994-96, the premium for a new enrollee would be approximately $3,600 per year.

C. Government Sector Impact:

To the extent some previously uninsured persons are unable to pay all of their medical expenses, the 500 new policies issued by the FCHA could offset some indeterminate portion of uncompensated care.

The Department of Insurance may incur additional costs related to conducting a review of the impact of new enrollment, the FCHA's effectiveness, and access to health insurance, as required by section 1 of the bill. In addition, the department may incur additional costs associated with developing and issuing request for proposals, as required by section 3 of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

It is unclear which duties and responsibilities would remain with the FCHA Board and which responsibilities would be assumed by the contracting insurer.

VIII. Amendments:

None.