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.)

BILL: CS/SB 1800

SPONSOR: Banking and Insurance Committee and Senator Latvala

SUBJECT: Health Insurance

DATE: April 5, 1999 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.			FP	
4.				
5.				

I. Summary:

Under current law, the Florida Comprehensive Health Association (FCHA) provides health insurance to individuals who, due to their health status, 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 such that legislation was enacted to prohibit the FCHA from issuing 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 approximately 900 individuals. According to representatives with FCHA, enrollment is declining at a rate of approximately 15 percent per year.

Committee Substitute for Senate Bill 1800 would replace the Florida Comprehensive Health Association with the newly created Florida Health Endowment Association (FHEA), a nonprofit legal entity which would provide insurance coverage to individuals whose health insurance has been involuntarily terminated or whose pre-existing medical conditions prevent them from obtaining coverage in the standard individual health insurance market. The assets and liabilities of the FCHA would be transferred to the FHEA and the provisions relating to the FCHA would be repealed. The Board of Directors of the FHEA would be composed of a five-member board which would include the Secretary of the Department of Health, the Insurance Commissioner (or a designee from their respective departments), and three members appointed by the Governor, including a policyholder representative, a health insurance industry representative and a member of the public.

The Board of the FHEA would be authorized to perform the following functions:

- ♦ adopt a plan of operation; administer the Florida Health Endowment Trust Fund which is created under a companion bill (CS/SB 1802); establish eligibility requirements for individuals participating in the plan; contract with a trustee services firm to supervise investment proposals; contract with preferred provider organizations and health maintenance

organizations; and, offer policies of major medical coverage with various premiums and deductibles and coinsurance.

- establish separate premium schedules for low-risk, medium-risk, and high-risk individuals; contract with insurers to provide disease management services for insurers that elect to participate; and, allow existing FCHA policyholders to purchase FHEA health coverage.

- allow insurers subject to the premium tax liability who contribute to the Florida Health Endowment Association to earn a vested credit against premium tax liability equal to 100 percent of the contribution and permit the limited transfer of a company's unused premium tax credits.

The committee substitute provides for the plan to be terminated by the state if it becomes financially infeasible and effective upon the date of the opening of the plan, all individuals who have insurance coverage issued by the Florida Comprehensive Health Association on that date would be issued insurance coverage under the plan. It also provides that the Florida Health Endowment Association shall assume all assets and liabilities of the Florida Comprehensive Health Association.

It provides for an appropriation of $50 million from the General Revenue Fund and that the bill would take effect on July 1,1999, contingent upon the sum of $50 million being appropriated to the Florida Health Endowment Trust Fund. The Trust Fund is established in the companion bill (CS/SB 1802).

The committee substitute repeals the following sections of the Florida Statutes effective on January 1, 2000: 627.648, 627.6482, 627.6484, 627.6486, 627.6487, 627.64871, 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, and 627.6498.

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 1991 - 1997: $5.6 million (1991), $7.1 million

(1992), $5.8 million (1993), $11.8 million (1994), $9.8 million (1995), $3.2 million (1996), and $1.9 million (1997). It is estimated that assessments/losses for fiscal year 1998 is $4.6 million.

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, 1997-98*, 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.
6. Allow alternative sources of funding for FCHA.

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 in that less than 5 percent of the non-elderly,

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. As of 1999, there are 28 states which have high-risk pools.

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 32 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 Department of Insurance annually establishes the standard risk rate that serve as the basis for determining premiums established for the FCHA (ch. 98-159, L.O.F.). The department uses reasonable actuarial techniques, and standards adopted by rule. As currently provided, the maximum rates for the FCHA would be 200 percent, 225 percent, and 250 percent of the standard risk rate for low, medium, and high risk individuals, respectively.

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 2 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 have declined slightly and have 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 April 1999, enrollment totaled 900 and was declining at a rate of approximately 15 percent per year.

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 1990-98 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
1998	**991**	**4652***	**3536***	**8538***	**41.4%***
1997	**1182**	**1637**	**3531**	**5653**	**62.5%**
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%**

*** Estimated**

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, while for 1997 net losses totaled $1.9 million and for 1998 totaled $4.6 million.

III. Effect of Proposed Changes:

Section 1. Creates the "Florida Health Endowment Association" (FHEA) as a nonprofit legal entity. The committee substitute, however, does not assign this newly created provision to a section of the Florida statutes. It provides for the association to be governed by a five-member Board of Directors composed of the following: the Secretary of the Department of Health (who is the chairperson), or his or her designee; the Insurance Commissioner, or his or her designee, and 3 persons appointed by the Governor, including one representative of policyholders who is not associated with the medical profession or a hospital, one representative of the health insurance industry, and one member of the public. It provides for removal of any appointed board member without cause, specifies that members shall be appointed to staggered 3-year terms, and prohibits the plan administrator from serving as a member of the board. It allows for reimbursement of

board member expenses and authorizes immunity from liability for board members and employees of the association. Specifies that meetings of the board are subject to the open meetings and records law pursuant to s. 286.011, F.S.

The board is authorized to do the following: adopt a plan of operations, subject to approval by the Department of Health; establish administrative and accounting procedures; administer the Trust Fund; contract with an actuary to recommend the opening and closing of the plan, based on the income of the trust fund, premiums, and other revenues; establish eligibility requirements for individuals participating in the plan to ensure the actuarial soundness of the insurance pool; develop policy forms to be used by the association which are subject to approval by the Department of Insurance; contract with preferred provider organizations and health maintenance organizations; employ a case manager to manage or coordinate the medical care of policyholders; appoint an executive director to serve as the chief administrative and operational officer to the board; establish an investment plan with approval of the State Board of Administration; contract with a trustee services firm to supervise investment proposals for the board; and make a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and the House of Representatives, not later than October 1 of each year.

Section 2. Provides for definitions for terms relating to the structure and operation of the FHEA: “association” means the FHEA which is created under section 1; “board” means the board of directors of the FHEA; “case management” means the management of medical care provided for an individual; “department” means the Department of Health; “medicaid” means the federal medical assistance program; “medicare” means parts A and B of Title XVII of the Social Security Act; “plan of operation” means the articles and bylaws adopted by the board; “plan” means the comprehensive health insurance plan adopted by the FHEA; and, “resident” means a person legally domiciled in this state.

Section 3. Creates “Eligibility” provisions for the FHEA. It states that a Florida resident shall be eligible for the FHEA plan provided he/she receives a notice of rejection or refusal to issue substantially similar coverage for health reasons by an insurer licensed to issue coverage in Florida, or at rates higher than the FHEA plan rates. Verification of residency is required. The board is given the authority to provide exceptions to the eligibility criteria by promulgating a list of medical or health conditions which would guarantee eligibility for the plan without applying and being rejected for coverage in the standard market. Also, resident dependent unmarried children of the insured are eligible, provided that no other coverage is available.

Restrictions for eligibility are included: persons who have or obtain substantially similar coverage (with the exception of COBRA); residents of public institutions or prisons; persons whose premiums are paid under any government sponsored program; persons who have reached the lifetime maximum of $500,000 in covered benefits; or persons who are eligible for Medicaid, unless their illness or disease requires supplies or medication which are covered under the FHEA plan, but not covered under Medicaid. The circumstances under which coverage will cease are specified as are provisions for the use of a case management system. Reentry into the FHEA is allowed, though currently prohibited under Florida Comprehensive Health Association. However, a person reentering would be subject to any new pre-existing condition limitations in effect at the

time and previous claim payments would be applied to the $500,000 lifetime maximum benefit limit.

Section 4. Specifies that the board appoint an administrator to administer the plan who shall serve for a period of 3 years and perform all administrative and claims-paying functions.

Section 5. Provides for minimum benefits coverage, exclusions, premiums, and deductibles. It specifies that the plan shall offer an annual renewable policy, that no persons eligible for Medicare coverage will be reimbursed for any expenses paid by Medicare, and that the coverage provided to a person who is eligible for Medicare benefits may not be issued as a Medicare supplement. It provides that any person who is involuntarily terminated for any reason other than non-payment of premium may apply for coverage and provides a mechanism to qualify for coverage effective as of the termination of the previous coverage.

The plan will offer major medical expense coverage and pay an eligible person's covered expenses, subject to limits on deductible and coinsurance. The maximum lifetime benefits allowed are $500,000, per covered individual, while the minimum deductible available for this plan is $1000. The plan may approve other deductibles and shall establish the schedule of premiums, which are subject to approval by the department.

This section specifies that the board shall establish separate premium schedules for low-risk, medium-risk, and high-risk individuals, and states that the rate may not exceed 150 percent of the standard risk rate for low-risk individuals, 200 percent for medium-risk, or 250 percent for high-risk individuals. The committee substitute provides how claims will be paid for individuals placed under a case management system, a preferred provider network, and other plans. Coverage is excluded for pre-existing conditions for a period of 12 months following the effective date of coverage for conditions that were manifested or for which medical advice or treatment was recommended within 6 months before the effective date of coverage.

Other sources of coverage are primary and the association has a cause of action against a participant for any benefits paid to the participant which should not have been claimed. This coverage is not an entitlement and coverage provided under this plan shall be directly insured by the Florida Health Endowment Association.

Section 6. The FHEA may contract with insurers to provide disease management services for insurers that elect to participate. Revenues collected by the association for this purpose shall be used to pay administrative expenses of the disease management program.

Section 7. Relates to tax credits and allows any insurance company subject to premium tax liability pursuant to s. 624.509, F.S., who contributes to the Florida Health Endowment Association, to earn a vested credit against premium tax liability equal to 100 percent of the contribution. However, this provision limits the annual use of the vested premium tax credit, including any carry-forward credits, to 25 percent, beginning with tax filings for calendar year 2001. This section clarifies that the credit may not exceed the premium tax liability of a company for that taxable year, and exempts the company from any additional retaliatory tax levied under s. 624.5091, F.S. It also permits the limited transfer of a company's unused premium tax credits.

Section 8. Allows the state to terminate the plan if it determines the plan to be financially infeasible although the committee substitute does not specify any procedure or standards to terminate the plan. Participants shall be entitled to exercise the complete benefits for which he or she has contracted, but additional participants may not be permitted to enter the plan.

Section 9. Specifies certain sections of the Florida Statutes and Laws of Florida (which relate to the current powers of the Florida Comprehensive Health Association) are to be repealed effective January 1, 2000. Provides effective upon the date of the opening of the plan, that all individuals who have insurance coverage issued by the Florida Comprehensive Health Association on that date shall be issued insurance coverage under the plan. Also, provides that the Florida Health Endowment Association shall assume all assets and liabilities of the Florida Comprehensive Health Association

Section 10. Specifies that an appropriation of $50 million be made from the General Revenue Fund to the Florida Health Endowment Trust Fund. The Trust Fund is created under the companion bill (CS/SB 1802).

Section 11. Provides the act will take effect July 1, 1999, contingent upon the $50 million being appropriated to the Florida Health Endowment Trust Fund.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Meetings of the Florida Health Endowment Association are subject to the same public notice and open meeting requirements that apply to the FCHA. Policyholders of the FHEA would have rights similar to those of the FCHA.

C. Trust Funds Restrictions:

Committee Substitute for Senate Bill 1802 establishes the Florida Health Endowment Trust Fund which funds the administration of the Florida Health Endowment Association. The provisions of CS/SB 1802 will not take effect if CS/SB 1800 does not become law.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Individuals who are not able to obtain health insurance will benefit from the establishment of the FHEA.

Under the provisions of the committee substitute, insurers would be allowed to contribute to the Florida Health Endowment Association and would earn a vested credit against premium tax liability equal to 100% of the contribution. The insurance company could use no more than 25% of the vested premium tax credit, including carry-forward credits, per year.

C. Government Sector Impact:

The Secretary of the Department of Health or his or her designee would serve as the chairperson of the association board of directors. The association would submit a plan of its articles, bylaws, operating rules to the Department of Health for approval.

Representatives with the Department of Health estimate the following expenses to implement the provisions of the committee substitute due to managing a contract for the FHEA as well as responsibilities to approve the FHA articles, bylaws, and administrative rules.

	FY 1999-00	**FY 2000-01**
Total (Non-Recurring) Expense	**$ 7,032**	
Total (Recurring) Expense	**$62,344**	**$77,001**
TOTAL	**$69,376**	**$77,001**

VI. Technical Deficiencies:

Assigning the created provisions to a designated provision of the Florida statutes would further clarify the applicability of these new requirements.

VII. Related Issues:

This committee substitute is linked to CS/SB 1802 which establishes the Florida Health Endowment Trust Fund within the State Board of Administration.

This bill provides that if the “state” determines the plan to be “financially infeasible,” the “state may discontinue the plan. However, the terms “state” and “financially infeasible” are not further defined or clarified. There are no standards pertaining to how the state is to determine whether the FHEA plan is or is not financially feasible.

Representatives with the Department of Health provide the following comments concerning this committee substitute: The Department of Health is charged with regulatory oversight over the FHEA, however, DOH does not have expertise in the area of regulating a commercial insurance entity like the FHEA. The Department of Health believes it would be more appropriate for the Department of Insurance to have oversight as it currently has with the FCHA. Also, it is unclear as to whether the committee substitute would foster "crowd-out," meaning that there are no provisions to prevent employers from dropping employee coverage and expecting the employee to purchase health insurance through the FHEA. Further, there is minimal reference in the committee substitute to any quality management or oversight of the FHEA plans or linkages with the Agency for Health Care Administration with respect to the quality of the commercial insurance plan.

VIII. Amendments:

None.