**By** Senator Peaden

2-1588-05

A bill to be entitled

An act relating to health insurance; amending s. 627.6487, F.S.; redefining the term "eligible individual" for purposes of guaranteed availability of individual health insurance coverage to eligible individuals; amending s. 627.64872, F.S.; revising definitions relating to the Florida Health Insurance Plan; providing for the Commissioner of Insurance Regulation to serve on the plan's board of directors; deleting obsolete provisions relating to an interim report; revising qualifications for eligibility; revising sources of additional revenue for the plan; prescribing a limit on health care provider reimbursement; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (3) of section 627.6487, Florida Statutes, is amended to read:

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

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

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

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

b. Whose most recent prior creditable coverage was under an individual plan issued in this state by a health insurer or health maintenance organization, which coverage is terminated due to the insurer or health maintenance organization becoming insolvent or discontinuing the offering of all individual coverage in the State of Florida, or due to the insured no longer living in the service area in the State of Florida of the insurer or health maintenance organization that provides coverage through a network plan in the State of Florida; or

c. Whose most recent creditable coverage was with the Florida Health Insurance Plan specified in s. 627.64872, which coverage is terminated due to inadequate funding of the Florida Health Insurance Plan as provided in s. 627.64872(15);

(b) Who is not eligible for coverage under:

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

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

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

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

5. The Florida Health Insurance Plan as specified in s. 627.64872 and such plan is accepting new enrollment;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) was not terminated based on a factor described in s. 627.6571(2)(a) or (b), relating to nonpayment of premiums or fraud, unless such nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

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

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

Section 2. Subsections (2), (3), (6), (9), and (15) of section 627.64872, Florida Statutes, are amended, present subsection (20) of that section is renumbered as subsection (21), and a new subsection (20) is added to that section to read:

627.64872 Florida Health Insurance Plan.--

(2) DEFINITIONS.--As used in this section:

(a) "Board" means the board of directors of the plan.

(b) "Commissioner" means the Commissioner of Insurance Regulation.

(c)~~(b)~~ "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 25 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

~~(c) "Director" means the Director of the Office of Insurance Regulation.~~

(d) "Health insurance" means any hospital or medical expense incurred policy or health maintenance organization subscriber contract pursuant to chapter 641. The term does not include short-term, accident, dental-only, vision-only, fixed-indemnity, limited-benefit, or credit insurance; disability income insurance; coverage for onsite medical clinics; insurance coverage specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, or other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191; benefits provided under a separate policy, certificate, or contract of insurance, under which there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor, such as for coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; coverage offered as a separate policy, certificate, or contract of insurance, such as Medicare supplemental health insurance as defined under s. 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under chapter 55 of Title 10, U.S.C., the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); similar supplemental coverage provided to coverage under a group health plan; coverage issued as a supplement to liability insurance; insurance arising out of a

workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(e) "Implementation" means the effective date after the first meeting of the board when legal authority and administrative ability exists for the board to subsume the transfer of all statutory powers, duties, functions, assets, records, personnel, and property of the Florida Comprehensive Health Association as specified in s. 627.6488.

(f) "Insurer" means any entity that provides health insurance in this state. For purposes of this section, insurer includes an insurance company with a valid certificate in accordance with chapter 624, a health maintenance organization with a valid certificate of authority in accordance with part I or part III of chapter 641, a prepaid health clinic authorized to transact business in this state pursuant to part II of chapter 641, multiple employer welfare arrangements authorized to transact business in this state pursuant to ss. 624.436-624.45, or a fraternal benefit society providing health benefits to its members as authorized pursuant to chapter 632.

(g) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. ss. 1395 et seq., as amended.

(h) "Medicaid" means coverage under Title XIX of the Social Security Act.

(i) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(j) "Participating insurer" means any insurer providing health insurance to citizens of this state.

(k) "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state.

(l) "Plan" means the Florida Health Insurance Plan created in subsection (1).

(m) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the board pursuant to this section.

(n) "Resident" means an individual who has been legally domiciled in this state for a period of at least 6 months and who physically resides in this state not less than 185 days a year.

(3) BOARD OF DIRECTORS.--

(a) The plan shall operate subject to the supervision and control of the board. The board shall consist of the commissioner ~~director~~ or his or her designated representative, who shall serve as a member of the board and shall be its chair, and an additional eight members, five of whom shall be appointed by the Governor, at least two of whom shall be individuals not representative of insurers or health care providers, one of whom shall be appointed by the President of the Senate, one of whom shall be appointed by the Speaker of the House of Representatives, and one of whom shall be appointed by the Chief Financial Officer.

(b) The term to be served on the board by the commissioner ~~Director of the Office of Insurance Regulation~~ shall be determined by continued employment in such position. The remaining initial board members shall serve for a period

of time as follows: two members appointed by the Governor and the members appointed by the President of the Senate and the Speaker of the House of Representatives shall serve a term of 2 years; and three members appointed by the Governor and the Chief Financial Officer shall serve a term of 4 years. Subsequent board members shall serve for a term of 3 years. A board member's term shall continue until his or her successor is appointed.

(c) Vacancies on the board shall be filled by the appointing authority, such authority being the Governor, the President of the Senate, the Speaker of the House of Representatives, or the Chief Financial Officer. The appointing authority may remove board members for cause.

(d) The commissioner ~~director~~, or his or her recognized representative, shall be responsible for any organizational requirements necessary for the initial meeting of the board which shall take place no later than September 1, 2004.

(e) Members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties in accordance with s. 112.061.

(f) The board shall submit to the Financial Services Commission a plan of operation for the plan and any amendments thereto necessary or suitable to ensure the fair, reasonable, and equitable administration of the plan. The plan of operation shall ensure that the plan qualifies to apply for any available funding from the Federal Government that adds to the financial viability of the plan. The plan of operation shall become effective upon approval in writing by the Financial Services Commission consistent with the date on

which the coverage under this section must be made available. If the board fails to submit a suitable plan of operation within 1 year after <u>implementation</u> ~~the appointment of the board of directors~~, or at any time thereafter fails to submit suitable amendments to the plan of operation, the Financial Services Commission shall adopt such rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the office or superseded by a plan of operation submitted by the board and approved by the Financial Services Commission.

(6) ~~INTERIM REPORT;~~ ANNUAL REPORT.--

~~(a) By no later than December 1, 2004, the board shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives the results of an actuarial study conducted by the board to determine, including, but not limited to:~~

~~1. The impact the creation of the plan will have on the small group insurance market and the individual market on premiums paid by insureds. This shall include an estimate of the total anticipated aggregate savings for all small employers in the state.~~

~~2. The number of individuals the pool could reasonably cover at various funding levels, specifically, the number of people the pool may cover at each of those funding levels.~~

~~3. A recommendation as to the best source of funding for the anticipated deficits of the pool.~~

~~4. The effect on the individual and small group market by including in the Florida Health Insurance Plan persons eligible for coverage under s. 627.6487, as well as the cost of including these individuals.~~

~~The board shall take no action to implement the Florida Health Insurance Plan, other than the completion of the actuarial study authorized in this paragraph, until funds are appropriated for startup cost and any projected deficits.~~

~~(b)~~ No later than December 1, 2005, and annually thereafter, the board shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the substantive legislative committees of the Legislature a report which includes an independent actuarial study to determine, including, but not be limited to:

(a)~~1.~~ The impact the creation of the plan has on the small group and individual insurance market, specifically on the premiums paid by insureds. This shall include an estimate of the total anticipated aggregate savings for all small employers in the state.

(b)~~2.~~ The actual number of individuals covered at the current funding and benefit level, the projected number of individuals that may seek coverage in the forthcoming fiscal year, and the projected funding needed to cover anticipated increase or decrease in plan participation.

~~3. A recommendation as to the best source of funding for the anticipated deficits of the pool.~~

(c)~~4.~~ A summarization of the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

(d)~~5.~~ A review of the operation of the plan as to whether the plan has met the intent of this section.

(9) ELIGIBILITY.--

(a) Any individual person who is and continues to be a resident of this state shall be eligible for coverage under the plan if:

1. Evidence is provided that the person received notices of rejection or refusal to issue substantially similar coverage for health reasons from at least two health insurers or health maintenance organizations. A rejection or refusal by an insurer offering only stop-loss, excess of loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this paragraph.

2. The person is enrolled in the Florida Comprehensive Health Association as of the date the plan is implemented.

3. The person is an eligible individual as defined in s. 627.6487(3), excluding s. 627.6487(3)(b)5.

(b) Each resident dependent of a person who is eligible for coverage under the plan shall also be eligible for such coverage.

(c) A person shall not be eligible for coverage under the plan if:

1. The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to obtain such coverage, unless a person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy or may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy.

2. The person is determined to be eligible for health care benefits under Medicaid, Medicare, the state's children's

health insurance program, or any other federal, state, or local government program that provides health benefits;

3. The person voluntarily terminated plan coverage unless 12 months have elapsed since such termination;

4. The person is an inmate or resident of a public institution; or

5. The person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency<u>,</u> ~~or~~ health care provider<u>, or health-care-provider-sponsored or affiliated organization</u>.

(d) Coverage shall cease:

1. On the date a person is no longer a resident of this state;

2. On the date a person requests coverage to end;

3. Upon the death of the covered person;

4. On the date state law requires cancellation or nonrenewal of the policy; ~~or~~

5. At the option of the plan, 30 days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply<u>; or</u>~~.~~

6. Upon failure of the insured to pay for continued coverage.

(e) Except under the circumstances described in this subsection, coverage of a person who ceases to meet the eligibility requirements of this subsection shall be terminated at the end of the policy period for which the necessary premiums have been paid.

(15) FUNDING OF THE PLAN.--

(a) Premiums.--

1. The plan shall establish premium rates for plan coverage as provided in this section. Separate schedules of

premium rates based on age, sex, and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the office for approval prior to use.

2. Initial rates for plan coverage shall be limited to no more than 200 ~~300~~ percent of rates established for individual standard risks as specified in s. 627.6675(3)(c). Subject to the limits provided in this paragraph, subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein, but in no event shall premiums exceed the 200-percent ~~300 percent~~ rate limitation provided in this section. Notwithstanding the 200-percent ~~300 percent~~ rate limitation, sliding scale premium surcharges based upon the insured's income may apply to all enrollees.

(b) Sources of additional revenue.--

1. ~~Any deficit incurred by the plan shall be primarily funded through amounts appropriated by the Legislature from general revenue sources, including, but not limited to, a portion of the annual growth in existing net insurance premium taxes.~~ The board shall operate the plan in such a manner that the estimated cost of providing health insurance during any fiscal year will not exceed total income the plan expects to receive from policy premiums and funds assessed ~~appropriated by the Legislature~~, including any interest on investments. After determining the amount of funds available ~~appropriated~~ to the board for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to ensure

that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure. In the event of inadequate funding, the board may cancel policies on a nondiscriminatory basis as necessary to remedy the situation. A policy may not be canceled if a covered individual under that policy is currently on claim.

2. As a condition of doing business in this state, an insurer shall pay an assessment to the board in the amount prescribed by this section. Each insurer shall annually be assessed by the board a percentage of the insurer's earned premium pertaining to direct writings of health insurance in the state during the calendar year preceding that for which the assessment is levied. Such percentage shall equal the percentage that the anticipated incurred operating losses of the plan for the upcoming fiscal year represent of all earned premium pertaining to direct writings of health insurance in the state during the calendar year preceding that for which the assessment is levied.

3. The total of all assessments under this paragraph upon an insurer may not exceed 1 percent of such insurer's health insurance premium earned in this state during the calendar year preceding the year for which the assessments were levied.

4. All rights, title, and interest in the assessment funds collected under this paragraph shall vest in this state. However, of all such funds and interest earned shall be used by the plan to pay claims and administrative expenses.

(c) If assessments and other receipts by the plan, board, or plan administrator exceed the actual losses and and administrative expenses of the plan, the excess shall be held in interest and used by the board to offset future losses. As

used in this subsection, the term "future losses" including reserves for claims incurred but not reported.

(d) Each insurer's assessment shall be determined annually by the board or plan administrator based on annual statements and other reports deemed necessary by the board or plan administrator and filed with the board or plan administrator by the insurer.

(e) Insurance may recover the assessment in the normal course of their respective businesses by including the percentage, as indicated in subparagraph (b)2., as a claim cost in determining rates.

(20) PROVIDER REIMBURSEMENT.--Notwithstanding any law to the contrary, the maximum reimbursement rate to health care providers for all covered, medically necessary services shall be 100 percent of Medicare's allowed payment amount for that particular provider and service. All providers licensed in this state shall accept assignment of plan benefits and consider the Medicare allowed payment amount as payment in full.

(21)~~(20)~~ COMBINING MEMBERSHIP OF THE FLORIDA COMPREHENSIVE HEALTH ASSOCIATION; ASSESSMENT.--

(a)1. Upon implementation of the Florida Health Insurance Plan, the Florida Comprehensive Health Association, as specified in s. 627.6488, is abolished as a separate nonprofit entity and shall be subsumed under the board of directors of the Florida Health Insurance Plan. All individuals actively enrolled in the Florida Comprehensive Health Association shall be enrolled in the plan subject to its rules and requirements, except as otherwise specified in this section. Maximum lifetime benefits paid to an individual in the plan shall not exceed the amount established under

subsection (16), and benefits previously paid for any individual by the Florida Comprehensive Health Association shall be used in the determination of total lifetime benefits paid under the plan.

2. All persons enrolled in the Florida Comprehensive Health Association upon implementation of the Florida Health Insurance Plan are only eligible for the benefits authorized under subsection (16). Persons identified by this section shall convert to the benefits authorized under subsection (16) no later than January 1, 2005.

3. Except as otherwise provided in this section, the administration of the coverage of persons actively enrolled in the Florida Comprehensive Health Association shall operate under the existing plan of operation without modification until the adoption of the new plan of operation for the Florida Health Insurance Plan.

(b)1. As a condition of doing business in this state, an insurer shall pay an assessment to the board in the amount prescribed by this section. For operating losses incurred on or after July 1, 2004, by persons enrolled in the Florida Comprehensive Health Association, each insurer shall annually be assessed by the board in the following calendar year a portion of such incurred operating losses of the plan. Such portion shall be determined by multiplying such operating losses by a fraction, the numerator of which equals the insurer's earned premium pertaining to direct writings of health insurance in the state during the calendar year preceding that for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by insurers in the state during such calendar year.

2. The total of all assessments under this paragraph upon an insurer shall not exceed 1 percent of such insurer's health insurance premium earned in this state during the calendar year preceding the year for which the assessments were levied.

3. All rights, title, and interest in the assessment funds collected under this paragraph shall vest in this state. However, all of such funds and interest earned shall be used by the plan to pay claims and administrative expenses.

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

(d) Each insurer's assessment shall be determined annually by the board or plan administrator based on annual statements and other reports deemed necessary by the board or plan administrator and filed with the board or plan administrator by the insurer. Any deficit incurred under the plan by persons previously enrolled in the Florida Comprehensive Health Association shall be recouped by the assessments against insurers by the board or plan administrator in the manner provided in paragraph (b), and the insurers may recover the assessment in the normal course of their respective businesses without time limitation.

(e) If a person actively enrolled in the Florida Comprehensive Health Association after implementation of the plan loses eligibility for participation in the Florida Comprehensive Health Association, such person shall not be

included in the calculation of the assessment if the person later regains eligibility for participation in the plan.

(f) When all persons actively enrolled in the Florida Comprehensive Health Association as of the date of implementation of the plan are no longer eligible for participation in the Florida Comprehensive Health Association, the board of directors and plan administrator shall no longer be allowed to assess insurers in this state for incurred losses in the Florida Comprehensive Health Association.

Section 3. This act shall take effect July 1, 2005.

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SENATE SUMMARY

Revises various provisions relating to health insurance and the Florida Health Insurance Plan, including definitions, eligibility requirements, revenue sources, and provider reimbursement. (See bill for details.)