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Florida Health Insurance Plan

Florida Department of Financial Services
Office of Insurance Regulation



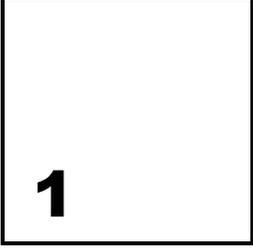
MERCER OLIVER WYMAN

Karen Bender, FCA, ASA, MAAA

Beth Fritchen, FSA, MAAA

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Executive Summary

The Florida Health Insurance Plan (FHIP) Board engaged Mercer Oliver Wyman Actuarial Consulting, Inc. (MOW) to perform a high-risk pool feasibility study.

We have used the information provided by the Florida Office of Insurance Regulation (Office), Florida Comprehensive Health Association (FCHA) and various state-generated reports and/or surveys along with other independent sources. While we have reviewed this information for reasonableness and consistency, we have not performed independent audits to verify its accuracy. Our conclusions could be impacted if there are significant errors or omissions in the information provided.

This study is a forecast of future events. With any forecast, there are many factors that can impact the results. The estimates shown in this study should be considered in this context. We have developed ranges of results which represent what we believe to be the 95% confidence intervals of possible outcomes under very specific circumstances. However, this range is meaningful only if all the major assumptions and circumstances are realized. For example, an exodus from the market by a nongroup carrier is not one of our major assumptions. Therefore, the model results could be understated if this occurs.

This study is intended for the use of the FHIP Board for determining if it will create a high-risk pool. MOW is not responsible for any other use of this document.

Chapters 2 and 3 provide a very general background on risk pools, Florida's experience with risk pools and the scope of the FHIP feasibility study. One of the goals of a high-risk pool is to more equitably spread the risk (and costs) of these individuals over the largest population base possible.

Chapter 4 shows the assumptions incorporated into our modeling. As with any type of modeling, the results will vary depending upon the assumptions being employed. The assumption that has the greatest financial impact is the definition of those that will be

eligible to join FHIP. Obviously, if the eligibility requirements are expanded, there will be greater enrollment in FHIP. We have modeled two eligibility scenarios: one that excludes group conversions from being able to join FHIP (which is consistent with the legislation as written), which we refer to as self-funded HIPAA (e.g., individuals leaving self-funded plans) and a scenario that would allow group conversions to join FHIP, which we refer to as All-HIPAA-eligibles. The latter would provide a consistent approach to HIPAA-eligibles, regardless of what type of plan from which they are leaving. However, there is a cost to this expansion of eligibility. Both scenarios include non-HIPAA-eligibles who meet the requirements for coverage.

The premium cap (e.g., the level that the FHIP premiums will be as a percentage of standard risk rates) also has a significant impact on enrollment. As prescribed in the request for proposal (RFP), we generated scenarios, when possible, based upon the following premium caps:

- 150%
- 200%
- 250%
- 300%
- Self-supporting (e.g., the premiums generated by FHIP enrollees will be sufficient to fund claims and expenses)

Another assumption that significantly impacts the financial results is the level of provider reimbursements. This should not be surprising since provider reimbursement levels drive claim levels. We have modeled two provider reimbursement assumptions: the levels that FCHA currently has and Medicare levels. Our analysis of the Florida commercial market shows that payors with large enrollments (either self-funded or large insurance companies and/or HMOs) are reimbursing providers much closer to or at Medicare levels.

Chapter 5 details the methodology we employed in creating the model. We developed a multiple regression model that used a database consisting of six years of experience of high-risk plans in the country that did not employ enrollment limitations. This enabled us to use historical experience to project enrollment levels. The enrollment model uses premium caps, median income per household, pool duration, the number of uninsured in a state and loss ratio. Each of these inputs can vary from year to year. To account for this, we developed probability distributions for each of the inputs and generated 1,000 simulations for each premium cap scenario. This also enabled us to generate ranges in outcomes that represent about a 95% confidence interval. It is extremely important for the FHIP Board to be cognizant of the underlying variability that can occur in such pools and models. While we present the results generated from expected enrollment in the Executive Summary as well as throughout the text, the Appendix shows the detailed results for the confidence intervals.

In Chapter 6 we discuss the tests for reasonableness we performed to ensure that the results the model was generating were consistent with Florida experience, and other high-risk pools.

Chapter 7 shows the financial results of the various provider reimbursement levels, eligibility levels and premium cap levels for expected enrollment. In total we show the results based upon expected enrollment for two provider reimbursement levels, two eligibility scenarios and four premium caps for a total of sixteen scenarios.

Since current FCHA members will be subsumed by FHIP, we completed financial forecasts for the various premium cap levels and provider reimbursement levels. (Changes in eligibility would not impact these members.) This resulted in eight additional models, which are shown in the Appendix.

Please note that we performed scenarios for four premium caps: 150%, 200%, 250% and 300%. We tried to identify a multiple of standard risk rates (SRRs) that would be necessary for FHIP to be self-supporting (e.g., the premiums generated from the members are adequate to fund claims and expense without requiring any outside subsidy). We tested premiums at 400%, 500% and 600% of SRRs. The morbidity increases as the premium cap increases. For each of the scenarios, the increase in morbidity is still greater than the increase in premiums. Based upon these results, we do not believe it is possible to create a premium cap that will be self-supporting in the long run. There may be an occasional year where a particular fund does not incur a loss. Such phenomenon can be attributed to the randomness inherent in the incidence of claims. If it was possible to create a self-supporting scenario, then we would expect insurance companies, who are experts at taking risks, to have determined such a premium level and market to these individuals.

The scenario that results in the least losses in FHIP is limiting eligibility to self-funded HIPAA individuals and incorporating provider reimbursement at Medicare levels. The following chart summarizes these results.

**Operating Losses
Self-Funded HIPAA Members
at Medicare Provider Reimbursement Levels**

Premium Cap	Membership (Rounded to nearest Hundred)	Fifth Year Loss (Millions of Dollars)
150%	11,300	\$41
200%	9,700	\$40
250%	8,100	\$32
300%	6,500	\$22

These results are based upon expected enrollment. The 95th confidence interval for the 200% premium cap operating losses is \$36 million to \$45 million. This shows the inherent variability associated with the modeling techniques and assumptions employed. The final set of financial forecasts involved what we refer to as the “California model.”

California has developed a different approach to its high-risk pool. California requests bids from carriers reflecting the loss ratios they will incur at a specified premium cap. The risk pool assumes the risk up to the loss ratio submitted and the carriers assume the risk for losses in excess of the loss ratios. In our discussions with individuals at the California high-risk pool, they indicated that the initial loss ratio maximums submitted by the carriers were high—at least 200%. While the loss ratio maximums are considered confidential information, they indicated that the pool had negotiated the maximums down and indicated that the range is about 140% to 170%. (The pool can charge individuals up to 137% of SRR if they enroll with carriers that have a higher maximum loss ratio. This encourages members to choose carriers that provide the maximum protection for the high-risk pool.) Using the maximum loss ratios as a pseudo premium, California then determines how many individuals their allotted funding can support. If necessary, benefits will be adjusted downward and enrollment levels frozen, both of which have occurred.

There are risks to the California model. The major risk is the ability to have carriers willing to accept losses for this pool. If there are insufficient carriers bidding and/or if the loss ratio attachment points are too high, then the State is effectively fully funding the high-risk pool. There are unique characteristics in California that may be difficult to realize in other states. We tested the impact of the California model at two stop loss attachment points: 175% and 200% for the entire anticipated FHIP pool. If FHIP is able to implement provider reimbursement at Medicare levels, then the risks associated with the California model do not offset any financial gain and the California model is not worth pursuing.

Chapter 8 discusses the possibility of federal funding. In order to be eligible for federal funds, the premium caps must not be greater than 150% of standard risk rates. We estimate the maximum amount of federal funds available to Florida is \$4.8 million with a more realistic sum being \$2.3 million. This is based upon the fifth year results for the scenario including all HIPAA-eligibles and FCHA members. Amounts available in earlier years will be significantly less. Given the magnitude of the losses generated from our model, the presence of federal funding will not be a major factor in the decision-making process.

Chapter 9 discusses the impacts a high-risk pool can have on the commercial market. We estimate the long-term direct impacts to rates as follows:

Direct Impacts to Rates

Segment	Source of Savings				Market Impacted
	Improved Claims	Administrative	Total	Annual \$ Amount (Millions)	
Elimination of Guarantee Issue of One-Life Groups	2% to 3%	1%	3% to 4%	\$92 to \$123	Small Group
Elimination of Nongroup Carriers Guarantee Issues HIPAA-Eligibles coming from Self-funded Plans	2% to 3%	1%	3% to 4%	\$35 to \$46	Nongroup
Elimination of Group Conversion for HIPAA Eligibles coming from Insured Policy	0.5%	-	0.5%	\$55*	All Groups

*The reason that Elimination of Group Conversion (0.5% of premium) has what appears to be a greater dollar amount of impact proportionally than the elimination of one-life groups, is that elimination of group conversion impacts the premium for *all* fully insured group sizes, whereas the elimination of one-life groups impacts the premium for only small groups.

High-risk pools have other positive impacts as well. Many believe that high-risk pools contribute to the stability of the individual market. Kentucky, New Hampshire and South Dakota recently created high-risk pools as a means of attracting more carriers into the individual market. High-risk pools provide the safety net that is necessary in a voluntary market while minimizing any disruption. At one time, the Washington high-risk pool was the only source of comprehensive health coverage in the nongroup market. Their presence can provide for less regulatory requirements for HIPAA-compliance and create a competitive market for the balance of the nongroup population. Iowa recently reverted back to a high-risk pool as a means for HIPAA compliance. Preliminary results indicate that, at least in the case of Kentucky and South Dakota, new carriers have entered the state.

In addition, providers have a better probability of collecting monies for their services if a patient has insurance as opposed to being self-pay. Therefore, even a lower level of reimbursement is preferable to none at all. Thus the presence of a high-risk pool should help to control the levels of uncompensated care.

Studies show that maintaining insurance coverage improves both access to health care and health care status. For high-risk individuals access to health care and monitoring is even more important if they are to avoid costly complications associated with their conditions. In 1999, 40% of personal bankruptcy filings were due to huge medical expenses. Such bankruptcies destroy life savings of the individuals and also affect providers who do not receive payment for their services. While implementing a high-risk pool will not resolve all the issues associated with access to affordable insurance, it can provide a safety net for those individuals that have the worst conditions.

High-risk pools are probably the most equitable means of spreading the costs for these individuals across a broad population.

In Chapter 10 we discuss the various means of funding high-risk pools and provide estimates of the assessment associated with the various methods. There are advantages and disadvantages to each of the methods. The following chart summarizes these. Details of the assessments are provided in the chapter.

Advantages and Disadvantages of Various Funding Sources

Funding Source	Advantages	Disadvantages
High-Risk Pool Enrollee’s Surcharged Premium	Equitable since they are the greatest beneficiaries of the pool.	If surcharge is too great, affordability becomes more problematic.
	Premiums fund 55% of costs in current high-risk pools across the country.	Impossible to develop a self-supporting high-risk pool.
Limit Provider Reimbursement to Medicare Levels	Since providers are also a beneficiary of a high-risk pool, they should share in the cost of its operation.	Providers may resent the State dictating reimbursement levels.
	Provider discounts are common in the industry.	Providers may argue level of reimbursement prevalent in current market.
	Providers in Florida currently accepting Medicare level reimbursements for commercial patients.	Providers may try to offset losses by cost shifting to other commercial patients.

Funding Source	Advantages	Disadvantages
	Currently a precedent in the Worker’s Compensation program to define provider reimbursement for a specific patient population.	Providers must not be allowed to balance bill.
Alternative 1		
Assessments to Carriers based upon Premium (includes Stop Loss Premiums)	Steady and reliable source that includes out-of-state insurance companies.	Does not include self-funded employer plans that do not purchase stop loss protection in assessment. Self-funded employer plans can represent as much as 50% of the market and it is the largest plans that do not purchase stop loss protection.
	Acceptable in the industry in that twenty-two states currently employ this as a source.	Stop loss premiums are significantly less than fully insured premiums. Therefore by using premiums as the basis for assessments, the costs of funding the losses of the high-risk pool are shifted to fully insured policies which are generally purchased by smaller employers and individuals.
	Some states allow assessments to offset premium tax.	Premium tax offsets reduce General Revenues for the State.
	Removes the State from all financial liability for the high-risk pool.	Requires accurate premium statistics.
	Information necessary to determine the assessment is generally easily available.	Provides another incentive for employers to become self funded and outside the oversight of the Office.

Funding Source	Advantages	Disadvantages
	Proponents of this method assert that since it is the insurance industry that is not willing to insure these individuals, it is only equitable that the insurance industry fund the losses.	High-risk individuals leaving self-funded employer plans are eligible for FHIP; therefore self-funded employer plans should share in its losses.
Alternative 2		
Assessments to Carriers based upon Number of Insured Lives (includes Stop Loss Premiums)	Steady and reliable source that includes out-of-state insurance companies.	Does not include self-funded employer plans that do not purchase stop loss protection in assessment. Self-funded employer plans can represent as much as 50% of the market and it is the largest plans that do not purchase stop loss protection.
	Six states are currently using this approach.	Need accurate enrollment statistics for all coverages, including stop loss.
	More equitable than using premiums as a base since stop loss carriers must contribute as much per life as fully insured products.	If premium tax offsets allowed, there will be a reduction to General Revenues for the State.
	Proponents of this method assert that since it is the insurance industry that is not willing to insure these individuals, it is only equitable that the insurance industry fund the losses.	Provides another incentive for employers to become self funded and outside the oversight of the Office.
		High-risk individuals leaving self-funded employer plans are eligible for FHIP; therefore self-funded employer plans should share in its losses.

Funding Source	Advantages	Disadvantages
Alternative 3		
Assessments to Hospitals based upon Number of Inpatient Days	Greatest advantage is that it includes all self-funded plans as well as fully insured plans and policies.	Hospitals may resist since they will be the bearer of the higher costs associated with assessments.
	Florida already taxes/assesses hospitals so the precedent is established.	Using the proceeds from the current hospital assessments/taxes reduces funds for other uses.
	Honors “no new tax” pledge.	Assessments must be in addition to the negotiated provider reimbursement levels.
	Removes the State from all financial liability for the high-risk pool.	Could be complicated to administer since assessment/tax cannot apply to Medicare, Medicaid, self-pay (e.g., uninsured), VA hospitals.
	Florida has accurate hospital data base upon which to base assessment estimate.	Assessment levels need to be established prior to effective date of days subject to assessment for ease in administration. Lag between time of service and assessment.
General Revenue	State has the most resources at its disposal to subsidize pool.	State has full responsibility for financial losses of high-risk pool.
	Eliminates costs attributable to administering assessments.	In reality the State does not have unlimited funds and there will always be competing interests for limited State funds.
	Costs of funding high-risk pool losses spread across all citizens in the State.	Opponents assert that some citizens, such as the elderly, should not have to bear this burden.
	Legislators will be fully cognizant of the costs of the high-risk pool.	Appropriations will need to be made well in advance which will necessitate forecasting for periods of up to two years.

Funding Source	Advantages	Disadvantages
		High-risk pools that have relied on general funds are more apt to close enrollment, which is what occurred previously in Florida. This would not satisfy the HIPAA requirements.
		Since funds must be appropriated every session, does not guarantee a reliable funding source.

We recommend using an assessment/tax on hospitals since it is the only method that includes self-funded plans in supporting the costs of high-risk pools.

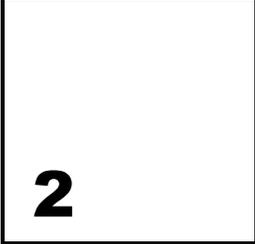
In the final chapter we discuss recommended changes to the existing legislation. The main changes reflect provider reimbursement levels, which we have already discussed, elimination of providers’ ability to balance bill and a reconsideration of the level of agent’s commission.

We strongly recommend that the FHIP Board consider a commission reimbursement closer to the levels in place in high-risk pools across the country. Providing a one-time \$100 placement fee would still be one of the richest “commissions.” Moving to this level results in the following fifth year losses.

**Operating Losses
Self-Funded HIPAA Members at Medicare Provider Reimbursement Levels
With Reduced Commissions**

Premium Cap	Membership (Rounded to nearest Hundred)	Fifth Year Loss (Millions of Dollars)
150%	11,300	\$40
200%	9,700	\$38
250%	8,000	\$31
300%	6,500	\$21

In the long run, the cost of the high-risk pool will be more than offset by the savings to the commercial market previously described.

**2****Background**

There are several purposes for a state to create a high-risk pool.

- Provide access to those individuals who do not have access to insurance through an employer group health insurance plan and have pre-existing conditions that preclude them from either being able to pass medical underwriting or requiring significant additional premium in the voluntary, commercial individual health insurance market.
- Satisfy the guarantee issues provisions of Health Insurance Portability and Accountability Act (HIPAA) that requires access to the individual market for qualified persons leaving group coverage.
- Provide some stability to the voluntary, commercial individual health insurance market.

High-risk pools were never intended to insure a significant portion of the individual market, nor were they intended to be self-supporting through premiums alone. They were intended as a means to spread the risk for these high-cost individuals across a very broad spectrum of the market. Ideally, the losses sustained by these plans would be spread across all health insuring entities, including insurance companies, HMOs and self-funding employers.

Florida has some experience with high-risk pools. The Florida Comprehensive Health Association (FCHA) and its former name, State Comprehensive Health Association, was created in 1983. Initial growth was slow. However, in the late 1980's, growth and losses increased significantly. The Florida legislature voted to halt membership in the pool effective October 1, 1990. Members enrolled in FCHA were allowed to stay in the pool.¹ Membership peaked in 1990 at 7,500. That same year, premiums paid by FCHA members

¹ "Comprehensive Health Insurance for High-Risk Individuals," 2003/2004, published by Communicating for Agriculture and the Self-Employed, Inc. (CA) page 87.

were about \$15 million compared with about \$47 million in claims. The total assessment for the year was about \$34 million. These losses were driven, in part, by very rich benefit plans. By 2003, FCHA membership had decreased to a little over 500. Premiums paid by FCHA members in 2003 were a little over \$2 million dollars compare to claims that were slightly greater than \$6 million. Assessments for 2003 were slightly under \$3 million², which is less than 0.01% of the 2003 premium for accident and health coverages.³

For all practical purposes, the passage of HIPAA at the federal level required health insurance companies and HMOs (collectively referenced as “carriers” in the rest of this report) to guarantee issue and guarantee renew health insurance policies to all small and large employers. By “guarantee issue” we mean that coverage could not be denied due to the health status of one or more employees or dependents. Thus, HIPAA guaranteed access to all employers with two or more total employees and all individuals whose employer was offering a health insurance plan. HIPAA does require that qualified individuals leaving a group plan be offered coverage in the individual market on a guarantee issued basis. HIPAA did not address premium levels, for either group or individual insurance, but left this to state regulation.

Florida has satisfied HIPAA by requiring group insurance carriers to issue conversion contracts to HIPAA-qualified individuals leaving an insured employer group health plan. The benefits of the conversion policies are determined by Florida regulation. Carriers may charge up to 200% of the standard risk rate determined by the Florida Office of Insurance Regulation (Office) for its conversions policies. Carriers in the individual (nongroup) health insurance market must guarantee issue their two most popular currently marketed plans to HIPAA-qualified persons leaving a self-funded plan.

Florida has also required its small group⁴ carriers (e.g., carriers selling health insurance in the small group market) to offer insurance on a guarantee issue basis each August to self-employed individuals (one-life groups). The carriers can charge up to 150% of their standard rate for these individuals.

The combination of requiring conversion contracts, guarantee issue to one-life groups (for one month open enrollment period each year) and guarantee issue by nongroup carriers to HIPAA-qualified individuals leaving self-funded plans more than satisfies the federal requirements for portability of insurance while providing access to the market for individuals with serious pre-existing health conditions.

There has been a price for this approach, however.

² Information provided by FCHA, September 2004.

³ Premium Source: Summary of Data Collection by Data Contributing Carriers for Calendar Year 2003, as issued by State of Florida, May 13, 2004.

⁴ HIPAA defines small group as employers with two to fifty employees.

Florida is re-visiting the concept of creating a high-risk pool as part of its overall analysis of solutions to minimize the number of uninsured Florida citizens. The Governor's Task Force on Access to Affordable Health Insurance, released February 14, 2004, cited the creation of health plans for the uninsurables and HIPAA-eligibles as one step that would aid in the stabilization of the health insurance markets, increase competition, increase access and increase affordability of health insurance across all markets.

As part of its Request for Proposal (RFP), the Florida Department of Insurance (the Office) provided the following background.

“In July 2004, The Governor signed House Bill 1629 into law. This bill included the creation of the Florida Health Insurance Plan (Plan) which will subsume the current Florida Comprehensive Health Association (FCHA). The Plan is created for the purposes of providing insurance coverage to certain designated groups as well as to provide insurance for currently uninsured residents of Florida. It is the legislative intent that the opening of the Plan will improve efficiency of the health insurance market in Florida. Before the Plan becomes operational, the board of directors (board) of the Plan shall have an actuarial study conducted to assist policy makes in making any final legislative decisions that may affect Plan implementation.

As long as the Plan is accepting new insured one-life groups, which are currently covered by Florida's small group reform, they will not be eligible for guaranteed issue employer group insurance. These insured shall be eligible for insurance by the Plan.

The Plan is currently designed to insure HIPAA eligible individuals and individuals unable to pass underwriting in the commercial market.”

3**Scope of Current Project**

The goals of the actuarial study are to determine:

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 FHIP persons eligible for coverage under s. 627.6487, as well as the cost of including these individuals.*

The objectives of the study are:

- An analysis of the impact the creation of the FHIP 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.
- Provide an identification of the elements of the savings, which should consider at least the following:
 - Elimination of carriers having to insure HIPAA eligible.
 - Elimination of carriers having to insure one-life groups.
 - Elimination of carriers having to insure group conversion to individuals.
 - Savings attributable to claim and expense subsidies as well as savings associated with efficiencies in administration, underwriting, marketing, etc. for not having to insure the above categories of individuals.

- Identification of 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.
- A recommendation as to the best source for funding for the anticipated deficits of the FHIP.
- The effect on the individual and small group market including in FHIP persons eligible for coverage under s 627.6487, as well as the cost of including these individuals.
- The impact on the FHIP of different premium levels, including the impact of access to Federal funding, charged to individuals covered under FHIP, including the following rates:
 - Actuarially sound so FHIP is self-supporting;
 - 300% of the standard risk rate;
 - 250% of the standard risk rate;
 - 200% the standard risk rate; and
 - 150% the standard risk rate.
- The impact on FHIP if it followed the California Major Risk Medical Insurance Program (MRMIP) model where services are delivered through contracts with health insurance plans which provide for premium sharing between the individual enrollee and the state. In this way the state is fully aware of its cost for each enrollee and can control its overall liability by placing limits on enrollment.

4**Assumptions**

During the course of our analysis, we have employed numerous assumptions, all of which could have an impact on the final estimates. In this section we have grouped these assumptions by major category. Each scenario that we have modeled reflects a high enrollment, expected enrollment and low enrollment. Some of the assumptions vary by enrollment level.

FHIP**Effective date**

- For modeling purposes, we assumed an effective date of January 1, 2005 and modeled five years of operations.

Eligibility

- The current legislation indicates that the individuals eligible to enroll in FHIP are HIPAA-eligible individuals leaving self-funded plans and individuals who have been denied insurance coverage in the commercial nongroup market due to pre-existing medical conditions.
- Individuals who have access to insurance elsewhere, including Medicare and Medicaid, are not eligible to join FHIP.
- As currently written, the legislation would still require carriers to issue group conversion contracts to HIPAA-eligibles leaving a group fully insured insurance plan. These individuals would not be eligible to participate in FHIP. However, we have modeled scenarios that include these conversion contracts into FHIP as well.

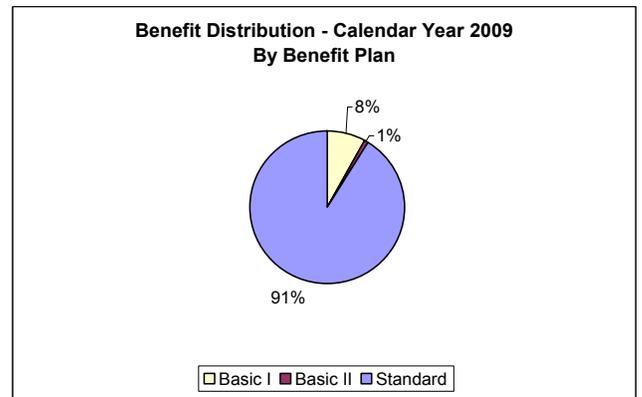
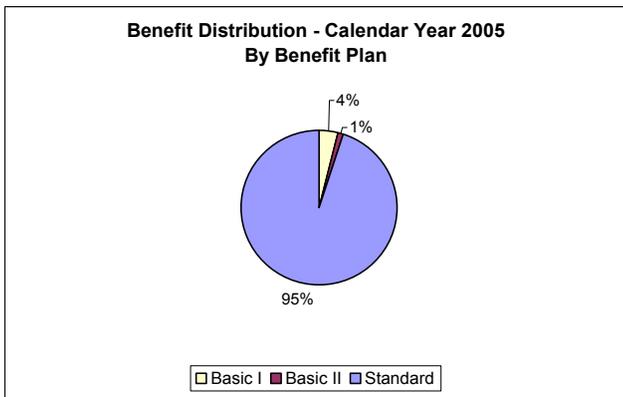
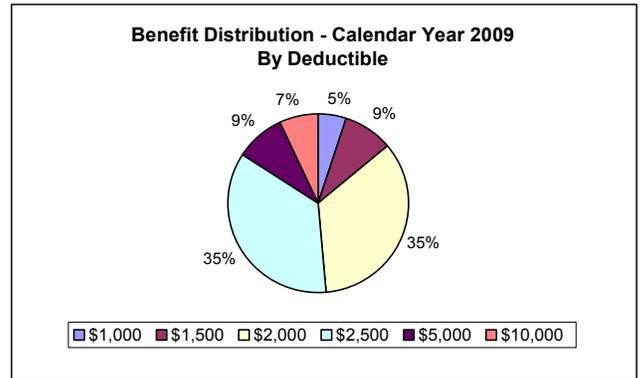
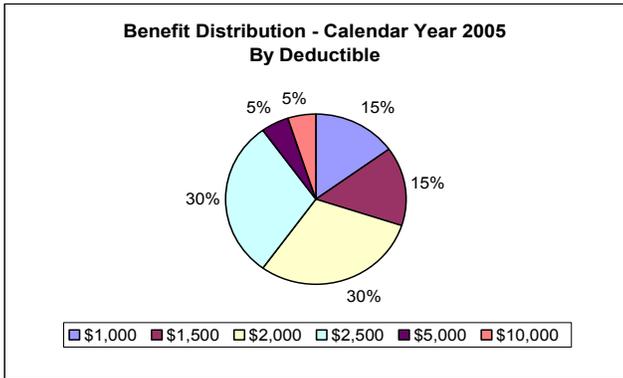
Premiums

- Pursuant to statute the Office would continue to generate standard risk rates (SRRs) each year. The FHIP rates will be a function of the current SRRs. For instance, when the Office releases the 2005 SRRs, the FHIP will immediately adopt these rates for the 2005 year.

- Rates will be available for individuals only.
- Rates will vary by benefit plan, age, gender and area.

Benefit Plans

- The only set of benefits modeled was PPO benefits since these are the most common in the commercial marketplace at this time.
- We assumed that the PPO benefits offered in FHIP will be similar to those being offered the FCHA members effective January 1, 2005. The following benefit plans were assumed to be available.
 - Standard Plan (\$1,000, \$1,500, \$2,000, \$2,500, \$5,000 and \$10,000 Deductibles)
 - Basic I (same deductibles as Standard Plan)
 - Basic II (same deductibles as Standard Plan)
- We assumed the following distribution of benefit plans initially as well as the migration for the next five years. The initial distribution is based upon a review of the distribution of members currently in high-risk programs in other states as well as FCHA.
- The migration of future benefits has been derived from historical patterns in the high-risk programs of other states. The graphs below show the distribution by deductibles and by benefit plans (i.e., Standard, Basic I and Basic II).



Administrative Costs

- Administrative costs per member for the expected membership scenarios are assumed to start at \$38 per member per month. This is a result of analysis of the administrative costs for all the existing high-risk pools in the country as well as FCHA. We projected the costs to 2005 using 4% annual increases. This is higher than the average administrative costs that self-funded employers enjoy. However, the administration for a high-risk pool is more complex than the administration for a self-funded employer. The administrative costs for the high membership scenarios are \$33; the analogous costs for the low membership scenarios are \$43.

Start-up Costs

- After a discussion with the Executive Director of FCHA, we estimated additional start-up costs of \$100,000. This reflects capital that will be needed to upgrade systems to support marketing efforts.

Commissions

- The legislation requires that “usual & customary” agent’s commission be paid for the initial placement of coverage with the plan and for one renewal only. We have assumed a “usual & customary” agent’s commission to be 5% of the SRR. Thus, for the scenario where FHIP premiums are 150% of the SRRs, agent’s commissions are 3.3% of premium for members for their first two years.
- We have interpreted the verbiage “for initial placement of coverage ... and for one renewal only” as meaning that commissions will be paid for each individual for two years (assuming they remain inforce), as opposed to meaning that commissions are only payable for the first two years that FHIP is in operation.
- There is variation among the other high-risk plans regarding agent’s commissions. Of the thirty-one high-risk pools shown in the 2003/2004 edition of “Comprehensive Health Insurance for High-Risk Individuals”, six states paid no commissions. Twenty-three states paid a flat, one-time only lump payment that averaged \$50. Louisiana pays a commission that is 3% of premium for the first year only. South Dakota is the only state that pays commission for more than one year and it pays a flat 3% commission.

Age/Gender Distribution

The following table shows the estimated age/gender distribution we employed. The distribution is based on information we obtained from Texas, Minnesota and Wisconsin high-risk pools. (These risk pools were chosen because they have large memberships and do not have any enrollment caps in place.)

**Florida Health Insurance Risk Pool
Estimated Members by Age Group**

Age	Members		
	<u>Male</u>	<u>Female</u>	<u>Total</u>
0-19	3%	3%	6%
20-24	1%	1%	2%
25-29	1%	1%	2%
30-34	1%	2%	3%
35-39	2%	3%	5%
40-44	4%	4%	8%
45-49	6%	6%	12%
50-54	8%	9%	17%
55-59	9%	11%	20%
60-64	12%	14%	25%
Total	46%	54%	100%

Claims Trend

- One of the most critical assumptions in forecasting and modeling FHIP experience is not the absolute level of the claims trend, but rather the differential between the claims trend and the premium trend. As indicated previously, the premiums will continue to be generated by the Office based upon a very sophisticated process that ensures consistency with the premium trends in the commercial nongroup market. We expect that, in the long run, the claims trend for FHIP will be higher than the claims trend for the commercial market because of the very nature of the risks in FHIP. We assumed the following differentials between claims trend and premium trend each enrollment scenario:

Amount that Claims Trend Exceeds Premium Trend

Enrollment Scenario	Claims Trend
High	+1%
Expected	+2%
Low	+3%

Higher enrollment scenarios should experience less variation in morbidity than lower enrollment scenarios, thus the lower differential.

Provider Reimbursement Levels

- We have provided two scenarios regarding provider reimbursement levels. The first scenario assumes that FHIP will experience provider reimbursement levels that are similar to the levels FCHA is experiencing, which reflects about a 25% overall discount.

- The second scenario assumes that FHIP will be able to negotiate (or mandate, if legislation is change accordingly) provider reimbursement levels that are equal to Medicare reimbursement levels. Our analysis of the Florida commercial market (including self-funded plans) shows that a Medicare-level of reimbursement would not be inconsistent with the levels currently in place.
- Providers are required to accept the negotiated reimbursement level and will not be allowed to balance bill FHIP members for any difference between these negotiated levels and the providers' usual and customary fees.

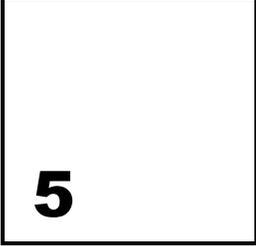
Premium Trend

- Premium will increase 10% per year for all scenarios. The 2003 Mercer National Survey of Employer-sponsored Health Plans (Mercer report), one of the most comprehensive surveys of health plans in the nation, shows that the average increase in employers' premiums for the last five years as 10.3%. For the last six years the average increase was 9.6%. The 2004 Kaiser survey shows a slightly higher range of premium increases, 10.4% to 11.2% for the last five and six years.⁵ The range in trends for the last ten years varies from -1.1% to 14.7% for the Mercer report and 0.8% to 13.9% for the Kaiser report. We used an average premium trend of 10% for forecasting FHIP premium trends for next five years. This is within the range we have observed for the last ten years and very close to the most recent five-year and six-year averages from both surveys.

Assessments

- When determining assessments based upon commercial premium, we have used the premium levels shown in the 2003 Summary of Data Collection by Data Contributing Carriers, Industry Totals issued by the State of Florida as the basis. These premiums are adjusted 10% per year to reflect trend.
- When determining assessments based upon the number of insured individuals, we have used the statistics shown in the 2003 Summary of Data Collection by Data Contributing Carriers, Industry Totals as the basis. We have adjusted for growth in future years. The future growth is based on our estimate of the growth of the Florida population of approximately 2.5% per year.
- When determining assessments based upon hospital days, we have used the Acute Care Hospital Inpatient Data Collection. We eliminated the "self-pay", Medicare and Medicaid categories. We have assumed the number of days in future years will increase by approximately 2.5% per year.

⁵ Employer Health Benefits 2004 Annual Survey, The Kaiser Family Foundation and Health Research and Educational Trust, September 2004.

**5**

Methodology

We developed a database for the years 1998-2003 consisting of the experience of all the high-risk pools in the nation. The source of this database was the various editions of the Comprehensive Health Insurance for High-Risk Individuals.

Enrollment Model

There are numerous factors that impact enrollment in high-risk pools. In his paper, “Health Insurance for the ‘Uninsurable’”⁶, Mark Browne identified the following factors that had a significant impact on enrollment in a high-risk pool:

- premium cap
- income
- new high-risk pool versus a high-risk pool that has been operating for several years
- number of uninsured in the state

It would seem intuitively obvious that premium cap and income will have a direct impact on the enrollment of any pool. Enrollments in “new” pools are lower than enrollments in pools that have been operating for several years. Part of this phenomenon can be attributed to a learning curve for the agents, insurance companies and population at large. Finally, it also seems logical that there would be a correlation between the number of uninsured in a state and the demand (e.g., enrollment) for a high-risk pool.

As a side note, Mr. Browne’s study showed that the presence of commission had no significant impact regarding enrollment in a high-risk pool. There may be other reasons for reimbursing agents, such as to ensure their cooperation in educating individuals with pre-existing health conditions about the presence of a high-risk pool, or partially

⁶ Mark Browne, “Health Insurance for the ‘Uninsurable’”, Journal of Insurance Regulation, Summer 1997, page 525-539.

compensating them for the time and resources expended to steer such individuals to the high-risk pool.

Mr. Browne noted, as we independently verified, that increasing the premium cap will not necessarily reduce losses in the pool. There is an inter-relationship between morbidity and premium cap that Mr. Browne's model did not incorporate (because an analysis of such a relationship was outside the scope of his study). This inter-relationship is critical for our purposes.

Premium Caps and Implied Morbidity

Each high-risk pool determines its own premium cap. By premium cap we mean the percentage amount that the high-risk pool premiums represent of the standard risk premium rates. Thus a 150% cap means that the premiums charged in the high-risk pool are 150% (or 1.50 times) the premiums charged for an individual that reflects a standard risk (e.g., no serious health conditions). Currently state high-risk pool caps range from a low of 125% in California and Minnesota, to a high of 200%. Eight states currently have a 200% cap. Some states, such as Texas, started with a much lower cap (137.5%) and through a period of years have just recently reached the 200% level.

If the premium cap is known and the loss ratio is known, then we can calculate the implied morbidity by multiplying the loss ratio by the premium cap. We performed this exercise for each state that has not artificially limited enrollment (such as California, Illinois, Florida) or artificially expanded enrollment by providing premium subsidies based upon income (such as Wisconsin).

Enrollment Formula

We developed a multiple regression model that would generate the number of enrollees that can be expected at various premium caps. The enrollment equation is:

$$E_{i,t} = a_0 + a_1[UI_{i,t}] + a_3[Income_{i,t}] + a_4 [Pool\ Duration_{i,t}] + a_5[Premium\ Cap_{i,t}] + a_6[Loss\ Ratio_{i,t}]$$

where

$E_{i,t}$ = enrollment in state "i's" high-risk pool during year "t"

$UI_{i,t}$ = number of uninsured in state "i" during year "t"

$Income_{i,t}$ = median income per household in state "i" during year "t"

$Pool\ Duration_{i,t}$ = Number of years since inception of pool for state "i" during year "t"

$Premium\ Cap_{i,t}$ = Premium cap for state "i" during year "t"

$Loss\ Ratio_{i,t}$ = Loss ratio for the high-risk pool for state "i" during year "t"

In order to use this equation for predictive purposes, we needed to have an expectation for loss ratios at different premium cap levels. We relied upon the historical high-risk pool database previously referenced for the most recent six years. We were able to develop

ranges of loss ratios around different premium cap levels and to use these relationships to extrapolate for other, higher caps.

We generated the enrollment equation by performing multiple regression on all of the experience for those high-risk pools we defined as being similar to the proposed Florida model (e.g., no premium subsidies based on income, no enrollment caps).

Simulations

For predictive purposes, each of the independent variables (e.g., the variables that are used to generate the enrollment) also have variability in the future. To further test the robustness of our enrollment equation, we developed reasonable ranges for each of the independent variables and performed 1,000 simulations using these various ranges. This enables us to develop a 95th confidence interval around our expected enrollment estimates for various premium caps. We labeled the upper end of this confidence interval as “High Enrollment,” the mean level as “Expected Enrollment” and the low end as “Low Enrollment.”

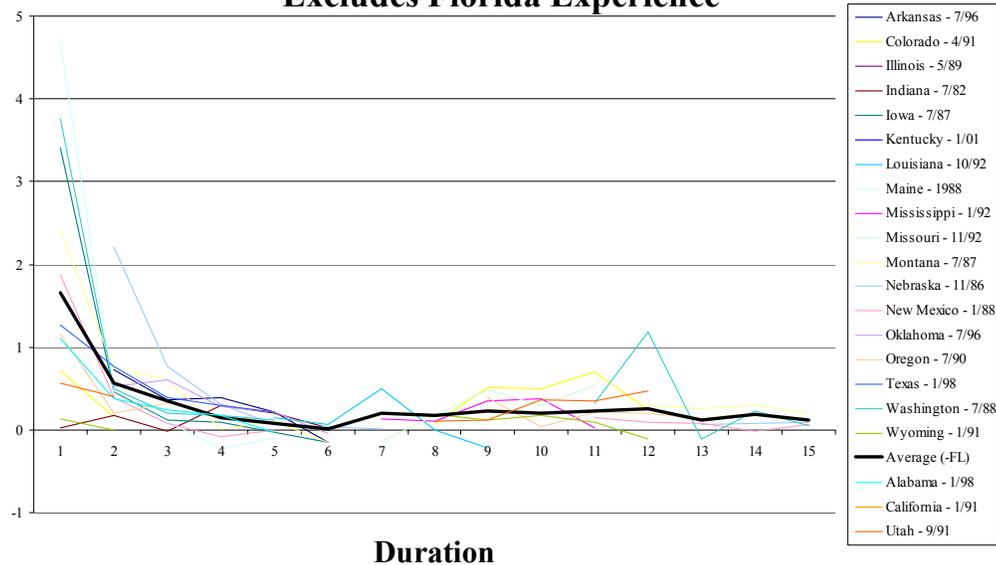
One of the by-products of this approach is that we obtained a starting loss ratio for each premium cap level. This, in turn, enables us to generate the starting implied morbidity for each premium cap level. The results of the model, which we discuss in greater depth in a subsequent chapter, shows that as the premium cap increases, the average morbidity of the pool increases.

Adjustments to Simulations---Duration

Up to this point, our model generates an enrollment based upon the experience of other high-risk pools. We did not have sufficient experience in our database for high-risk pools that began during our experience period. Thus we had to complete a separate analysis for start-up pools.

We reviewed the average growth patterns for start up pools using historical data dating back to the 1980's. The following chart shows the graphs of the growth patterns experienced by various pools.

Historical Enrollment Growth In Other Pools Excludes Florida Experience



This shows that there is a great deal of variation in the growth patterns. We developed an average growth rate and used this pattern in our model to generate the build-up of the enrollment in the Florida high-risk program.

Adjustments to Simulations---FHIP-Specific Legislation

The enrollment estimates produced by the model reflect enrollment of a typical high-risk pool. The legislation as currently written is not “typical” in that it provides access to only a subset of HIPAA-eligibles (e.g., only those HIPAA-eligibles leaving self-funded plans). To model the current legislation, we needed to estimate the impact of barring HIPAA-eligibles leaving fully insured plans (i.e., who receive group conversion policies) from joining FHIP. We reviewed the available statistics reflecting HIPAA-eligibles currently insured through the nongroup carriers and group conversion policies. We also reviewed the composition that HIPAA-eligibles are of existing risk pools. We recognize that HIPAA-eligibles are not the only source of members into the high-risk pool. Therefore, we assumed that the current legislation results in a 40% decrease in the enrollment projections generated by our model for the high and expected enrollment scenarios. The low enrollment scenario results were adjusted by lower factors because we believe the impact of group conversions will be smaller since this level is at the “floor” of enrollment growth.

Financial Model

The detailed results of the financial model can be found in the Appendix to this report.

The 2004 SRR for Florida served as the basis for our starting premium, since SRRs will be the foundation for future premiums if FHIP becomes operational. We developed an

average area factor for the state by weighting the county factors developed by the Office against the population in each county. We developed an expected age/gender mix by studying the age/gender mix for several large high-risk pools (Minnesota, Texas and Wisconsin). We used the age/gender population from each of these states and the 2004 Florida SRR to develop a starting premium prior to area adjustment and benefit adjustment. There was very little difference between the premiums developed using each of the three states demographics. We averaged the results.

The next step was to develop a benefit factor. Using the distribution of members among the various benefit plans that we described in the “Assumptions” chapter and the Office’s benefit factors for each of these plans, we generated an aggregate benefit factor for each year.

Enrollments and starting premiums are generated from the simulations for the corresponding estimate (High, Expected, or Low). Premiums per member for subsequent years are generated by multiplying the premium in the current year by the 10% (our assumed premium trend) and by a factor that reflects the expected “buy-down” in benefits. This factor is the ratio of the benefit factor in the current year to the benefit factor in the previous year. For example, the 2006 premium per member is generated by multiplying 2005 premium per member by 1.10 and then by the ratio of 2006 benefit factor to 2005 benefit factor.

Starting claims (which reflect the provider reimbursement levels similar to those FCHA is currently experiencing) are generated by the loss ratio resulting from our simulations. Claims for subsequent years are generated by multiplying the claims in the current year by the appropriate trend factor and applying the same benefit factor ratio used to develop premium. Subsequent loss ratios are generated by dividing incurred claims by earned premiums.

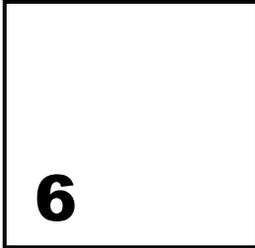
Adjusted Claims

One of the scenarios that we provide reflects modifying the assumed provider reimbursement level to Medicare levels. To generate claims for these scenarios, we multiplied the claims generated in the original scenarios by 0.67 to reflect the lower reimbursements. The loss ratios were generated by dividing the adjusted claims by the earned premiums.

We incorporated our estimates for administration and start-up costs as discussed in the “Assumptions” chapter.

Commissions are shown on a separate line in the detailed tables in the Appendix of this report. Consistent with our understanding of the current legislation, we have incorporated commissions that represent 5% of the SRR for two years for each member. The resulting operating gains/losses are generated by subtracting the claims, administrative expenses and commissions from the premium revenue. Investment income

has not been taken into account in this analysis for several reasons. The first is the current low level of interest rates for short-term investments. Since it is currently unknown how the pool will be funded, it is difficult to estimate the level of available funds to invest. If the pool is operated on a cash basis, there may be no material funds available to invest. In our opinion, the impact is immaterial. The results of our model are discussed in further detail in Chapter 7 of this report.



Tests for Reasonableness

The best model needs to be tested to ensure that the results are reasonable and consistent with existing experience.

Claims and Morbidity

The first test that we performed was to test the initial claims and implied morbidity using the Expected Enrollment results from our simulations with the claims and implied morbidity of the existing FCHA members. The FCHA is a closed pool. Its members are older than what we would expect of a typical high-risk pool for the very fact that it has not allowed new membership. The average loss ratio for FCHA from 1990 (the year the block was closed to new members) through 2003 is about 200%. The premium cap is about 210% of the SRRs. This combination of loss ratio and premium cap generates an implied morbidity of about 4.20 (e.g., a morbidity of 4.2 means that the morbidity is 4.2 times as great as the morbidity for a standard risk). Our model shows an implied morbidity of about 3.80 for a 200% premium cap and about 4.46 for a 250% premium cap. FCHA’s implied morbidity falls within this range.

We also compared the implied morbidity of the conversion policies for the one year for which we had experience. The following chart summarizes the results.

	Premium Cap	Morbidity
Model	150%	3.00
Model	200%	3.80
Conversion	170%	3.60

The conversion implied morbidity is within the range predicted by the model.

Our final check for reasonableness of starting claims was to analyze HIPAA-eligible experience. This was more challenging since we do not know for certainty the actual rate-

ups companies are using for HIPAA-eligibles. Let’s assume that the rate-up is somewhere between 150% and 300%.

We must make one modification to our methodology. Up to this point we have assumed that the loss ratio times the premium cap is a proxy for the implied morbidity. This is true if the premiums are not expected to generate a profit, which is true for high-risk plans and conversion plans. However, when we analyze HIPAA-eligible experience, we must compare their loss ratio relative to the medically underwritten loss ratios to generate an implied morbidity. Our analysis shows that these morbidities fell within the ranges generated by our model.

Premium

Since we used the 2004 SRR as the basis for our premium, we were confident that the model reflects Florida costs. As a further test, we were able to balance our starting premium using the current FCHA membership and rates, projecting forward to realize the same premium basis and adjusting for differences in benefits.

Enrollment

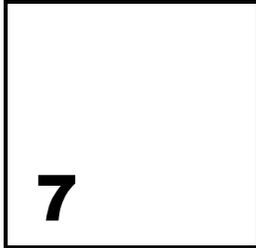
We compared the fifth year projected enrollment levels for the full enrollment scenario (e.g., enrollment absent any barriers such as barring those eligible for group conversion from joining FHIP) to the anticipated individual market membership. This statistic represents the percentage the high-risk pool is to the total individual market. We compared this statistic to statistics developed for the other risk pools. High-risk pools represent about 1.2% of the total individual medical population. The range is as low as 0.2% (for pools still open to new members) to a high of 6.0% (Minnesota, which has a 125% premium cap now, but has had as low as 115%).⁷ The results of our testing are as follows:

	2009 (Fifth Year) Estimates Expected Enrollment Scenarios All HIPAA-Eligibles		
Premium Cap Scenario (% of SRR)	Estimated Enrollment in Commercial Nongroup Market	Model-Generated FHIP Enrollment (Rounded to nearest Hundred)	FHIP Enrollment as % of Individual Commercial Nongroup Model
150%	752,000	18,900	2.5%
200%	Same as Above	16,100	2.1%
250%		13,400	1.8%
300%		10,900	1.5%

⁷ Lori Achman and Deborah Chollet, “Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools”, The Commonwealth Fund, August 2001, page 21.

This demonstrates that our model is generating results consistent with the experience of other high-risk pools.

We performed numerous tests that compared the enrollment from various scenarios and years to ensure reasonable results.



Results

We modeled results for the following scenarios:

Unadjusted Claims - Provider Reimbursements at Current FCHA Levels

- 150% Premium Cap
- 200% Premium Cap
- 250% Premium Cap
- 300% Premium Cap

Adjusted Claims - Provider Reimbursements at Medicare Levels

- 150% Premium Cap
- 200% Premium Cap
- 250% Premium Cap
- 300% Premium Cap

Within each scenario we provide results based upon high enrollment, expected enrollment and low enrollment. The range in enrollments reflects an approximate 95% confidence interval, or the probability that the actual enrollment will fall within the low enrollment and high enrollment estimates is about 95%. It is important for decision-makers to be fully cognizant of the potential range. We will focus our analysis on the expected enrollment results. However, all enrollment scenarios can be found in the Appendix to this report.

For each of the premium cap and claim scenarios, we have modeled two enrollment scenarios:

- HIPAA-eligibles from self-funded plans and other eligible high-risk individuals (HIPAA self-funded)
- All HIPAA-eligibles and other eligible high-risk individuals (All HIPAA-eligibles, including group conversions)

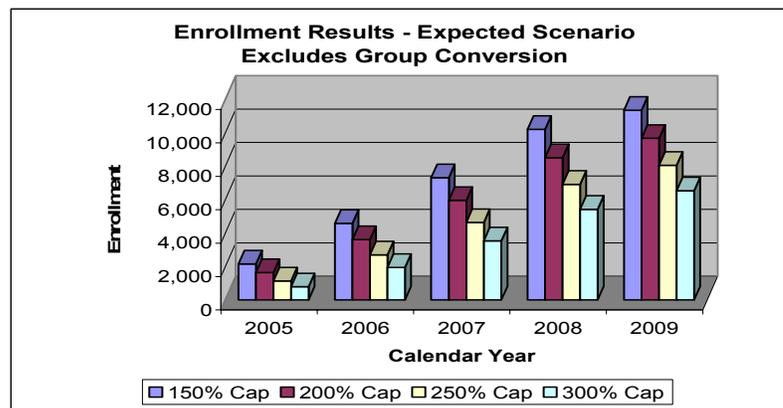
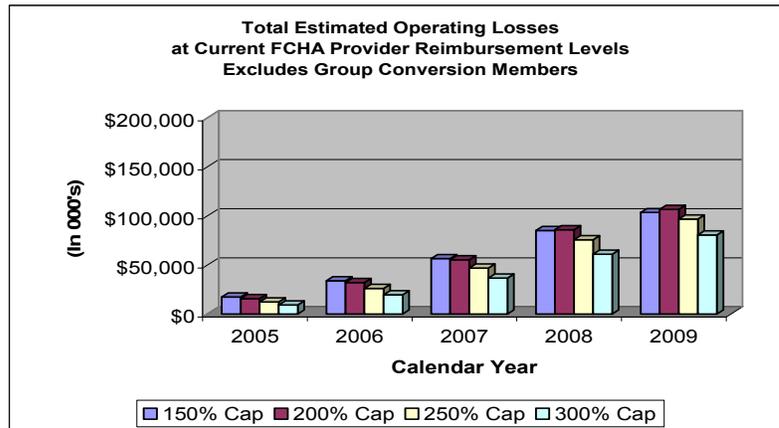
We tried to identify what multiple of SRRs would be necessary for FHIP to be self-supporting (e.g., the premiums generated from the members are adequate to fund claims and expense without requiring any outside subsidy). We tested premiums at 400%, 500% and 600% of SRRs. As discussed previously, the morbidity increases as the premium cap increases. For each of the scenarios, the increase in morbidity is still greater than the increase in premiums. Based upon these results, we do not believe it is possible to create such a scenario in the long run. There may be an occasional year where a particular fund does not incur a loss. Such phenomenon can be attributed to the randomness inherent in the incidence of claims. However, in our opinion, it is not possible to create a high-risk pool that is self-supporting (e.g., premium revenue is sufficient to fund claims and expenses) in the long-run. If it was possible, then we would expect insurance companies, who are experts at taking risks, to have determined such a premium level and market to these individuals.

We have also modeled the “California model,” which we will discuss later.

Results

HIPAA Self-Funded

The following graphs show the growth in enrollment and operating losses for each of the premium caps.



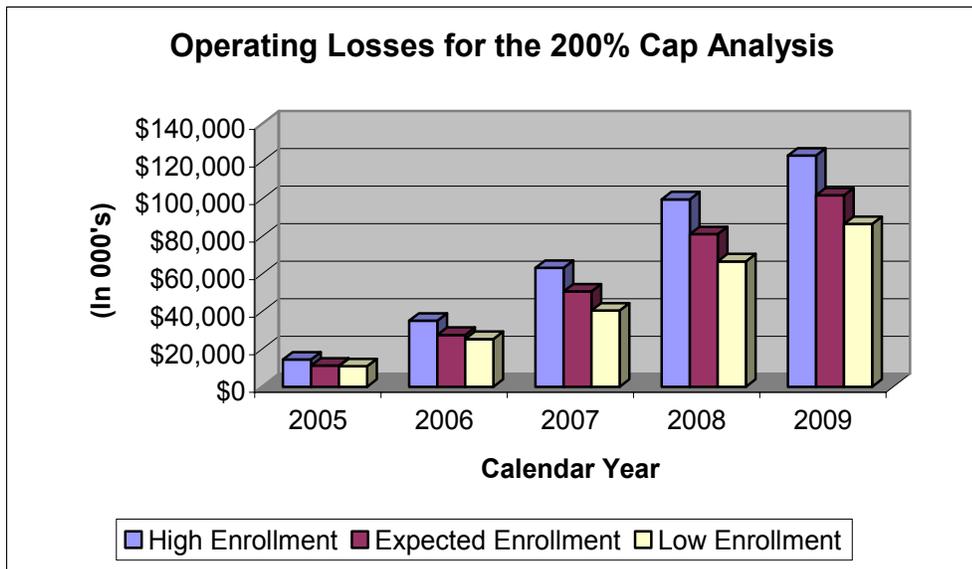
Contrary to what some may believe, increasing the premium cap does not necessarily result in decreased losses. For example, the fifth year losses for the 200% cap are greater than the fifth year losses for the 150% cap. The reason for this is that as the premium cap increases, the average morbidity of the individuals enrolling in the pool increases. While the relative increase in morbidity levels off at some point, it is greatest between the 150% and 200% caps. We focus on the fifth year because by this stage the enrollment growth is more predictable. The following table shows the fifth year losses.

**Operating Losses
FCHA Provider Reimbursement Levels
Excludes Group Conversions from FHIP Pool**

Premium Cap	Membership (Rounded to nearest Hundred)	Fifth Year Loss (Millions of Dollars)
150%	11,300	\$98
200%	9,700	\$102
250%	8,100	\$93
300%	6,500	\$77

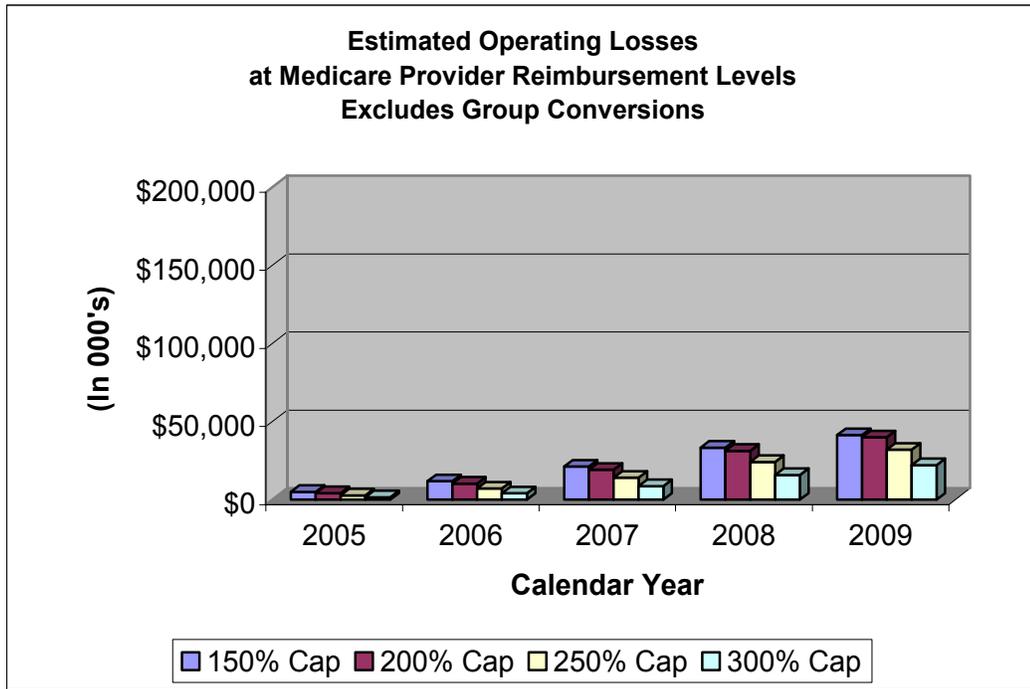
Although we are not going to focus on the High and Low scenarios, we believe the following graphs demonstrate the range of possible results that can reasonably be expected.

**Operating Losses
FCHA Provider Reimbursement Levels
Excludes Group Conversions from FHIP Pool**



Provider reimbursement levels have a significant impact on claims. The following graphs show the same scenarios as just previously discussed with providers being reimbursed at Medicare levels, which our analysis shows is very similar to the current commercial

reimbursements. The growth in enrollment will be unaffected by changes to provider reimbursement levels. Therefore, we are showing only the growth in losses.



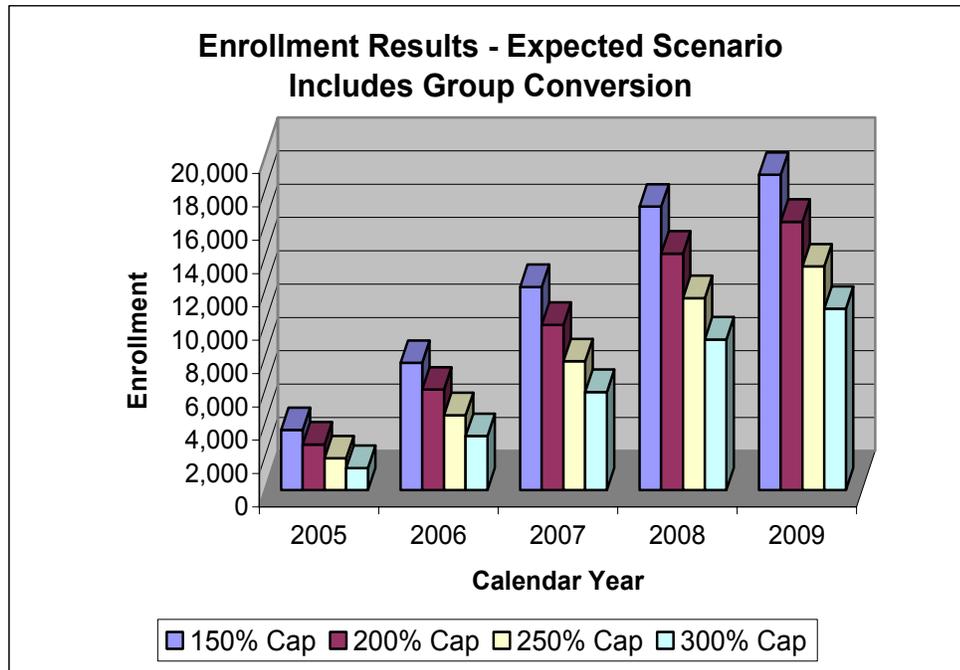
The following table shows the fifth year losses associated with the above graph.

Premium Cap	Membership (Rounded to nearest Hundred)	Fifth Year Loss (Millions of Dollars)
150%	11,300	\$41
200%	9,700	\$40
250%	8,100	\$32
300%	6,500	\$22

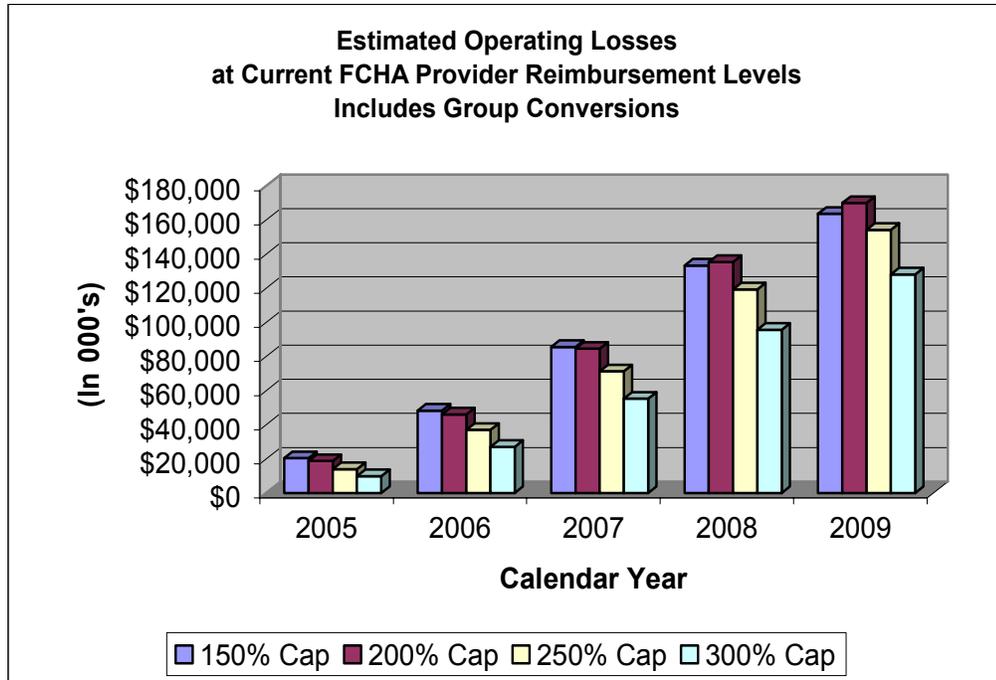
All HIPAA Eligibles

The next scenario is to expand enrollment eligibility to include all HIPAA eligibles. If the FHIP elects a premium cap other than 200%, then HIPAA-eligibles would be subject to two different premium levels. Those being issued group conversion contracts would receive premium rates that are 200% of SRR, while those in FHIP would receive either a higher or lower level, depending upon the decision of the Board/Commission. We understand that this situation exists today where the HIPAA-eligibles receiving group conversion contracts have limits placed on their rates whereas there are no regulatory limits placed on the HIPAA-eligibles going to nongroup carriers. However there is logic

to treating all HIPAA-eligibles the same. There is also a cost. The following graphs show the growth in enrollment and losses for the various premium caps when all HIPAA-eligibles can enroll in FHIP.



The following graph shows the operating losses if all HIPAA eligibles were allowed to enroll in FHIP and at FCHA current provider reimbursement levels.



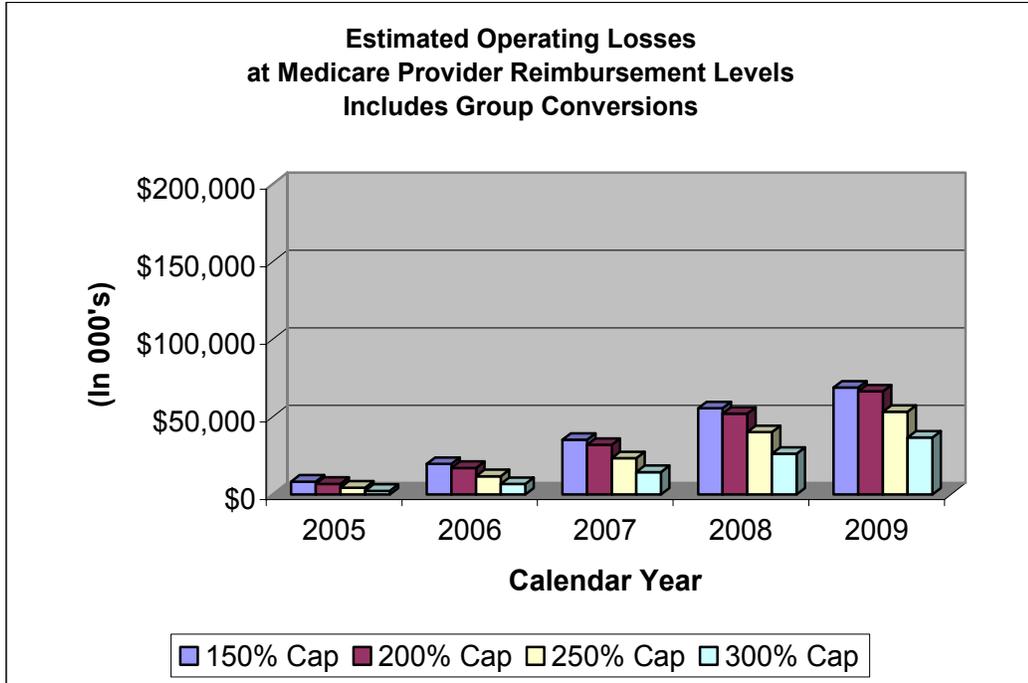
The following table shows the fifth year losses for the previous graph.

**Operating Losses
FCHA Provider Reimbursement Levels
All HIPAA-Eligibles**

Premium Cap	Membership (Rounded to nearest Hundred)	Fifth Year Loss (Millions of Dollars)
150%	18,900	\$164
200%	16,100	\$170
250%	13,400	\$154
300%	10,900	\$128

Once again we see the phenomenon that increasing the premium cap does not necessarily result in decreased losses.

Incorporating modified provider reimbursement levels generates the following:



The following table shows the fifth year losses for the all HIPAA –eligibles modifying the claims to reflect provider reimbursement at Medicare levels.

**Operating Losses
Provider Reimbursements at Medicare Levels
All HIPAA-Eligibles**

Premium Cap	Membership (Rounded to nearest Hundred)	Fifth Year Loss (Millions of Dollars)
150%	18,900	\$69
200%	16,100	\$66
250%	13,400	\$53
300%	10,900	\$37

California Model

California has developed a different approach to its high-risk pool. California requests bids from carriers reflecting the loss ratios they will incur at a specified premium cap which is 125% of standard rates. The risk pool assumes the risk up to the loss ratio submitted and the carriers assume the risk for losses in excess of the loss ratios. In our discussions with individuals at the California high-risk pool, they indicated that the initial loss ratio maximums submitted by the carriers were high—at least 200%. While the loss ratio maximums are considered confidential information, they indicated that the pool had negotiated the maximums down and indicated that the range is about 140% to 170%. (The pool can charge individuals up to 137% of SRR if they enroll with carriers that have a higher maximum loss ratio. This encourages members to choose carriers that provide the

maximum protection for the high-risk pool.) Using the maximum loss ratios as a pseudo premium, California then determines how many individuals their allotted funding can support. If necessary, benefits will be adjusted downward and enrollment levels frozen, both of which have occurred.

California has recently modified their model to allow an individual to be in the pool for a maximum of three years. At that time, they must leave the pool. However, they are guaranteed insurance from the carrier with whom they were insured when they were in the high-risk pool at a premium rate of 110% of the high-risk pool rate. The risk for these individuals is split 50/50 between the carriers and the high-risk pool. The funding for these individuals comes from the same source as the funding for the high-risk pool so theoretically, there may be a longer waiting list or leaner benefits in the high-risk pool as a result.

We have modeled the pre-reform California model using loss ratio maximums of 175% and 200%. We believe it will be difficult to get carriers to bid anything more aggressive initially (if Florida can get carriers to bid at all). California is a unique market in that they still have a majority of the health care lives enrolled in managed care plans that actively incorporate capitation. There has been a general movement away from capitation elsewhere in the country. California has managed to convince enough carriers that it is their social responsibility to participate in the high-risk pool and have succeeded in obtaining coverage for the entire state. This may be difficult to replicate elsewhere.

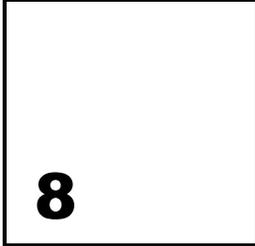
The detailed results of this modeling are shown in the appendix. The following shows the fifth year results (based upon expected enrollment levels) if the loss ratios are capped at 175% and 200%. The following are the results assuming the program retains the same discounts. If the pool is able to negotiate reimbursement at approximately Medicare levels, *our analysis shows there would be no additional savings to the FHIP pool.*

**California Model
Operating Losses for Self-Funded HIPAA-Eligibles
Current Provider Reimbursements**

Premium Cap	Membership (Rounded to nearest Hundred)	Fifth Year Loss (Millions of Dollars)	Fifth Year Loss @200% Loss Ratio Maximum	Fifth Year Loss @175% Loss Ratio Maximum
150%	11,300	\$98	\$88	\$68
200%	9,700	\$102	\$98	\$75
250%	8,100	\$93	\$93	\$77
300%	6,500	\$77	\$77	\$74

There are risks to the California model. The major risk is the ability to have carriers willing to accept losses for this pool. If there are insufficient carriers bidding and/or if the loss ratio attachment points are too high, then the State is effectively fully funding the

high-risk pool. The unique characteristics of the California market may be difficult to realize in other states. If FHIP is able to implement provider reimbursement at Medicare levels, then the risks associated with the California model do not offset any financial gain and the California model is not worth pursuing.



Federal Funding

The Senate Health, Education, Labor and Pensions Committee approved legislation (S 2283) to extend and increase funds for states that create high-risk health insurance pools. The risk pool program was created two years ago by the Trade Adjustment Assistance Reform Act and provided \$20 million in fiscal year 2003 that was available to states creating new, qualified risk pools. Grants up to \$1.0 million per state were available to subsidize the start-up costs of such pools. The Trade Act provided \$40 million per fiscal year to qualified existing state pools to subsidize normal operating losses.

In order to qualify for federal funding, the premium cap cannot be greater than 150% of the standard risk rate.

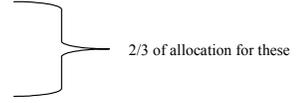
The bill, which to our knowledge has not yet been signed into law, provides the following funding for high-risk pools shown on the next page. We estimate the maximum realistic funding to be approximately \$2.3 million. This is based upon the fifth year results for the scenario including all HIPAA-eligibles and FCHA members. Amounts available in earlier years will be significantly less. Given the magnitude of the losses generated from our model, the presence of federal funding will not be a major factor in the decision-making process.

Federal Legislation Analysis - Applies only to 150% Cap Scenario

Allocation of Federal Dollars:

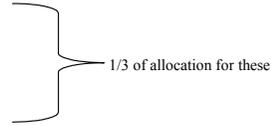
Under section b(2) -

- a. 50% of the appropriated amount is allocated equally among the states
- b. 25% of the appropriated amount is allocated based on the uninsured amount to federal uninsured amounts
- c. 25% of the appropriated amount is enrollment of high risk pool to enrollment of all high risk pools



Under section c(2) - Bonus Grants for Supplemental Consumer Benefits

- a. low-income premium subsidies
- b. reduction in premium trends, premiums or cost-sharing requirements
- c. expansion of eligibility
- d. less stringent pre-ex
- e. increased benefits
- g. disease management program



Allocation: 75,000,000

	<u>All \$</u>	<u>Florida's Share</u>
1. 2/3 allocation for b(2)	\$ 50,000,000	
a. each state get equal share	25,000,000	\$ 500,000
b. proportion to uninsured	12,500,000	853,056
Florida's uninsured	3,071,000	
Nationwide uninsured	45,000,000	
Ratio	6.8%	
c. proportion of high risk enrollment	12,500,000	907,394
Florida's enrollment (ultimate)	19,206	
Nationwide enrollment	264,577	
Ratio	7.3%	
d. Total under this section		\$ 2,260,450
2. 1/3 allocation for c(2)	\$ 25,000,000	
no guidelines for allocation; however there is a limitation of 10% to any state		
maximum possible funding (if qualified)		2,500,000
Maximum Total Funding		\$ 4,760,450



Impact on Commercial Market

One of the primary focuses of this feasibility study is to ascertain what impact, if any, the introduction of a high-risk pool will have on the current small employer group and individual health insurance market. Large employers are much better able to spread the risk of employees and/or dependents with health conditions than small employers, or individuals. It is these two segments, small employers and individuals, that are most at-risk in the current insurance market.

As part of the high-risk pool feasibility study, the Office issued a data request from carriers currently marketing in the small group and individual health insurance market. The data request included estimates for the impact of removing several requirements. Thus carriers had the opportunity to provide input into the process. Nineteen insurance companies and/or HMOs provided information regarding the small employer market and seventeen companies provided information about the individual. There were some carriers that provided information about both markets.

One-Life Experience

The following table shows the incurred loss ratio for the one-life groups that small group carriers are required to accept on a guarantee issued basis during an annual open enrollment period compared to the loss ratio for the small group market.

	Members		Loss Ratio	
	1-Life Groups	2-50 Groups	1-Life Groups	2-50 Groups
2001	35,210	147,079	111.4%	78.3%
2002	29,591	152,687	112.1%	78.2%
2003	25,657	154,641	103.3%	74.6%

Loss ratios were generated by using members as the weight

The statistic reported for 2-50 groups is a mix between members and groups. We compared the 2003 members reported from the most recent Office data request to the

information published by the State of Florida in May 2004 for similar data. The May 2004 report entitled “Summary of Data Collection by Data Contributing Carriers Calendar Year 2003, Industry Totals” shows a total of 25,500 members in one-life groups. This compares well to the recent data request. The small group totals do not compare well because of the reporting inconsistencies among companies. However, since the one-life group numbers compare well, we have assumed that we have almost the entire small group market represented in the above statistics.

We only had access to the 2003 Summary of Data Collection by Data, so impacts on premiums are stated using 2003 premiums.

The loss ratio for one-life groups is clearly worse than the loss ratio for the small groups. For 2003 the one life groups as a whole had a loss ratio that was almost thirty percentage points higher than the small group loss ratio. And 2003 is the year with the lowest difference.

The following table shows the dollar losses that small group carriers have incurred as a result of being required to guarantee issue self-employed individuals during an annual open enrollment period.

Losses Incurred Attributable to One-Life Groups

Year	\$ Losses (Rounded to nearest \$100,000)	Losses per One-Life Member per Year (Rounded to nearest \$100)	Losses as % of Total 2003 Small Group Market Premium
2001	\$76,400,000	\$2,200	2.5%
2002	\$77,000,000	\$2,600	2.5%
2003	\$45,700,000	\$1,800	1.5%
Cumulative	\$199,100,000	\$2,200	2.2%*

*This reflects the average percentage.

The reason that the dollar of losses decreased in 2003 was that companies were allowed to increase the rates for these groups up to 150% of the standard risk rates for the small employer pool. Prior to this time the maximum allowed was the same as the maximum allowed for the small employer pool, which was 115%.

The use of 2003 small group premium as the basis for comparison understates the percentage of losses for the years 2001 and 2002 due to the impact of trend. Offsetting this, at least partially, is the change in rating limits. We believe it is reasonable to use an estimate based upon three years as opposed to only 2003 since the improvement in 2003 could be (and is) indicative of an overall improvement in loss ratios for the overall small group market.

This analysis shows that eliminating guarantee issue of one-life groups should result in a decrease to small group rates by 2.0% to 3.0% in the long run. Since small group carriers

will not be able to immediately terminate one-life groups, they will continue to incur losses. However, the block will decrease over time as new groups will no longer be written.

Reponses from Carriers

Nine carriers indicated that there would be no impact on small group rates if they were no longer required to guarantee issue one-life groups. Several more indicated they either could not determine or did not have sufficient membership to generate credible estimates. Seven companies indicated that rates could decrease. Two companies indicated the decrease in rates would be 5%. Several companies provided sufficient details for us to generate our own estimates. This experience warranted decreases in the 7% to 10% range, which seems to represent the upper bound.

Administrative Savings

The analysis so far has focused on a reduction to small group premium due to the elimination of losses attributable to high claims associated with the one-life groups. It has not addressed any administrative savings. Some of the sources of these savings are elimination of the annual open-enrollment, marketing, possibly more streamlined regulatory reporting requirements, higher administrative costs associated with all one-life or individual policies such as billing, accounting, consumer service. Responses from carriers were mixed. Some carriers indicated there would be no savings; others indicated there would be administrative savings. None provided a numerical estimate.

We believe there are real administrative savings associated with the elimination of guarantee issue to one life groups. While we have no quantitative data, we have are including an estimate of a 1% savings to the small employer groups to reflect this.

HIPAA Experience for Nongroup Carriers

Nongroup carriers are required to offer their two most popular products on a guarantee issue basis for HIPAA-eligible individuals leaving a self-funded benefit plan. The following chart shows the loss ratios for this subgroup compared to the loss ratio for medically-underwritten nongroup lives as reported by the responding nongroup carriers.

Year	HIPAA-Members	Loss Ratio	Underwritten Nongroup Members	Loss Ratio
2001	4,489	109.8%	448,151	70.5%
2002	5,796	106.2%	507,936	67.6%
2003	7,338	106.5%	676,143	64.4%

This table shows that the HIPAA-members incurred significantly higher loss ratios than the underwritten nongroup members. These higher loss ratios translate into the following dollar losses.

Nongroup Carrier Losses Attributable to HIPAA

Year	\$ Losses (Rounded to nearest \$100,000)	Losses per HIPAA Member per Year (Rounded to nearest \$100)
2001	\$7,800,000	\$1,700
2002	\$9,700,000	\$1,700
2003	\$14,400,000	\$2,000
Cumulative	\$31,900,000	\$1,800

According to the Summary by Reported Premium and Covered Lives Calendar Year 2003 report issued by the State of Florida, there were a total of 12,656 HIPAA-eligible contracts issued by nongroup carriers. According to this statistic, the responding carriers from the current survey represent about 60% of the total HIPAA lives. There is reason to believe that there are reporting inconsistencies between the HIPAA-eligibles on the State of Florida report and other reports submitted to the Office regarding HIPAA-eligibles. We need an estimate of the premium for the total individual market. For consistency purposes, we “grossed up” the losses shown in the previous table to reflect the same approximate number of HIPAA-eligible lives shown on the Summary by Reported Premium and Covered Lives for 2003.

The losses as a percentage of the total 2003 nongroup market premium range from 1.2% to 2.2% in the long run. Companies will still have these risks in their pools since they will not be able to terminate existing lives.

Responses from Carriers

The following chart shows the reduction in premiums submitted by participating carriers.

	# of Carriers	% of Nongroup Lives
Did Not Know	5	54%
No Impact	3	4%
0.5%	3	7%
Up to 3%	4	24%
5.0% to 7.5%	2	9%

If we ignore the carriers that did not provide an estimate, the weighted averaged (based upon lives) is about a 3% reduction in nongroup premiums.

Administration

The nongroup carriers indicated that administrative savings attributable to no longer being the HIPAA alternative would be minimal. If an estimate was given it was in the 0.1% to 0.5% of premium range.

We believe the administrative savings (which includes marketing) are understated. It is often difficult for companies to track such costs and savings. We believe a conservative estimate is an additional 1.0% savings.

Group Conversion

Carriers selling fully insured products are required by Florida law to guarantee issue group conversion contracts all individuals leaving an insured employer group. The majority of these individuals are HIPAA-qualified. The benefits of the group conversion contracts are defined by Florida regulations as well as the rates, which cannot exceed 200% of the SRRs that the Office develops through a very sophisticated process. The SRRs reflect the average rate charged by the nongroup carriers that represent 80% of the nongroup market.

While the recent data request did not specifically ask for conversion experience, the Office had previously gathered such experience for 2002. The actual loss ratio for conversion members insured by the eight insurance largest companies in the group insurance market was 211%. If we estimate that 85% is a break even loss ratio, then these eight companies incurred losses of about \$58,400,000 in 2002. We estimate this to be a little more than 0.5% of total group premium.

Response From Carriers

The Office asked for carriers’ input on the impact of relieving them from being the HIPAA alternative for fully insured group contracts.

**Reduction in Small Group Premiums
if Conversion Contracts no Longer Had to Be Issued to HIPAA-Eligibles**

Reduction to Small Group Premium	# Carriers	% of Small Group Market
No Impact	10	19%
1% or less	7	78%
2%	2	3%

There was no discussion regarding administrative savings.

Conclusion

These three segments: one-life groups, conversion and HIPAA-members account for significant losses in the current insurance market. If these losses could be removed, then it is logical to assume that the premium rates for the residual remaining market, (e.g., the small employer market and the medically underwritten nongroup market) could decrease in the long run. In the short run the decreases to premium will not be as great since the carriers will still have the risk for the currently insured individuals. We do not recommend, nor does the existing legislature provide, that carriers be allowed to immediately terminate these individuals and transfer them to a high-risk pool.

We have estimated the following long term decreases in premiums associated with each of the segments.

Potential Premium Savings

Segment	Source of Savings				
	Improved Claims	Administrative	Total	Annual \$ Amount (Millions)	Market Impacted
Elimination of Guarantee Issue of One-Life Groups	2% to 3%	1%	3% to 4%	\$92 to \$123	Small Group
Elimination of Nongroup Carriers Guarantee Issues HIPAA-Eligibles coming from Self-funded Plans	2% to 3%	1%	3% to 4%	\$35 to \$46	Nongroup
Elimination of Group Conversion for HIPAA Eligibles coming from Insured Policy	0.5%	-	0.5%	\$55*	All Groups

*The reason that Elimination of Group Conversion (0.5% of premium) has what appears to be a greater dollar amount of impact proportionally than the elimination of one-life groups is that elimination of group conversion impacts the premium for *all* fully insured group sizes, whereas the elimination of one-life groups impacts the premium for only small groups.

The proposed Florida legislation would eliminate the requirement of issuing one-life cases on a guarantee issue bases during the open enrollment period for small group carriers as well as eliminate nongroup carriers being forced to accept HIPAA-eligible members leaving self-funded groups on a guarantee issue basis. The legislation as currently written would still require group carriers to issue conversion contracts.

Non-Quantifiable Impact

Many believe that high-risk pools contribute to the stability of the individual market. Kentucky, New Hampshire and South Dakota recently created high-risk pools as a means of attracting more carriers into the individual market. High-risk pools provide the safety

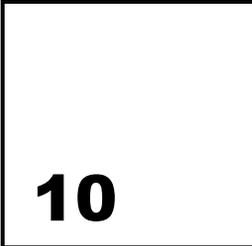
net that is necessary in a voluntary market while minimizing any disruption. At one time, the Washington high-risk pool was the only source of comprehensive health coverage in the nongroup market. Their presence can provide for less regulatory requirements for HIPAA-compliance and create a competitive market for the balance of the nongroup population. Iowa recently reverted back to a high-risk pool as a means for HIPAA compliance. Preliminary results indicate that, at least in the case of Kentucky and South Dakota, new carriers have entered the state.

Providers have a better probability of collecting monies for their services if a patient has insurance as opposed to being self-pay. Therefore, even a lower level or reimbursement is preferable to none at all. Thus the presence of a high-risk pool should help to control the levels of uncompensated care.

Studies show that maintaining insurance coverage improves both access to health care and health care status.⁸ For high-risk individuals access to health care and monitoring is even more important if they are to avoid costly complications associated with their conditions. In 1999, 40% of personal bankruptcy filings were due to huge medical expenses.⁹ Such bankruptcies destroy life savings of the individuals and also affect providers who do not receive payment for their services. While implementing a high-risk pool will not resolve all the issues associated with access to affordable insurance, it can provide a safety net for those individuals that have the worst conditions.

⁸ Leighton Ku and Donna Cohen Ross, "Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families," The Commonwealth Fund, December 2002.

⁹ Communicating for Agriculture



Funding Sources and Assessments

By their very nature, high-risk pools are going to incur losses. As our modeling shows, the magnitude of these losses are dependent upon numerous factors including but not limited to enrollment, premium caps, provider reimbursement levels, expense levels including commissions and the morbidity of the enrollees. It is reasonable to assume and plan for deficits in the program. In fact, all the operating high-risk pools in the country sustained losses in 2003.¹⁰ The aggregate 2003 losses were slightly less than \$540 million. In 2003, there were thirty-three states that either had operational high-risk pools or had passed legislation enabling the creation of such pools. In 2003 premiums from high-risk enrollees provided about 55% of total operating costs while the remaining balance, 45% of all operating costs, had to be funded from other sources.

Since losses are to be expected, it is critical for the ongoing viability of a high-risk pool to have reliable access to sufficient funds to provide the necessary subsidies to cover these losses. Furthermore, the funds should come from as broad a base as possible. From a theoretical perspective, the losses of high-risk pools should be shared by at least three sectors of society: the high-risk individuals who receive the most direct benefits, providers who have a better probability of receiving reimbursement for services if individuals are insured and employers/insurers who are at least part of the reason for the high-risk individual being in the situation of needing a pool. A strong case can be made for including one additional sector, state government, who, through its ability to tax, can provide the greatest source of funds.

The contributions from each of these sources can be as follows:

- Enrollees in a high-risk pool
 - They make their contributions via their premiums

¹⁰ Mr. Bruce Abbey provided preliminary results to update to 2004/2005 edition of Comprehensive Health Insurance for High-Risk Individuals” published by CA, Inc., 2004.

- Providers
 - They can make their contributions via accepting lower reimbursement levels for the services they provide enrollees in a high-risk pool.
- Employers/insurers
 - They can make their contributions via some type of assessment. Historically, states have had difficulties including self-funded plans into the assessment base because of ERISA (the federal legislation which precludes states from regulating self-funded employee benefit plans). However, there have been recent approaches to assessments that have passed court tests as being ERISA-compliant that effectively include self-funded plans in the assessment base.
- State general funds
 - The State general funds are always a possible source of funding losses to a high-risk pool. Since all sectors contribute to the general funds, some argue that this is the most equitable source.

We will discuss the “contributions” from each sector and provide the strengths and weaknesses for each approach.

Enrollees

Enrollee premium is the major source for funding for high-risk pools. This is appropriate since they receive the greatest direct benefit. By paying a “surcharge” to premiums, (e.g., high-risk pool premiums are always above the premium levels for a standard risk in the commercial nongroup health insurance market), enrollees are making a contribution to the pool’s losses. The magnitude of this surcharge varies by high-risk pool. Florida is considering levels varying from 150% to 300% of the standard risk rate. In order to obtain federal funding, high-risk pool premiums cannot be greater than 150% of the standard risk premiums. However, the magnitude of the federal funds may not be sufficient to be a major factor in determining the optimal level.

The disadvantage of employing “surcharges” to premium is that if the surcharge becomes too great, affordability becomes more problematic.

Providers

Providers readily acknowledge that their probability of collecting the fees for services they provide increases significantly if their patients have insurance. In trying to collect fees from “self-pay” (e.g., uninsured) patients, providers either must expend significant resources, discount their fees or both. Recently there has been a lot of publicity (as well as class action suits) regarding the fee levels that providers (particularly hospitals) charge self-pay individuals. Providers routinely accept discounts from carriers and/or payors that represent a significant portion of the providers’ patient population. A case can be made that it is reasonable to require providers to accept fees at Medicare-levels as their “contribution” to high-risk pool losses. Our analysis of the Florida commercial market indicates that providers are currently accepting fees at or near the Medicare levels for patients insured or administered by the major carriers.

Opponents may assert that the providers will simply shift these costs to other commercial patients. However, if the general reimbursement level is near Medicare, coupled with the fact that the high-risk pool will never have a significant portion of the market, then there should be no need for providers to shift costs. To protect FHIP members, providers should not be allowed to “balance bill” the patients for the difference between their normal charges and FHIP required reimbursement levels.

The Office indicates that there is precedent to defining provider reimbursement levels for targeted patient populations. Providers treating patients covered under workman’s compensation must accept State-defined levels of reimbursement.

Carriers/Employers

There are several methods by which carriers and employers contribute either directly or indirectly to the losses of high-risk pools. In its “Model Health Plan for Uninsurable Individuals Act,” the model bill for high-risk pool legislation, the National Association of Insurance Commissioners (NAIC) proposed four methods of assessment to fund high-risk pool losses. Two of these methods directly involve carriers and employers.

Assessments Based Upon Premiums

Carriers historically have been the major source of funding losses (other than enrollee’s premiums) incurred by high-risk pools for most states. Alternative One of the NAIC model bill provides that losses will be funded by “assessing” the carriers doing business in the state a portion of the losses based upon their health insurance premium volume in the state. This often has been expressed as a percentage of earned premium. Sometimes the amounts paid in assessments can fully or partially offset any premium taxes. Twenty-two states, including FCHA, currently use assessments as a percentage of premium to fund high-risk pool losses.¹¹

The pros for this approach is that it is easily defined and calculated. Usually the premium base subject to the assessments excludes disability insurance, specialty insurance such as hospital indemnity, long term care, Medicare supplement, and non-medical group coverages such as dental or vision premiums. Stop loss premiums have been included in the assessment base as a means of getting self-funded plans to contribute to the losses. In addition, assessments enable the State to include out-of-state carriers in the assessment process.

Another major advantage of this approach is that the State has no liability for the on-going losses of the pool. Thus the premium and membership levels are not subjected to changes in administrations or competition for state funds from other groups. In reality, however, eligibility and benefits are subject to scrutiny if the assessments are perceived as becoming too great.

¹¹ CA, page 35.

Some support this approach because they assert that since it is the insurance industry's unwillingness to cover these individuals that creates the need for a high-risk pool, the insurance industry should have to support its losses. While this assertion certainly seems logical, it is far too simplistic.

The major disadvantage to this approach is that self-funded employers who do not purchase stop loss premiums contribute nothing to the losses of the high-risk pool. (ERISA, the federal legislation governing self-funded plans, precludes states from regulating or directly assessing self-funded plans.) Since high-risk individuals leaving self-funded employers are eligible to join high-risk pools, it is inequitable that they do not contribute to the losses. Generally it is the very largest self-funded groups (in terms of members) that elect not to purchase stop loss protection. Thus it is this population that is not making any contributions.

Another disadvantage to this approach is that stop loss premiums are by the nature of their risk, very small when compared to fully insured premiums. Thus by computing assessments on a percentage-of-premium basis, self-funded plans that purchase stop loss premiums, while contributing somewhat to the high-risk pool losses, do not contribute their fair share when compared to fully insured policies. In essence, assessments based upon premiums enable self-funded plans to avoid contributing to high-risk pool losses on an equitable basis when compared to fully insured plans. Thus, the cost of high-risk pools are shifted to smaller employers and individuals who purchase insurance.

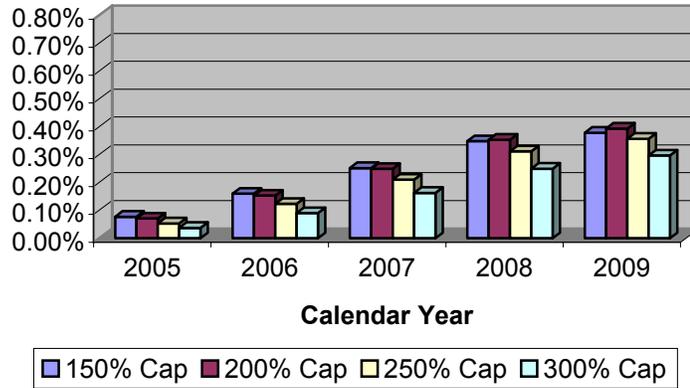
Implementing assessments based upon premiums may also be one of the factors that encourage employers to create self-funded plans, although avoiding assessments certainly is not the major reason for any employer to decide to self-fund.

Another disadvantage is a reduction to State general funds if assessments can be used to offset premium taxes.

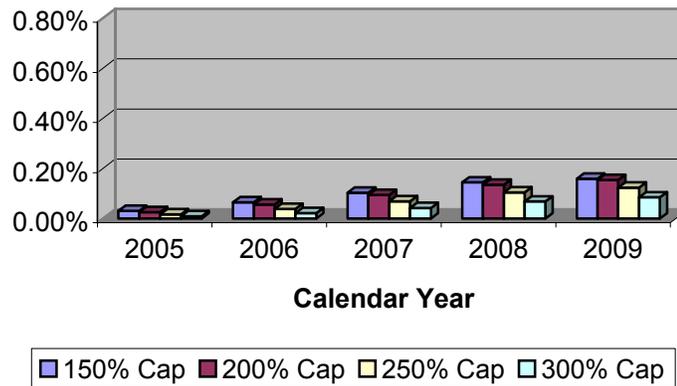
To calculate the assessments, the State will need accurate premium information, including stop loss premiums. The Office has reports that include these statistics, although concern has been expressed regarding the completeness and accuracy of the information provided.

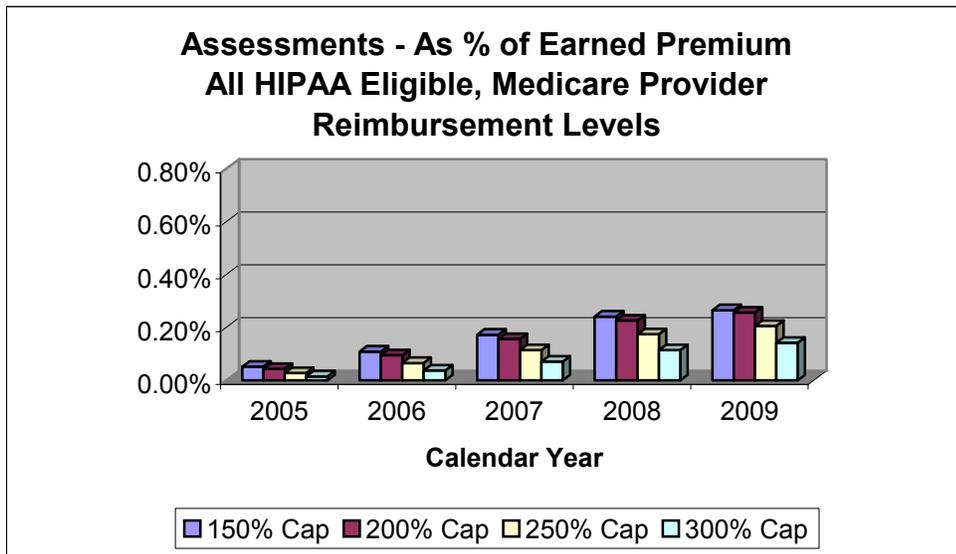
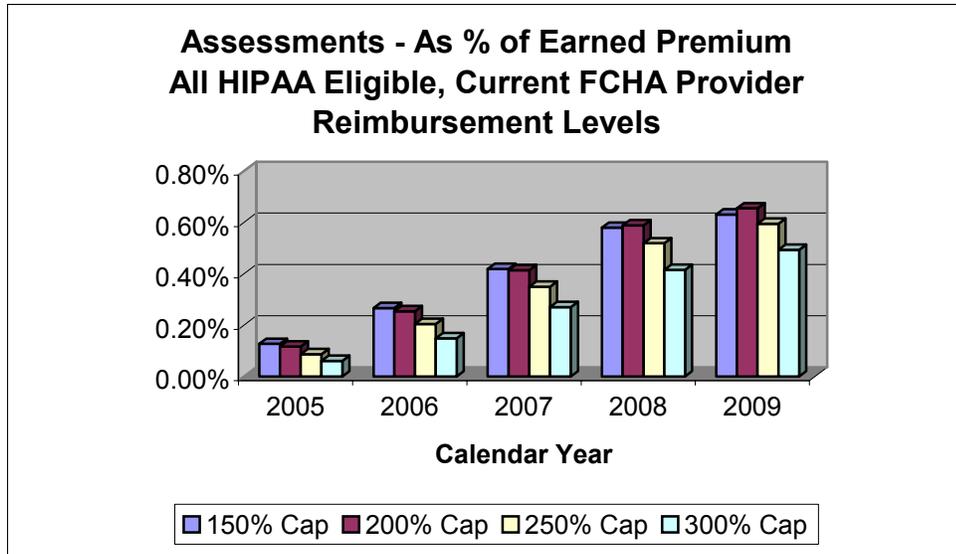
We have estimated the potential assessments that would be required if this approach is implemented. Our analysis shows the fifth year assessments range from 0.08% to 0.66% of earned premium, depending on the number of enrollees in the pool and the level of discounts the pool is able to achieve. The following graphs depict the results of our analysis. The full detailed analysis can be found in the appendix of this report.

**Assessments - As % of Earned Premium
HIPAA Self Funded, Current FCHA Provider
Reimbursement Levels**



**Assessments - As % of Earned Premium
HIPAA Self Funded, Medicare Provider
Reimbursement Levels**





Assessments Based upon the Number of Persons Insured

Alternative Two of the NAIC model bill provides for determining the assessments based upon the number of persons each carrier insures for primary, excess and stop loss insurance in the state. Six states¹² have elected this approach.

The advantages of this approach are similar to the advantages described in the previous section with one major difference. Because assessments are calculated on a per insured

¹² The six states are Colorado, Indiana, New Hampshire, Oregon, South Dakota and Washington. “Comprehensive Health Insurance for High-Risk Individuals,” 2003/2004 Edition, page 35.

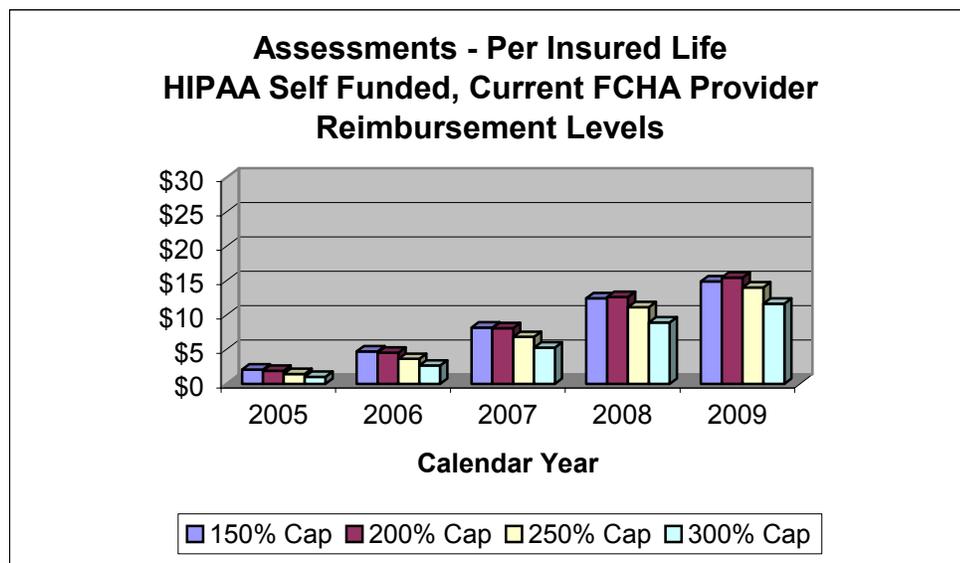
basis, stop loss carriers bear a significantly greater share of total assessments than under Alternative One of the NAIC model bill.

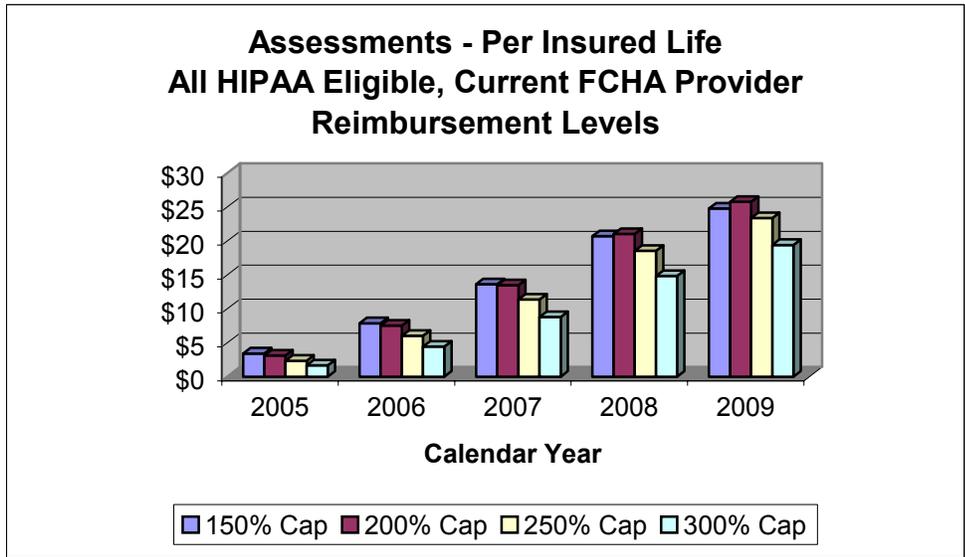
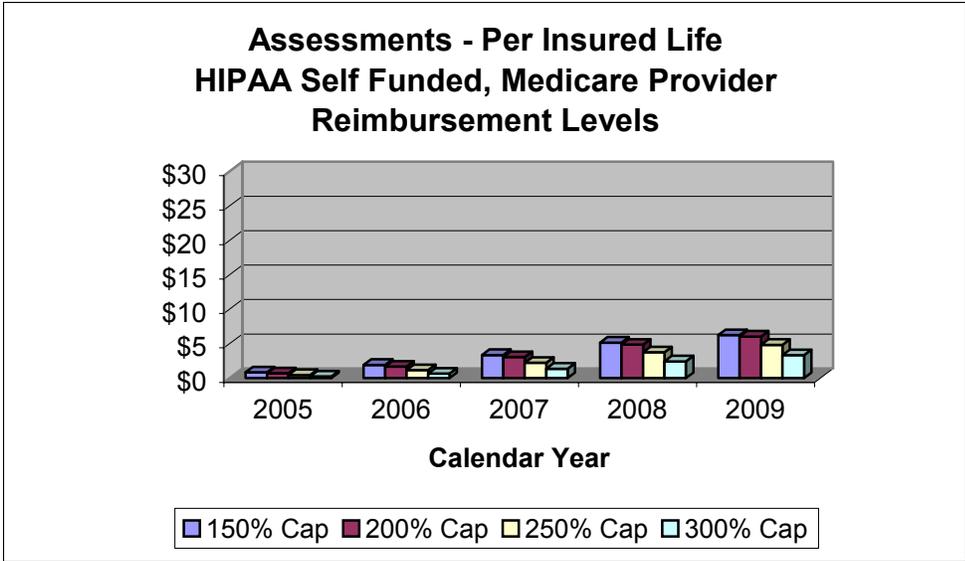
The disadvantage of this approach is that it still does not have any means to require self-funded employers that do not purchase stop loss insurance to contribute to the losses of the pool.

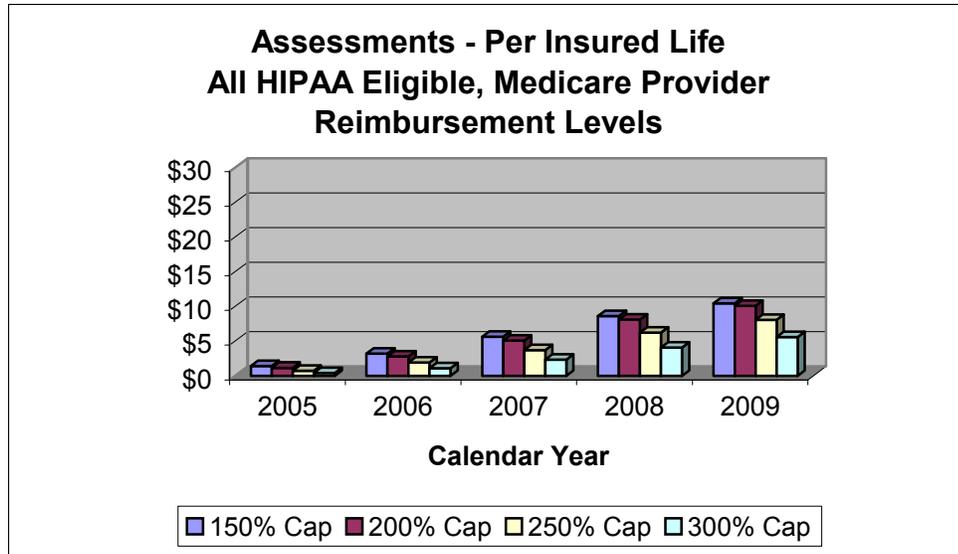
In order for this method to work, the State will need accurate and timely statistics regarding the number of insured for all carriers, including stop loss carriers. The Office has reports that include these statistics, although concern has been expressed regarding the completeness and accuracy of the information provided.

Twenty-eight states use assessments based either on premium or insured lives to fund their high-risk pool losses.

The following graphs show the estimated assessments based on our analysis of the high-risk pool and an estimate of the number of insured members in Florida.







The fifth year assessments range from \$3 per life to \$26 per life per year.

Service Charge on Hospital and Surgical Centers

Alternative Three of the NAIC model bill provides for a service charge of \$2 per day for each admission to a hospital or outpatient surgical centers. Patients covered by Medicare, Medicaid, or self-pay are excluded. Hospitals operated by the Department of Veteran’s Affairs (VA) are excluded. Under this alternative, the pool is to determine how many members it anticipates it can insure from premiums and the maximum \$2 per day assessment. We have varied Alternative Three in our modeling to exclude any maximum on the per-day assessment. This, in turn, eliminates the need to cap enrollment.

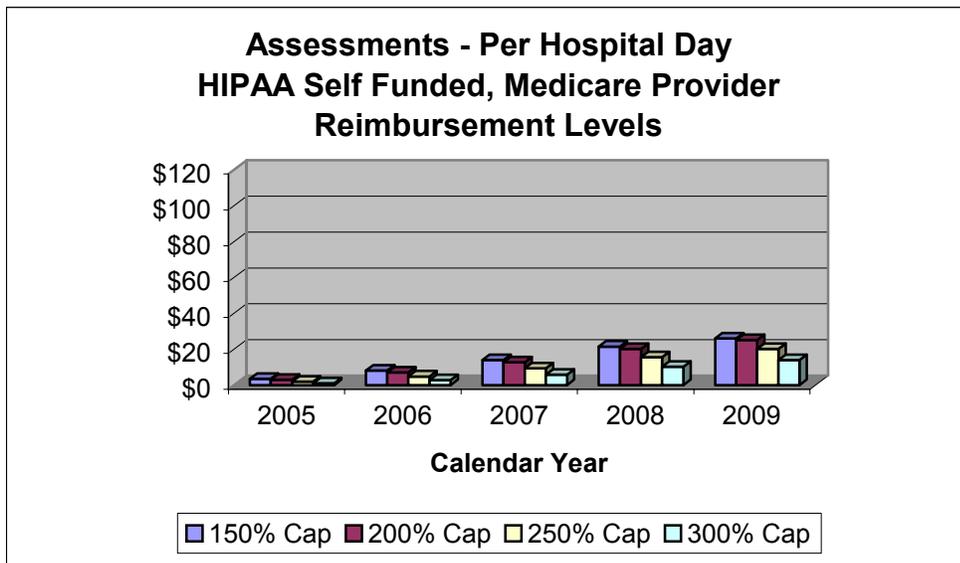
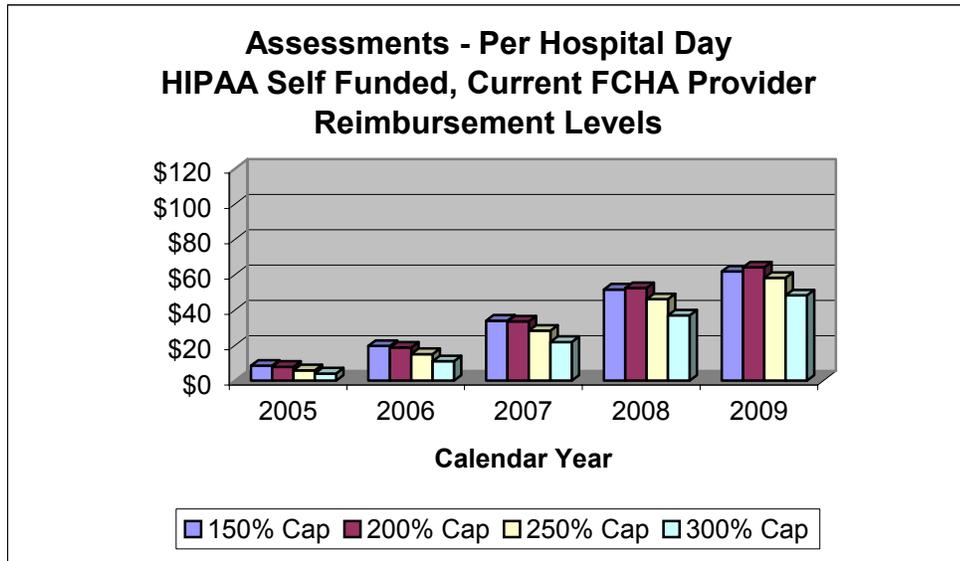
One of the criteria given to us is that there should not be any new taxes to support FHIP. Alternatives One and Two of the NAIC model bill do not, in our opinion, represent new taxes since assessments are currently employed to fund the FCHA. Determining the method of assessments (e.g., a function of premium or a function of members) does not conflict with a “no new taxes” pledge.

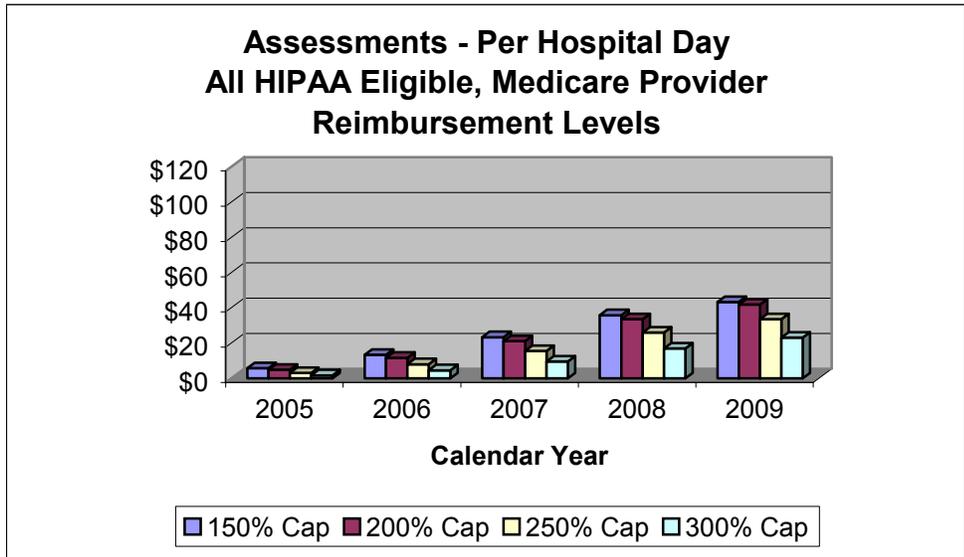
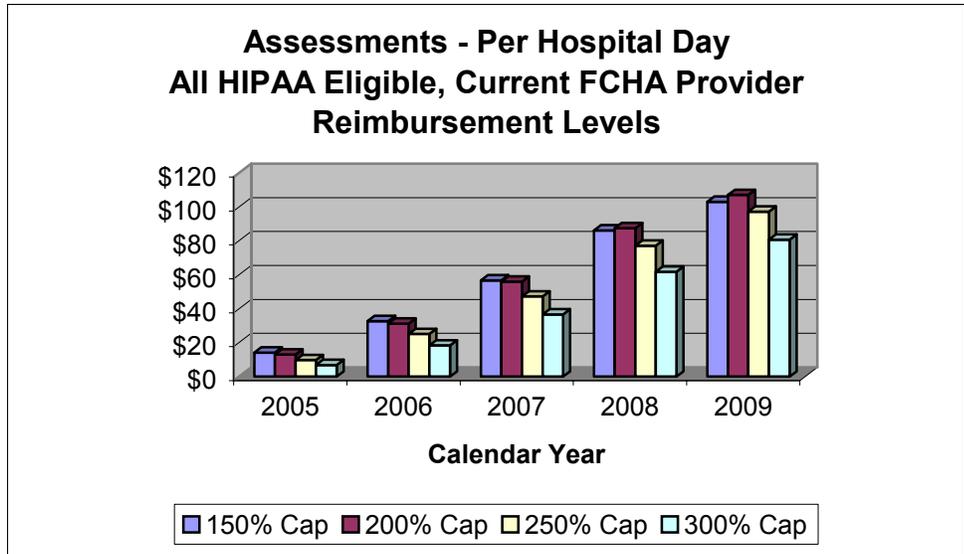
Florida hospitals are currently required to pay an assessment to the state. Surgical centers are not. To be consistent with the criteria given to us, we have not included surgical centers in our estimates of assessments.

Assessments would need to be in addition to any prescribed fee level required for providers. In other words, hospitals would be able to pass the assessments on to their payors (carriers or self-funded plans) in addition to the prescribed fee level. This is necessary to avoid the providers from having to fund more than their share of the high-risk pool losses.

Minnesota uses both assessments to insurance carriers and a tax on health care providers to fund the losses in its high-risk pool. This tax has withstood court challenges from self-funded employers.

We used data from the Acute Care Hospital Inpatient Data Collection for Florida Hospitals. The graphs below show our estimate of the hospital surcharge required for each day to cover the losses of the high-risk pool.





The fifth year hospital assessments range from \$14 to over \$100 per day.

The greatest advantage of this approach is that it indirectly includes *all* group health plans, insured and self-funded. Thus this creates the largest base upon which to spread the risks.

Similar to Alternatives One and Two, hospital assessments remove the State from any financial burden for funding the high-risk pool.

The disadvantage to this approach is that it may complicate the administration of health plans. Hospitals must be able to pass the assessment to the payors and may believe that they will be held responsible for increasing costs attributable to the high-risk pool

assessments. Payors need to be able to pass the assessment along to members as part of premium costs as well as cost sharing at time of claim. The trends that carriers use to price health insurance will increase to reflect the higher hospital costs associated with assessments.

Another disadvantage may be in the determination of the assessment. There is a timing lag between the date the services are provided and the date the assessment are calculated. We recommend estimating the assessment for the succeeding year and adjusting the subsequent assessments based upon a combination of actual experience and forecasts.

Accurate and timely statistics regarding hospital inpatient days are required. We believe this information is available in the Acute Care Hospital Inpatient Data Collection.

As indicated previously, Florida currently requires hospitals to pay a tax. These funds could be allocated to fund the losses in the high-risk pool.

General Funds

Alternative Four of the NAIC model bill provides that pool losses are funded from the State's general funds.

One advantage of this approach is the elimination of administrative challenges associated with determination and collection of assessments, be it from insurance companies or hospitals. Legislators need only appropriate the amounts necessary to fund anticipated losses. Another advantage is that the State, at least theoretically, is able to adequately fund the losses since it has the power to generate revenues via taxation. By using General Funds, the cost of funding the losses are spread among all State citizens.

There are several disadvantages with the General Funds approach. The major disadvantage is that the State is now totally liable for all losses in the high-risk pool. There are always going to be competing interests for limited state funds. During economic downturns when State revenues are lower, the competition intensifies. Several states, including Florida, that rely on general funding have had to close and or limit enrollment in high-risk pools. Another disadvantage is that appropriations must be determined well in advance, sometimes up to two years. The appropriations will need to be made based upon forecasts of membership, premium increases in the commercial market (which determine the premium increases in the high-risk pool) and claims trends. Forecasting for pools with small populations is always challenging. Doing so for high-risk pools is even more problematic because of the very nature of the underlying risk. If the appropriations are not adequate, then either benefits will need to be lowered, enrollment caps implemented, or both.

While spreading the cost of high-risk individuals across all citizens in the State may initially seem like an advantage, some would assert that some classes of citizens, such as the elderly, should not have to bear this burden.

Out-of-state carriers will not contribute as much to the losses as in other alternatives. Some states have tried to earmark specific revenue sources from the General Funds. Until 2001, Colorado, for instance, funded its pools from the State Unclaimed Business Association Property Fund. Louisiana tried to obtain appropriations from the state lottery proceeds. This was defeated in a statewide referendum. Some states have used the Tobacco Settlement Funds. California receives a fixed amount each year from state cigarette and tobacco surtax revenues. California, however, has had a waiting list for its high-risk pool almost since inception demonstrating that the funding levels are inadequate to meet demand.

Funding Sources-Conclusions.

The following chart summarizes the advantages and disadvantages of the funding sources discussed in this section.

Advantages and Disadvantages of Various Funding Sources

Funding Source	Advantages	Disadvantages
High-Risk Pool Enrollee’s Surcharged Premium	Equitable since they are the greatest beneficiaries of the pool.	If surcharge is too great, affordability becomes more problematic.
	Premiums fund 55% of costs in current high-risk pools across the country.	Impossible to develop a self-supporting high-risk pool.
Limit Provider Reimbursement to Medicare Levels	Since providers are also a beneficiary of a high-risk pool, they should share in the cost of its operation.	Providers may resent the State dictating reimbursement levels.
	Provider discounts are common in the industry.	Providers may argue level of reimbursement prevalent in current market.
	Providers in Florida currently accepting Medicare level reimbursements for commercial patients.	Providers may try to offset losses by cost shifting to other commercial patients.
	Currently a precedent in the Worker’s Compensation program to define provider reimbursement for a specific patient population.	Providers must not be allowed to balance bill.

Funding Source	Advantages	Disadvantages
Alternative 1		
Assessments to Carriers based upon Premium (includes Stop Loss Premiums)	Steady and reliable source that includes out-of-state insurance companies.	Does not include self-funded employer plans that do not purchase stop loss protection in assessment. Self-funded employer plans can represent as much as 50% of the market and it is the largest plans that do not purchase stop loss protection.
	Acceptable in the industry in that twenty-two states currently employ this as a source.	Stop loss premiums are significantly less than fully insured premiums. Therefore by using premiums as the basis for assessments, the costs of funding the losses of the high-risk pool are shifted to fully insured policies which are generally purchased by smaller employers and individuals.
	Some states allow assessments to offset premium tax.	Premium tax offsets reduce General Revenues for the State.
	Removes the State from all financial liability for the high-risk pool.	Requires accurate premium statistics.
	Information necessary to determine the assessment is generally easily available.	Provides another incentive for employers to become self funded and outside the oversight of the Office.
	Proponents of this method assert that since it is the insurance industry that is not willing to insure these individuals, it is only equitable that the insurance industry fund the losses.	High-risk individuals leaving self-funded employer plans are eligible for FHIP; therefore self-funded employer plans should share in its losses.

Funding Source	Advantages	Disadvantages
Alternative 2		
Assessments to Carriers based upon Number of Insured Lives (includes Stop Loss Premiums)	Steady and reliable source that includes out-of-state insurance companies.	Does not include self-funded employer plans that do not purchase stop loss protection in assessment. Self-funded employer plans can represent as much as 50% of the market and it is the largest plans that do not purchase stop loss protection.
	Six states are currently using this approach.	Need accurate enrollment statistics for all coverages, including stop loss.
	Proponents of this method assert that since it is the insurance industry that is not willing to insure these individuals, it is only equitable that the insurance industry fund the losses.	Provides another incentive for employers to become self funded and outside the oversight of the Office.
		High-risk individuals leaving self-funded employer plans are eligible for FHIP; therefore self-funded employer plans should share in its losses.
Alternative 3		
Assessments to Hospitals based upon Number of Inpatient Days	Greatest advantage is that it includes all self-funded plans as well as fully insured plans and policies.	Hospitals may resist since they will be the bearer of the higher costs associated with assessments.
	Florida already taxes/assesses hospitals so the precedent is established.	Using the proceeds from the current hospital assessments/taxes reduces funds for other uses.
	Honors “no new tax” pledge.	Assessments must be in addition to the negotiated provider reimbursement levels.

Funding Source	Advantages	Disadvantages
	Removes the State from all financial liability for the high-risk pool.	Could be complicated to administer since assessment/tax cannot apply to Medicare, Medicaid, self-pay (e.g., uninsured), VA hospitals.
	Florida has accurate hospital data base upon which to base assessment estimate.	Assessment levels need to be established prior to effective date of days subject to assessment for ease in administration. Lag between time of service and assessment.
General Revenue	State has the most resources at its disposal to subsidize pool.	State has full responsibility for financial losses of high-risk pool.
	Eliminates costs attributable to administering assessments.	In reality the State does not have unlimited funds and there will always be competing interests for limited State funds.
	Costs of funding high-risk pool losses spread across all citizens in the State.	Opponents assert that some citizens, such as the elderly, should not have to bear this burden.
	Legislators will be fully cognizant of the costs of the high-risk pool.	Appropriations will need to be made well in advance which will necessitate forecasting for periods of up to two years.
		High-risk pools that have relied on general funds are more apt to close enrollment, which is what occurred previously in Florida. This would not satisfy the HIPAA requirements.
		Since funds must be appropriated every session, does not guarantee a reliable funding source.

We believe that Alternative 3, Hospital Assessments, is the most equitable means of distribution losses from high-risk pools to the broadest appropriate population. It also has the advantage of currently being in existence in the State of Florida.

11**Recommended Changes in Legislation**

We are recommending several changes in the existing legislation for consideration.

Modified Provider Reimbursement Levels

Losses from high-risk pools should be spread across as broad of population as possible. The high-risk individuals contribute by paying higher-than-standard premiums. Carriers and employers should share in the losses. Providers should also share by being willing to accept lower reimbursement levels. The levels we are recommending, Medicare levels, are the levels that our research shows providers are readily accepting from the commercial market currently. Therefore, it does not seem unreasonable to codify these levels for the high-risk pool to enable more members to participate.

Codification of Elimination of Balance Billing

While many may assume that prescribing the provider reimbursement levels would eliminate the providers' ability to balance bill patients for difference between those levels and usual charges, it is prudent to incorporate such language into the legislation.

Funding Sources

We recommend that a funding source, other than general funds, be codified so FHIP is guaranteed a steady source of renewable funds from which to operate. We believe that Alternative 3, Hospital Assessments, is the most equitable means of distribution losses from high-risk pools to the broadest appropriate population. It also has the advantage of currently being in existence in the State of Florida.

Commission Scales

Current language provides for payment of the usual and customary commission levels. Our review of current practices in other high-risk pools indicates that this is very much the exception to rule. We recommend that a one-time referral fee of \$100 be considered.

This would still reflect one of the most generous agent reimbursement levels in the country.

Expand Eligibility

Expanding eligibility to include all HIPAA-eligibles regardless of whether they are coming from a fully insured plan or a self-funded plan simplifies the eligibility of the pool. If this is granted, then there should be a decrease in the small employer group premium as carriers no longer have to directly subsidize this subgroup via conversion contracts. There is a definite cost to this modification.

12

Enabling Legislation

The following pages show the legislation that provides for the creation of FHIP.

627.64872 Florida Health Insurance Plan.--

(1) LEGISLATIVE INTENT.--

(a) The Legislature recognizes that to secure a more stable and orderly health insurance market, the establishment of a plan to assume risks deemed uninsurable by the private marketplace is required.

(b) The Florida Health Insurance Plan is to make coverage available to individuals who have no other option for similar coverage, at a premium that is commensurate with the risk and benefits provided, and with benefit designs that are reasonable in relation to the general market. While plan operations may include supplementary funding, the plan shall fundamentally operate on sound actuarial principles, using basic insurance management techniques to ensure that the plan is run in an economical, cost-efficient, and sound manner, conserving plan resources to serve the maximum number of people possible in a sustainable fashion.

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

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

(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.

(3) BOARD OF DIRECTORS.--

(a) The plan shall operate subject to the supervision and control of the board. The board shall consist of the 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 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 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 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.

(4) PLAN OF OPERATION.--The plan of operation shall:

(a) Establish procedures for operation of the plan.

(b) Establish procedures for selecting an administrator in accordance with subsection (11).

(c) Establish procedures to create a fund, under management of the board, for administrative expenses.

(d) Establish procedures for the handling, accounting, and auditing of assets, moneys, and claims of the plan and the plan administrator.

(e) Develop and implement a program to publicize the existence of the plan, plan eligibility requirements, and procedures for enrollment and maintain public awareness of the plan.

(f) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board after completion of the review, with the committee's recommendation for grievance resolution. The board shall retain all written grievances regarding the plan for at least 3 years.

(g) Provide for other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this section.

(5) POWERS OF THE PLAN.--The plan shall have the general powers and authority granted under the laws of this state to health insurers and, in addition thereto, the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this section, including the authority, with the approval of the Chief Financial Officer, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions.

(b) Take any legal actions necessary or proper to recover or collect assessments due the plan.

(c) Take such legal action as is necessary to:

1. Avoid payment of improper claims against the plan or the coverage provided by or through the plan;
2. Recover any amounts erroneously or improperly paid by the plan;
3. Recover any amounts paid by the plan as a result of mistake of fact or law; or
4. Recover other amounts due the plan.

(d) Establish, and modify as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' commissions, claims reserve formulas, and any other actuarial functions appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices. For purposes of this paragraph, usual and customary agent's commissions shall be paid for the initial placement of coverage with the plan and for one renewal only.

(e) Issue policies of insurance in accordance with the requirements of this section.

(f) Appoint appropriate legal, actuarial, investment, and other committees as necessary to provide technical assistance in the operation of the plan and develop and educate its policyholders regarding health savings accounts, policy and contract design, and any other function within the authority of the plan.

(g) Borrow money to effectuate the purposes of the plan. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets.

(h) Employ and fix the compensation of employees.

(i) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(j) Provide for reinsurance of risks incurred by the plan.

(k) Provide for and employ cost-containment measures and requirements, including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the plan more cost-effective.

(l) Design, use, contract, or otherwise arrange for the delivery of cost-effective health care services, including, but not limited to, establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(m) Adopt such bylaws, policies, and procedures as may be necessary or convenient for the implementation of this section and the operation of the plan.

(n) Subsume the transfer of statutory powers, duties, functions, assets, records, personnel, and property of the Florida Comprehensive Health Association as specified in ss. [627.6488](#), [627.6489](#), [627.649](#), [627.6492](#), [627.6496](#), [627.6498](#), and [627.6499](#), unless otherwise specified by law.

(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:

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.
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.

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.

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

(7) LIABILITY OF THE PLAN.--Neither the board nor its employees shall be liable for any obligations of the plan. No member or employee of the board shall be liable, and no cause of action of any nature may arise against a member or employee of the board, for any act or omission related to the performance of any powers and duties under this section, unless such act or omission constitutes willful or wanton misconduct. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

(8) AUDITED FINANCIAL STATEMENT.--No later than June 1 following the close of each calendar year, the plan shall submit to the Financial Services Commission an audited financial statement prepared in accordance with statutory accounting principles as adopted by the National Association of Insurance Commissioners.

(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.

(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 or health care provider.

(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.

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.

(10) UNFAIR REFERRAL TO PLAN.--It is an unfair trade practice for the purposes of part IX of chapter 626 or s. [641.3901](#) for an insurer, health maintenance organization insurance agent, insurance broker, or third-party administrator to refer an individual employee to the plan, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

(11) PLAN ADMINISTRATOR.--The board shall select through a competitive bidding process a plan administrator to administer the plan. The board shall evaluate bids submitted based on criteria established by the board, which shall include:

(a) The plan administrator's proven ability to handle health insurance coverage to individuals.

(b) The efficiency and timeliness of the plan administrator's claim processing procedures.

(c) An estimate of total charges for administering the plan.

(d) The plan administrator's ability to apply effective cost-containment programs and procedures and to administer the plan in a cost-efficient manner.

(e) The financial condition and stability of the plan administrator.

The administrator shall be an insurer, a health maintenance organization, or a third-party administrator, or another organization duly authorized to provide insurance pursuant to the Florida Insurance Code.

(12) ADMINISTRATOR TERM LIMITS.--The plan administrator shall serve for a period specified in the contract between the plan and the plan administrator subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the plan and the plan administrator. At least 1 year prior to the expiration of each period of service by a plan administrator, the board shall invite eligible entities, including the current plan administrator, to submit bids to serve as the plan administrator. Selection of the plan administrator for each succeeding period shall be made at least 6 months prior to the end of the current period.

(13) DUTIES OF THE PLAN ADMINISTRATOR.--

(a) The plan administrator shall perform such functions relating to the plan as may be assigned to it, including, but not limited to:

1. Determination of eligibility.
2. Payment of claims.
3. Establishment of a premium billing procedure for collection of premiums from persons covered under the plan.
4. Other necessary functions to ensure timely payment of benefits to covered persons under the plan.

(b) The plan administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content, and form of the reports shall be specified in the contract between the board and the plan administrator.

(c) On March 1 following the close of each calendar year, the plan administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the Governor on a form prescribed by the Governor.

(14) PAYMENT OF THE PLAN ADMINISTRATOR.--The plan administrator shall be paid as provided in the contract between the plan and the plan administrator.

(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 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 300-percent rate limitation provided in this section. Notwithstanding the 300-percent rate limitation, sliding scale premium surcharges based upon the insured's income may apply to all enrollees.

(b) *Sources of additional revenue.*--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 appropriated by the Legislature, including any interest on investments. After determining the amount of funds 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.

(16) BENEFITS.--

(a) The benefits provided shall be the same as the standard and basic plans for small employers as outlined in s. [627.6699](#). The board shall also establish an option of alternative coverage such as catastrophic coverage that includes a minimum level of primary care coverage and a high deductible plan that meets the federal requirements of a health savings account.

(b) In establishing the plan coverage, the board shall take into consideration the levels of health insurance provided in the state and such medical economic factors as may be deemed appropriate and adopt benefit levels, deductibles, copayments, coinsurance factors, exclusions, and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.

(c) The board may adjust any deductibles and coinsurance factors annually according to the medical component of the Consumer Price Index.

(d)1. Plan coverage shall exclude charges or expenses incurred during the first 6 months following the effective date of coverage for any condition for which medical advice, care, or treatment was recommended or received for such condition during the 6-month period immediately preceding the effective date of coverage.

2. Such preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, provided application for pool coverage is made not later than 63 days following such involuntary termination. In such case, coverage under the plan shall be effective from the date on which such prior coverage was terminated and the applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to plan coverage.

(17) NONDUPLICATION OF BENEFITS.--

(a) The plan shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance, by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(b) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(18) ANNUAL AND MAXIMUM BENEFITS.--Maximum benefits under the plan shall be determined by the board.

(19) TAXATION.--The plan is exempt from any tax imposed by this state. The plan shall apply for federal tax exemption status.

(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.

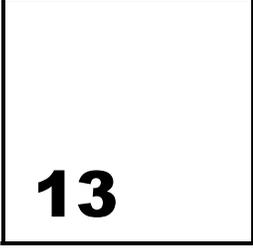
(c) If assessments and other receipts by the plan, board, or plan administrator exceed the actual losses and administrative expenses of the plan, the excess shall be held in interest and used by the board to offset future losses. As used in this subsection, the term "future losses" includes reserves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

History.--s. 21, ch. 2004-297



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Appendix

The following pages show the detailed results of the various scenarios that we have modeled.

Eligible uninsurables not associated with HIPAA are included in all non-FCHA scenarios.

In the assessment calculation, the reference to Assessment Scenarios 1, 2 and 3 are analogous to Alternatives 1, 2 and 3 found in Chapter 10.

HIPAA - Self-funded

Current FCHA Provider Reimbursement Levels

**Florida High Risk Pool
Self-Funded HIPAA at Current FCHA Provider Reimbursement Levels
150% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,658	5,699	9,136	12,800	14,324
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 13,642,789	\$ 31,773,740	\$ 55,320,594	\$ 84,226,277	\$ 101,331,689
Claims	\$ 27,012,716	\$ 63,483,916	\$ 111,535,341	\$ 171,357,677	\$ 208,032,666
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 1,052,568	\$ 2,347,241	\$ 3,913,159	\$ 5,701,622	\$ 6,635,979
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 454,760	\$ 1,059,125	\$ 1,500,671	\$ 2,007,465	\$ 1,998,949
Loss Ratio	198%	200%	202%	203%	205%
Inherent Morbidity	297%	300%	302%	305%	308%
Gain/Loss of Pool	\$ (14,977,254)	\$ (35,116,542)	\$ (61,628,578)	\$ (94,840,486)	\$ (115,335,904)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,160	4,580	7,309	10,204	11,348
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,088,628	\$ 25,534,978	\$ 44,257,747	\$ 67,147,645	\$ 80,273,084
Claims	\$ 21,955,478	\$ 51,478,503	\$ 90,845,842	\$ 140,336,901	\$ 170,819,081
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 985,132	\$ 2,172,173	\$ 3,604,953	\$ 5,234,211	\$ 6,053,399
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 369,621	\$ 851,166	\$ 1,196,191	\$ 1,595,272	\$ 1,572,718
Loss Ratio	198%	202%	205%	209%	213%
Inherent Morbidity	297%	302%	308%	313%	319%
Gain/Loss of Pool	\$ (12,321,603)	\$ (28,966,864)	\$ (51,389,238)	\$ (80,018,738)	\$ (98,172,114)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,298	4,529	6,191	8,867	9,998
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,794,494	\$ 25,250,992	\$ 37,485,997	\$ 58,349,290	\$ 70,728,237
Claims	\$ 23,353,093	\$ 51,360,504	\$ 78,325,948	\$ 125,244,289	\$ 155,955,590
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 1,185,716	\$ 2,430,649	\$ 3,455,129	\$ 5,146,842	\$ 6,035,414
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 393,150	\$ 841,700	\$ 952,701	\$ 1,309,144	\$ 1,423,331
Loss Ratio	198%	203%	209%	215%	220%
Inherent Morbidity	297%	305%	313%	322%	331%
Gain/Loss of Pool	\$ (13,237,465)	\$ (29,381,861)	\$ (45,247,781)	\$ (73,350,986)	\$ (92,686,098)

**Florida High Risk Pool
Self-Funded HIPAA at Current FCHA Provider Reimbursement Levels
200% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,128	4,715	7,736	11,086	12,554
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 14,560,521	\$ 35,050,682	\$ 62,459,555	\$ 97,261,813	\$ 118,408,474
Claims	\$ 27,737,807	\$ 67,378,599	\$ 121,158,723	\$ 190,383,125	\$ 233,883,275
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 842,530	\$ 1,941,990	\$ 3,313,605	\$ 4,938,038	\$ 5,815,723
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 364,013	\$ 876,267	\$ 1,286,655	\$ 1,769,601	\$ 1,792,686
Loss Ratio	191%	192%	194%	196%	198%
Inherent Morbidity	381%	384%	388%	391%	395%
Gain/Loss of Pool	\$ (14,483,829)	\$ (35,146,174)	\$ (63,299,428)	\$ (99,828,951)	\$ (123,083,211)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,642	3,615	5,951	8,515	9,662
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,236,148	\$ 26,872,599	\$ 48,047,422	\$ 74,709,243	\$ 91,130,043
Claims	\$ 21,404,873	\$ 52,123,097	\$ 94,889,024	\$ 150,226,158	\$ 186,577,012
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 748,678	\$ 1,714,470	\$ 2,935,227	\$ 4,367,733	\$ 5,154,092
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 280,904	\$ 671,815	\$ 989,100	\$ 1,360,232	\$ 1,380,124
Loss Ratio	191%	194%	197%	201%	205%
Inherent Morbidity	381%	388%	395%	402%	409%
Gain/Loss of Pool	\$ (11,298,307)	\$ (27,636,783)	\$ (50,765,928)	\$ (81,244,880)	\$ (101,981,186)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,580	3,245	4,575	6,628	7,654
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 10,812,946	\$ 24,119,008	\$ 36,934,044	\$ 58,153,231	\$ 72,188,960
Claims	\$ 20,598,672	\$ 47,199,828	\$ 74,249,510	\$ 120,095,389	\$ 153,147,188
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 815,280	\$ 1,741,264	\$ 2,553,191	\$ 3,847,161	\$ 4,620,046
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 270,324	\$ 602,975	\$ 719,254	\$ 998,335	\$ 1,114,334
Loss Ratio	191%	196%	201%	207%	212%
Inherent Morbidity	381%	391%	402%	413%	424%
Gain/Loss of Pool	\$ (10,971,330)	\$ (25,425,058)	\$ (40,587,910)	\$ (66,787,654)	\$ (86,692,608)

**Florida High Risk Pool
Self-Funded HIPAA at Current FCHA Provider Reimbursement Levels
250% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,604	3,746	6,419	9,448	10,944
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 13,719,780	\$ 34,809,845	\$ 64,783,502	\$ 103,619,680	\$ 129,030,885
Claims	\$ 24,476,070	\$ 62,665,271	\$ 117,684,575	\$ 189,944,911	\$ 238,676,346
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 635,105	\$ 1,542,917	\$ 2,749,516	\$ 4,208,664	\$ 5,069,961
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 274,396	\$ 696,197	\$ 1,088,498	\$ 1,546,477	\$ 1,611,845
Loss Ratio	178%	180%	182%	183%	185%
Inherent Morbidity	446%	450%	454%	458%	462%
Gain/Loss of Pool	\$ (11,765,790)	\$ (30,094,540)	\$ (56,739,087)	\$ (92,080,371)	\$ (116,327,268)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,141	2,695	4,637	6,914	8,050
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 9,763,407	\$ 25,042,054	\$ 46,793,428	\$ 75,822,798	\$ 94,909,077
Claims	\$ 17,417,906	\$ 45,487,265	\$ 86,542,627	\$ 142,780,978	\$ 181,971,609
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 520,438	\$ 1,278,145	\$ 2,286,896	\$ 3,546,268	\$ 4,294,260
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 195,268	\$ 500,841	\$ 788,439	\$ 1,138,113	\$ 1,198,432
Loss Ratio	178%	182%	185%	188%	192%
Inherent Morbidity	446%	454%	462%	471%	479%
Gain/Loss of Pool	\$ (8,470,205)	\$ (22,224,197)	\$ (42,824,533)	\$ (71,642,561)	\$ (92,555,224)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,056	2,325	3,391	5,056	5,980
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 9,031,152	\$ 21,598,772	\$ 34,217,694	\$ 55,445,421	\$ 70,501,336
Claims	\$ 16,111,563	\$ 39,583,059	\$ 64,419,417	\$ 107,230,293	\$ 140,066,706
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 544,748	\$ 1,247,453	\$ 1,892,331	\$ 2,934,420	\$ 3,609,631
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 180,623	\$ 431,975	\$ 547,982	\$ 782,588	\$ 898,335
Loss Ratio	178%	183%	188%	193%	199%
Inherent Morbidity	446%	458%	471%	483%	497%
Gain/Loss of Pool	\$ (7,905,782)	\$ (19,663,715)	\$ (32,642,036)	\$ (55,501,880)	\$ (74,073,336)

**Florida High Risk Pool
Self-Funded HIPAA at Current FCHA Provider Reimbursement Levels
300% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,142	2,813	5,110	7,828	9,295
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Annual Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,725,100	\$ 31,362,310	\$ 61,885,532	\$ 103,015,611	\$ 131,501,147
Claims	\$ 19,463,688	\$ 52,534,781	\$ 104,606,412	\$ 175,712,440	\$ 226,338,953
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 452,307	\$ 1,158,424	\$ 2,188,768	\$ 3,486,774	\$ 4,305,853
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 195,418	\$ 522,705	\$ 883,883	\$ 1,322,068	\$ 1,420,489
Loss Ratio	166%	168%	169%	171%	172%
Inherent Morbidity	498%	503%	507%	512%	516%
Gain/Loss of Pool	\$ (8,486,314)	\$ (22,853,600)	\$ (45,793,530)	\$ (77,505,672)	\$ (100,564,149)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	791	1,946	3,533	5,423	6,525
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 8,121,234	\$ 21,694,874	\$ 42,787,598	\$ 71,369,055	\$ 92,311,045
Claims	\$ 13,481,265	\$ 36,668,323	\$ 73,633,793	\$ 125,053,125	\$ 164,688,627
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 360,752	\$ 922,754	\$ 1,742,602	\$ 2,781,637	\$ 3,480,591
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 135,354	\$ 361,581	\$ 610,933	\$ 916,341	\$ 1,005,312
Loss Ratio	166%	169%	172%	175%	178%
Inherent Morbidity	498%	507%	516%	526%	535%
Gain/Loss of Pool	\$ (5,956,136)	\$ (16,257,785)	\$ (33,199,730)	\$ (57,382,047)	\$ (76,863,485)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	686	1,547	2,385	3,660	4,445
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 7,038,403	\$ 17,247,424	\$ 28,881,629	\$ 48,174,112	\$ 62,886,900
Claims	\$ 11,683,763	\$ 29,411,596	\$ 50,594,323	\$ 86,692,112	\$ 116,255,044
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 353,790	\$ 830,115	\$ 1,331,027	\$ 2,124,658	\$ 2,683,147
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 117,307	\$ 287,457	\$ 392,793	\$ 585,753	\$ 688,202
Loss Ratio	166%	171%	175%	180%	185%
Inherent Morbidity	498%	512%	526%	540%	555%
Gain/Loss of Pool	\$ (5,216,456)	\$ (13,281,744)	\$ (23,436,513)	\$ (41,228,410)	\$ (56,739,493)

HIPAA - Self-funded

Medicare Provider Reimbursement Levels

**Florida High Risk Pool
Self-Funded HIPAA at Medicare Provider Reimbursement Levels
150% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,658	5,699	9,136	12,800	14,324
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 13,642,789	\$ 31,773,740	\$ 55,320,594	\$ 84,226,277	\$ 101,331,689
Claims	\$ 18,017,482	\$ 42,343,772	\$ 74,394,073	\$ 114,295,570	\$ 138,757,788
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 1,052,568	\$ 2,347,241	\$ 3,913,159	\$ 5,701,622	\$ 6,635,979
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 454,760	\$ 1,059,125	\$ 1,500,671	\$ 2,007,465	\$ 1,998,949
Loss Ratio	132%	133%	134%	136%	137%
Inherent Morbidity	198%	200%	202%	204%	205%
Gain/Loss of Pool	\$ (5,982,020)	\$ (13,976,398)	\$ (24,487,309)	\$ (37,778,379)	\$ (46,061,027)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,160	4,580	7,309	10,204	11,348
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,088,628	\$ 25,534,978	\$ 44,257,747	\$ 67,147,645	\$ 80,273,084
Claims	\$ 14,644,304	\$ 34,336,162	\$ 60,594,176	\$ 93,604,713	\$ 113,936,327
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 985,132	\$ 2,172,173	\$ 3,604,953	\$ 5,234,211	\$ 6,053,399
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 369,621	\$ 851,166	\$ 1,196,191	\$ 1,595,272	\$ 1,572,718
Loss Ratio	132%	134%	137%	139%	142%
Inherent Morbidity	198%	202%	205%	209%	213%
Gain/Loss of Pool	\$ (5,010,429)	\$ (11,824,523)	\$ (21,137,573)	\$ (33,286,550)	\$ (41,289,360)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,298	4,529	6,191	8,867	9,998
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,794,494	\$ 25,250,992	\$ 37,485,997	\$ 58,349,290	\$ 70,728,237
Claims	\$ 15,576,513	\$ 34,257,456	\$ 52,243,407	\$ 83,537,941	\$ 104,022,378
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 1,185,716	\$ 2,430,649	\$ 3,455,129	\$ 5,146,842	\$ 6,035,414
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 393,150	\$ 841,700	\$ 952,701	\$ 1,309,144	\$ 1,423,331
Loss Ratio	132%	136%	139%	143%	147%
Inherent Morbidity	198%	204%	209%	215%	221%
Gain/Loss of Pool	\$ (5,460,885)	\$ (12,278,813)	\$ (19,165,240)	\$ (31,644,637)	\$ (40,752,887)

**Florida High Risk Pool
Self-Funded HIPAA at Medicare Provider Reimbursement Levels
200% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,128	4,715	7,736	11,086	12,554
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 14,560,521	\$ 35,050,682	\$ 62,459,555	\$ 97,261,813	\$ 118,408,474
Claims	\$ 18,501,117	\$ 44,941,526	\$ 80,812,868	\$ 126,985,545	\$ 156,000,145
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 842,530	\$ 1,941,990	\$ 3,313,605	\$ 4,938,038	\$ 5,815,723
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 364,013	\$ 876,267	\$ 1,286,655	\$ 1,769,601	\$ 1,792,686
Loss Ratio	127%	128%	129%	131%	132%
Inherent Morbidity	254%	256%	259%	261%	263%
Gain/Loss of Pool	\$ (5,247,139)	\$ (12,709,101)	\$ (22,953,573)	\$ (36,431,370)	\$ (45,200,080)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,642	3,615	5,951	8,515	9,662
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,236,148	\$ 26,872,599	\$ 48,047,422	\$ 74,709,243	\$ 91,130,043
Claims	\$ 14,277,050	\$ 34,766,106	\$ 63,290,979	\$ 100,200,847	\$ 124,446,867
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 748,678	\$ 1,714,470	\$ 2,935,227	\$ 4,367,733	\$ 5,154,092
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 280,904	\$ 671,815	\$ 989,100	\$ 1,360,232	\$ 1,380,124
Loss Ratio	127%	129%	132%	134%	137%
Inherent Morbidity	254%	259%	263%	268%	273%
Gain/Loss of Pool	\$ (4,170,485)	\$ (10,279,792)	\$ (19,167,883)	\$ (31,219,569)	\$ (39,851,041)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,580	3,245	4,575	6,628	7,654
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 10,812,946	\$ 24,119,008	\$ 36,934,044	\$ 58,153,231	\$ 72,188,960
Claims	\$ 13,739,314	\$ 31,482,285	\$ 49,524,423	\$ 80,103,624	\$ 102,149,175
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 815,280	\$ 1,741,264	\$ 2,553,191	\$ 3,847,161	\$ 4,620,046
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 270,324	\$ 602,975	\$ 719,254	\$ 998,335	\$ 1,114,334
Loss Ratio	127%	131%	134%	138%	142%
Inherent Morbidity	254%	261%	268%	275%	283%
Gain/Loss of Pool	\$ (4,111,972)	\$ (9,707,516)	\$ (15,862,824)	\$ (26,795,890)	\$ (35,694,594)

**Florida High Risk Pool
Self-Funded HIPAA at Medicare Provider Reimbursement Levels
250% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,604	3,746	6,419	9,448	10,944
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 13,719,780	\$ 34,809,845	\$ 64,783,502	\$ 103,619,680	\$ 129,030,885
Claims	\$ 16,325,539	\$ 41,797,735	\$ 78,495,611	\$ 126,693,255	\$ 159,197,123
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 635,105	\$ 1,542,917	\$ 2,749,516	\$ 4,208,664	\$ 5,069,961
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 274,396	\$ 696,197	\$ 1,088,498	\$ 1,546,477	\$ 1,611,845
Loss Ratio	119%	120%	121%	122%	123%
Inherent Morbidity	297%	300%	303%	306%	308%
Gain/Loss of Pool	\$ (3,615,259)	\$ (9,227,004)	\$ (17,550,124)	\$ (28,828,716)	\$ (36,848,044)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,141	2,695	4,637	6,914	8,050
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 9,763,407	\$ 25,042,054	\$ 46,793,428	\$ 75,822,798	\$ 94,909,077
Claims	\$ 11,617,743	\$ 30,340,006	\$ 57,723,932	\$ 95,234,912	\$ 121,375,063
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 520,438	\$ 1,278,145	\$ 2,286,896	\$ 3,546,268	\$ 4,294,260
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 195,268	\$ 500,841	\$ 788,439	\$ 1,138,113	\$ 1,198,432
Loss Ratio	119%	121%	123%	126%	128%
Inherent Morbidity	297%	303%	308%	314%	320%
Gain/Loss of Pool	\$ (2,670,042)	\$ (7,076,938)	\$ (14,005,839)	\$ (24,096,495)	\$ (31,958,678)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,056	2,325	3,391	5,056	5,980
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 9,031,152	\$ 21,598,772	\$ 34,217,694	\$ 55,445,421	\$ 70,501,336
Claims	\$ 10,746,412	\$ 26,401,900	\$ 42,967,751	\$ 71,522,605	\$ 93,424,493
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 544,748	\$ 1,247,453	\$ 1,892,331	\$ 2,934,420	\$ 3,609,631
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 180,623	\$ 431,975	\$ 547,982	\$ 782,588	\$ 898,335
Loss Ratio	119%	122%	126%	129%	133%
Inherent Morbidity	297%	306%	314%	322%	331%
Gain/Loss of Pool	\$ (2,540,632)	\$ (6,482,556)	\$ (11,190,370)	\$ (19,794,192)	\$ (27,431,123)

**Florida High Risk Pool
Self-Funded HIPAA at Medicare Provider Reimbursement Levels
300% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,142	2,813	5,110	7,828	9,295
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Annual Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,725,100	\$ 31,362,310	\$ 61,885,532	\$ 103,015,611	\$ 131,501,147
Claims	\$ 12,982,280	\$ 35,040,699	\$ 69,772,477	\$ 117,200,198	\$ 150,968,082
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 452,307	\$ 1,158,424	\$ 2,188,768	\$ 3,486,774	\$ 4,305,853
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 195,418	\$ 522,705	\$ 883,883	\$ 1,322,068	\$ 1,420,489
Loss Ratio	111%	112%	113%	114%	115%
Inherent Morbidity	332%	335%	338%	341%	344%
Gain/Loss of Pool	\$ (2,004,906)	\$ (5,359,518)	\$ (10,959,595)	\$ (18,993,429)	\$ (25,193,277)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	791	1,946	3,533	5,423	6,525
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 8,121,234	\$ 21,694,874	\$ 42,787,598	\$ 71,369,055	\$ 92,311,045
Claims	\$ 8,992,004	\$ 24,457,772	\$ 49,113,740	\$ 83,410,434	\$ 109,847,314
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 360,752	\$ 922,754	\$ 1,742,602	\$ 2,781,637	\$ 3,480,591
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 135,354	\$ 361,581	\$ 610,933	\$ 916,341	\$ 1,005,312
Loss Ratio	111%	113%	115%	117%	119%
Inherent Morbidity	332%	338%	344%	351%	357%
Gain/Loss of Pool	\$ (1,466,875)	\$ (4,047,234)	\$ (8,679,677)	\$ (15,739,356)	\$ (22,022,172)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	686	1,547	2,385	3,660	4,445
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 7,038,403	\$ 17,247,424	\$ 28,881,629	\$ 48,174,112	\$ 62,886,900
Claims	\$ 7,793,070	\$ 19,617,535	\$ 33,746,413	\$ 57,823,639	\$ 77,542,115
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 353,790	\$ 830,115	\$ 1,331,027	\$ 2,124,658	\$ 2,683,147
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 117,307	\$ 287,457	\$ 392,793	\$ 585,753	\$ 688,202
Loss Ratio	111%	114%	117%	120%	123%
Inherent Morbidity	332%	341%	351%	360%	370%
Gain/Loss of Pool	\$ (1,325,763)	\$ (3,487,682)	\$ (6,588,604)	\$ (12,359,937)	\$ (18,026,563)

HIPAA – AII

Current FCHA Provider Reimbursement Levels

**Florida High Risk Pool
All HIPAA at Current FCHA Provider Reimbursement Levels
150% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	4,430	9,499	15,227	21,333	23,874
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 22,737,982	\$ 52,956,233	\$ 92,200,990	\$ 140,377,129	\$ 168,886,148
Claims	\$ 45,021,193	\$ 105,806,527	\$ 185,892,236	\$ 285,596,128	\$ 346,721,110
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 1,754,280	\$ 3,912,068	\$ 6,521,931	\$ 9,502,703	\$ 11,059,964
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 757,933	\$ 1,765,208	\$ 2,501,119	\$ 3,345,774	\$ 3,331,581
Loss Ratio	198%	200%	202%	203%	205%
Inherent Morbidity	297%	300%	302%	305%	308%
Gain/Loss of Pool	\$ (24,895,424)	\$ (58,527,570)	\$ (102,714,296)	\$ (158,067,476)	\$ (192,226,507)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	3,601	7,634	12,182	17,007	18,913
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 18,481,047	\$ 42,558,297	\$ 73,762,911	\$ 111,912,742	\$ 133,788,474
Claims	\$ 36,592,464	\$ 85,797,505	\$ 151,409,736	\$ 233,894,834	\$ 284,698,468
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 1,641,887	\$ 3,620,289	\$ 6,008,255	\$ 8,723,685	\$ 10,088,999
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 616,035	\$ 1,418,610	\$ 1,993,651	\$ 2,658,787	\$ 2,621,197
Loss Ratio	198%	202%	205%	209%	213%
Inherent Morbidity	297%	302%	308%	313%	319%
Gain/Loss of Pool	\$ (20,469,338)	\$ (48,278,107)	\$ (85,648,731)	\$ (133,364,563)	\$ (163,620,189)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,298	5,033	8,254	11,823	13,331
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,794,494	\$ 28,056,657	\$ 49,981,329	\$ 77,799,054	\$ 94,304,316
Claims	\$ 23,353,093	\$ 57,067,226	\$ 104,434,597	\$ 166,992,386	\$ 207,940,786
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 1,185,716	\$ 2,700,721	\$ 4,606,838	\$ 6,862,457	\$ 8,047,218
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 393,150	\$ 935,222	\$ 1,369,212	\$ 1,886,822	\$ 1,897,775
Loss Ratio	198%	203%	209%	215%	220%
Inherent Morbidity	297%	305%	313%	322%	331%
Gain/Loss of Pool	\$ (13,237,465)	\$ (32,646,512)	\$ (60,429,318)	\$ (97,942,610)	\$ (123,581,464)

**Florida High Risk Pool
All HIPAA at Current FCHA Provider Reimbursement Levels
200% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	3,546	7,859	12,894	18,476	20,923
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 24,267,535	\$ 58,417,804	\$ 104,099,259	\$ 162,103,022	\$ 197,347,456
Claims	\$ 46,229,678	\$ 112,297,665	\$ 201,931,204	\$ 317,305,209	\$ 389,805,459
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 1,404,216	\$ 3,236,651	\$ 5,522,676	\$ 8,230,063	\$ 9,692,872
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 606,688	\$ 1,460,445	\$ 2,144,425	\$ 2,949,334	\$ 2,987,810
Loss Ratio	191%	192%	194%	196%	198%
Inherent Morbidity	381%	384%	388%	391%	395%
Gain/Loss of Pool	\$ (24,073,048)	\$ (58,576,957)	\$ (105,499,046)	\$ (166,381,584)	\$ (205,138,685)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,736	6,025	9,919	14,192	16,103
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 18,726,913	\$ 44,787,664	\$ 80,079,037	\$ 124,515,406	\$ 151,883,405
Claims	\$ 35,674,788	\$ 86,871,828	\$ 158,148,373	\$ 250,376,930	\$ 310,961,687
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 1,247,797	\$ 2,857,450	\$ 4,892,044	\$ 7,279,554	\$ 8,590,154
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 468,173	\$ 1,119,692	\$ 1,648,501	\$ 2,267,054	\$ 2,300,207
Loss Ratio	191%	194%	197%	201%	205%
Inherent Morbidity	381%	388%	395%	402%	409%
Gain/Loss of Pool	\$ (18,763,846)	\$ (46,061,306)	\$ (84,609,881)	\$ (135,408,133)	\$ (169,968,643)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,580	3,605	6,100	8,838	10,205
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 10,812,946	\$ 26,798,898	\$ 49,245,392	\$ 77,537,641	\$ 96,251,947
Claims	\$ 20,598,672	\$ 52,444,253	\$ 98,999,346	\$ 160,127,185	\$ 204,196,251
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 815,280	\$ 1,934,737	\$ 3,404,254	\$ 5,129,549	\$ 6,160,061
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 270,324	\$ 669,972	\$ 1,027,038	\$ 1,432,334	\$ 1,485,779
Loss Ratio	191%	196%	201%	207%	212%
Inherent Morbidity	381%	391%	402%	413%	424%
Gain/Loss of Pool	\$ (10,971,330)	\$ (28,250,065)	\$ (54,185,246)	\$ (89,151,427)	\$ (115,590,144)

**Florida High Risk Pool
All HIPAA at Current FCHA Provider Reimbursement Levels
250% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,673	6,244	10,699	15,747	18,240
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 22,866,300	\$ 58,016,409	\$ 107,972,504	\$ 172,699,467	\$ 215,051,474
Claims	\$ 40,793,450	\$ 104,442,118	\$ 196,140,958	\$ 316,574,851	\$ 397,793,911
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 1,058,508	\$ 2,571,529	\$ 4,582,527	\$ 7,014,440	\$ 8,449,935
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 457,326	\$ 1,160,328	\$ 1,814,164	\$ 2,577,461	\$ 2,686,408
Loss Ratio	178%	180%	182%	183%	185%
Inherent Morbidity	446%	450%	454%	458%	462%
Gain/Loss of Pool	\$ (19,542,984)	\$ (50,157,566)	\$ (94,565,146)	\$ (153,467,285)	\$ (193,878,779)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,902	4,492	7,728	11,523	13,416
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 16,272,345	\$ 41,736,757	\$ 77,989,047	\$ 126,371,330	\$ 158,181,796
Claims	\$ 29,029,843	\$ 75,812,108	\$ 144,237,711	\$ 237,968,296	\$ 303,286,014
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 867,397	\$ 2,130,242	\$ 3,811,493	\$ 5,910,446	\$ 7,157,100
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 325,447	\$ 834,735	\$ 1,314,065	\$ 1,896,856	\$ 1,997,387
Loss Ratio	178%	182%	185%	188%	192%
Inherent Morbidity	446%	454%	462%	471%	479%
Gain/Loss of Pool	\$ (14,050,342)	\$ (37,040,328)	\$ (71,374,222)	\$ (119,404,268)	\$ (154,258,706)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,056	2,583	4,521	6,741	7,973
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 9,031,152	\$ 23,998,636	\$ 45,623,593	\$ 73,927,228	\$ 94,001,782
Claims	\$ 16,111,563	\$ 43,981,176	\$ 85,892,557	\$ 142,973,724	\$ 186,755,608
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 544,748	\$ 1,386,059	\$ 2,523,108	\$ 3,912,560	\$ 4,812,841
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 180,623	\$ 479,973	\$ 776,100	\$ 1,115,966	\$ 1,197,780
Loss Ratio	178%	183%	188%	193%	199%
Inherent Morbidity	446%	458%	471%	483%	497%
Gain/Loss of Pool	\$ (7,905,782)	\$ (21,848,572)	\$ (43,568,172)	\$ (74,075,022)	\$ (98,764,447)

**Florida High Risk Pool
All HIPAA at Current FCHA Provider Reimbursement Levels
300% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,904	4,688	8,517	13,046	15,491
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 19,541,833	\$ 52,270,517	\$ 103,142,554	\$ 171,692,684	\$ 219,168,578
Claims	\$ 32,439,480	\$ 87,557,969	\$ 174,344,020	\$ 292,854,067	\$ 377,231,589
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 753,845	\$ 1,930,706	\$ 3,647,947	\$ 5,811,290	\$ 7,176,422
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 325,697	\$ 871,175	\$ 1,473,138	\$ 2,203,446	\$ 2,367,481
Loss Ratio	166%	168%	169%	171%	172%
Inherent Morbidity	498%	503%	507%	512%	516%
Gain/Loss of Pool	\$ (14,077,190)	\$ (38,089,333)	\$ (76,322,551)	\$ (129,176,120)	\$ (167,606,914)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,319	3,243	5,889	9,038	10,874
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 13,535,391	\$ 36,158,123	\$ 71,312,663	\$ 118,948,425	\$ 153,851,742
Claims	\$ 22,468,775	\$ 61,113,872	\$ 122,722,988	\$ 208,421,875	\$ 274,481,044
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 601,253	\$ 1,537,924	\$ 2,904,337	\$ 4,636,061	\$ 5,800,986
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 225,590	\$ 602,635	\$ 1,018,222	\$ 1,527,234	\$ 1,675,521
Loss Ratio	166%	169%	172%	175%	178%
Inherent Morbidity	498%	507%	516%	526%	535%
Gain/Loss of Pool	\$ (9,860,227)	\$ (27,096,309)	\$ (55,332,883)	\$ (95,636,745)	\$ (128,105,808)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	686	1,719	3,180	4,881	5,927
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 7,038,403	\$ 19,163,805	\$ 38,508,838	\$ 64,232,150	\$ 83,849,200
Claims	\$ 11,683,763	\$ 32,679,552	\$ 67,459,097	\$ 115,589,483	\$ 155,006,726
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 353,790	\$ 922,350	\$ 1,774,703	\$ 2,832,877	\$ 3,577,529
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 117,307	\$ 319,397	\$ 553,246	\$ 829,259	\$ 917,602
Loss Ratio	166%	171%	175%	180%	185%
Inherent Morbidity	498%	512%	526%	540%	555%
Gain/Loss of Pool	\$ (5,216,456)	\$ (14,757,493)	\$ (31,278,207)	\$ (55,019,469)	\$ (75,652,657)

HIPAA – AII

Medicare Provider Reimbursement Levels

**Florida High Risk Pool
All HIPAA at Medicare Provider Reimbursement Levels
150% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	4,430	9,499	15,227	21,333	23,874
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 22,737,982	\$ 52,956,233	\$ 92,200,990	\$ 140,377,129	\$ 168,886,148
Claims	\$ 30,029,136	\$ 70,572,954	\$ 123,990,121	\$ 190,492,617	\$ 231,262,980
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 1,754,280	\$ 3,912,068	\$ 6,521,931	\$ 9,502,703	\$ 11,059,964
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 757,933	\$ 1,765,208	\$ 2,501,119	\$ 3,345,774	\$ 3,331,581
Loss Ratio	132%	133%	134%	136%	137%
Inherent Morbidity	198%	200%	202%	204%	205%
Gain/Loss of Pool	\$ (9,903,366)	\$ (23,293,996)	\$ (40,812,182)	\$ (62,963,966)	\$ (76,768,378)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	3,601	7,634	12,182	17,007	18,913
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 18,481,047	\$ 42,558,297	\$ 73,762,911	\$ 111,912,742	\$ 133,788,474
Claims	\$ 24,407,173	\$ 57,226,936	\$ 100,990,294	\$ 156,007,854	\$ 189,893,878
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 1,641,887	\$ 3,620,289	\$ 6,008,255	\$ 8,723,685	\$ 10,088,999
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 616,035	\$ 1,418,610	\$ 1,993,651	\$ 2,658,787	\$ 2,621,197
Loss Ratio	132%	134%	137%	139%	142%
Inherent Morbidity	198%	202%	205%	209%	213%
Gain/Loss of Pool	\$ (8,284,048)	\$ (19,707,538)	\$ (35,229,288)	\$ (55,477,584)	\$ (68,815,600)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,298	5,033	8,254	11,823	13,331
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 5,133	\$ 5,575	\$ 6,055	\$ 6,580	\$ 7,074
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 11,794,494	\$ 28,056,657	\$ 49,981,329	\$ 77,799,054	\$ 94,304,316
Claims	\$ 15,576,513	\$ 38,063,840	\$ 69,657,876	\$ 111,383,921	\$ 138,696,504
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 1,185,716	\$ 2,700,721	\$ 4,606,838	\$ 6,862,457	\$ 8,047,218
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	3.3%	3.3%	3.3%	3.3%	3.3%
Commission Expenses	\$ 393,150	\$ 935,222	\$ 1,369,212	\$ 1,886,822	\$ 1,897,775
Loss Ratio	132%	136%	139%	143%	147%
Inherent Morbidity	198%	204%	209%	215%	221%
Gain/Loss of Pool	\$ (5,460,885)	\$ (13,643,126)	\$ (25,652,597)	\$ (42,334,146)	\$ (54,337,182)

**Florida High Risk Pool
All HIPAA at Medicare Provider Reimbursement Levels
200% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	3,546	7,859	12,894	18,476	20,923
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 24,267,535	\$ 58,417,804	\$ 104,099,259	\$ 162,103,022	\$ 197,347,456
Claims	\$ 30,835,196	\$ 74,902,543	\$ 134,688,113	\$ 211,642,574	\$ 260,000,241
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 1,404,216	\$ 3,236,651	\$ 5,522,676	\$ 8,230,063	\$ 9,692,872
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 606,688	\$ 1,460,445	\$ 2,144,425	\$ 2,949,334	\$ 2,987,810
Loss Ratio	127%	128%	129%	131%	132%
Inherent Morbidity	254%	256%	259%	261%	263%
Gain/Loss of Pool	\$ (8,678,565)	\$ (21,181,835)	\$ (38,255,955)	\$ (60,718,950)	\$ (75,333,467)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,736	6,025	9,919	14,192	16,103
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 18,726,913	\$ 44,787,664	\$ 80,079,037	\$ 124,515,406	\$ 151,883,405
Claims	\$ 23,795,084	\$ 57,943,509	\$ 105,484,965	\$ 167,001,412	\$ 207,411,445
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 1,247,797	\$ 2,857,450	\$ 4,892,044	\$ 7,279,554	\$ 8,590,154
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 468,173	\$ 1,119,692	\$ 1,648,501	\$ 2,267,054	\$ 2,300,207
Loss Ratio	127%	129%	132%	134%	137%
Inherent Morbidity	254%	259%	263%	268%	273%
Gain/Loss of Pool	\$ (6,884,141)	\$ (17,132,987)	\$ (31,946,472)	\$ (52,032,615)	\$ (66,418,402)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,580	3,605	6,100	8,838	10,205
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 6,844	\$ 7,433	\$ 8,073	\$ 8,774	\$ 9,432
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 10,812,946	\$ 26,798,898	\$ 49,245,392	\$ 77,537,641	\$ 96,251,947
Claims	\$ 13,739,314	\$ 34,980,317	\$ 66,032,564	\$ 106,804,832	\$ 136,198,899
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 815,280	\$ 1,934,737	\$ 3,404,254	\$ 5,129,549	\$ 6,160,061
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.5%	2.5%	2.5%	2.5%	2.5%
Commission Expenses	\$ 270,324	\$ 669,972	\$ 1,027,038	\$ 1,432,334	\$ 1,485,779
Loss Ratio	127%	131%	134%	138%	142%
Inherent Morbidity	254%	261%	268%	275%	283%
Gain/Loss of Pool	\$ (4,111,972)	\$ (10,786,129)	\$ (21,218,464)	\$ (35,829,074)	\$ (47,592,792)

**Florida High Risk Pool
All HIPAA at Medicare Provider Reimbursement Levels
250% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	2,673	6,244	10,699	15,747	18,240
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 22,866,300	\$ 58,016,409	\$ 107,972,504	\$ 172,699,467	\$ 215,051,474
Claims	\$ 27,209,231	\$ 69,662,892	\$ 130,826,019	\$ 211,155,426	\$ 265,328,538
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 1,058,508	\$ 2,571,529	\$ 4,582,527	\$ 7,014,440	\$ 8,449,935
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 457,326	\$ 1,160,328	\$ 1,814,164	\$ 2,577,461	\$ 2,686,408
Loss Ratio	119%	120%	121%	122%	123%
Inherent Morbidity	297%	300%	303%	306%	308%
Gain/Loss of Pool	\$ (5,958,765)	\$ (15,378,341)	\$ (29,250,206)	\$ (48,047,859)	\$ (61,413,407)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,902	4,492	7,728	11,523	13,416
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 16,272,345	\$ 41,736,757	\$ 77,989,047	\$ 126,371,330	\$ 158,181,796
Claims	\$ 19,362,905	\$ 50,566,676	\$ 96,206,553	\$ 158,724,853	\$ 202,291,771
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 867,397	\$ 2,130,242	\$ 3,811,493	\$ 5,910,446	\$ 7,157,100
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 325,447	\$ 834,735	\$ 1,314,065	\$ 1,896,856	\$ 1,997,387
Loss Ratio	119%	121%	123%	126%	128%
Inherent Morbidity	297%	303%	308%	314%	320%
Gain/Loss of Pool	\$ (4,383,404)	\$ (11,794,896)	\$ (23,343,064)	\$ (40,160,825)	\$ (53,264,463)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,056	2,583	4,521	6,741	7,973
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 8,555	\$ 9,292	\$ 10,092	\$ 10,967	\$ 11,790
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 9,031,152	\$ 23,998,636	\$ 45,623,593	\$ 73,927,228	\$ 94,001,782
Claims	\$ 10,746,412	\$ 29,335,445	\$ 57,290,335	\$ 95,363,474	\$ 124,565,990
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 544,748	\$ 1,386,059	\$ 2,523,108	\$ 3,912,560	\$ 4,812,841
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	2.0%	2.0%	2.0%	2.0%	2.0%
Commission Expenses	\$ 180,623	\$ 479,973	\$ 776,100	\$ 1,115,966	\$ 1,197,780
Loss Ratio	119%	122%	126%	129%	133%
Inherent Morbidity	297%	306%	314%	322%	331%
Gain/Loss of Pool	\$ (2,540,632)	\$ (7,202,841)	\$ (14,965,950)	\$ (26,464,772)	\$ (36,574,830)

**Florida High Risk Pool
All HIPAA at Medicare Provider Reimbursement Levels
300% of Standard Individual Rate**

High Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,904	4,688	8,517	13,046	15,491
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 19,541,833	\$ 52,270,517	\$ 103,142,554	\$ 171,692,684	\$ 219,168,578
Claims	\$ 21,637,133	\$ 58,401,165	\$ 116,287,461	\$ 195,333,663	\$ 251,613,470
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 753,845	\$ 1,930,706	\$ 3,647,947	\$ 5,811,290	\$ 7,176,422
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 325,697	\$ 871,175	\$ 1,473,138	\$ 2,203,446	\$ 2,367,481
Loss Ratio	111%	112%	113%	114%	115%
Inherent Morbidity	332%	335%	338%	341%	344%
Gain/Loss of Pool	\$ (3,274,843)	\$ (8,932,529)	\$ (18,265,992)	\$ (31,655,715)	\$ (41,988,795)

Expected Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	1,319	3,243	5,889	9,038	10,874
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 13,535,391	\$ 36,158,123	\$ 71,312,663	\$ 118,948,425	\$ 153,851,742
Claims	\$ 14,986,673	\$ 40,762,953	\$ 81,856,233	\$ 139,017,391	\$ 183,078,856
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 601,253	\$ 1,537,924	\$ 2,904,337	\$ 4,636,061	\$ 5,800,986
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 225,590	\$ 602,635	\$ 1,018,222	\$ 1,527,234	\$ 1,675,521
Loss Ratio	111%	113%	115%	117%	119%
Inherent Morbidity	332%	338%	344%	351%	357%
Gain/Loss of Pool	\$ (2,378,125)	\$ (6,745,389)	\$ (14,466,128)	\$ (26,232,260)	\$ (36,703,620)

Low Enrollment Scenario

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	686	1,719	3,180	4,881	5,927
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 10,265	\$ 11,150	\$ 12,110	\$ 13,161	\$ 14,148
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 7,038,403	\$ 19,163,805	\$ 38,508,838	\$ 64,232,150	\$ 83,849,200
Claims	\$ 7,793,070	\$ 21,797,261	\$ 44,995,218	\$ 77,098,185	\$ 103,389,486
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 353,790	\$ 922,350	\$ 1,774,703	\$ 2,832,877	\$ 3,577,529
Start Up Costs	\$ 100,000	\$ -	\$ -	\$ -	\$ -
Commission %	1.7%	1.7%	1.7%	1.7%	1.7%
Commission Expenses	\$ 117,307	\$ 319,397	\$ 553,246	\$ 829,259	\$ 917,602
Loss Ratio	111%	114%	117%	120%	123%
Inherent Morbidity	332%	341%	351%	360%	370%
Gain/Loss of Pool	\$ (1,325,763)	\$ (3,875,202)	\$ (8,814,328)	\$ (16,528,172)	\$ (24,035,418)

California Modeling

California Model Analysis - Expected Enrollment Scenario

Assumptions: California model requires carriers to bid a loss ratio; losses above the bid ratio are the carriers' responsibility
 Florida carriers will be interested in this process
 Two analyses - bid loss ratio is 175% and 200%
 Bids will only apply to new members; state retains losses on current FHCA members
 Expected Enrollment Scenarios used

150% Cap					
Self Funded HIPAA Eligibles; Current FCHA Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (12,321,603)	\$ (28,966,864)	\$ (51,389,238)	\$ (80,018,738)	\$ (98,172,114)
Premium	11,088,628	25,534,978	44,257,747	67,147,645	80,273,084
Claims	21,955,478	51,478,503	90,845,842	140,336,901	170,819,081
L/R	198%	202%	205%	209%	213%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	19,405,099	44,686,212	77,451,057	117,508,380	140,477,898
Losses of Pool	(9,771,224)	(22,174,573)	(37,994,453)	(57,190,217)	(67,830,931)
Savings to Pool	\$ 2,550,379	\$ 6,792,291	\$ 13,394,785	\$ 22,828,521	\$ 30,341,183
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	\$ 22,177,256	51,069,957	88,515,493	134,295,291	160,546,169
Losses of Pool	(12,321,603)	\$ (28,558,318)	\$ (49,058,890)	\$ (73,977,128)	\$ (87,899,202)
Savings to Pool	\$ -	\$ 408,546	\$ 2,330,348	\$ 6,041,610	\$ 10,272,912

200% Cap					
Self Funded HIPAA Eligibles; Current FCHA Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (11,298,307)	\$ (27,636,783)	\$ (50,765,928)	\$ (81,244,880)	\$ (101,981,186)
Premium	11,236,148	26,872,599	48,047,422	74,709,243	91,130,043
Claims	21,404,873	52,123,097	94,889,024	150,226,158	186,577,012
L/R	191%	194%	197%	201%	205%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	19,663,259	47,027,047	84,082,989	130,741,176	159,477,575
Losses of Pool	(9,556,693)	(22,540,734)	(39,959,894)	(61,759,898)	(74,881,749)
Savings to Pool	\$ 1,741,614	\$ 5,096,049	\$ 10,806,035	\$ 19,484,982	\$ 27,099,437
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	22,472,296	53,745,197	96,094,845	149,418,487	182,260,086
Losses of Pool	\$ (11,298,307)	\$ (27,636,783)	\$ (50,765,928)	\$ (80,437,208)	\$ (97,664,260)
Savings to Pool	\$ -	\$ -	\$ -	\$ 807,671	\$ 4,316,926

250% Cap					
Self Funded HIPAA Eligibles; Current FCHA Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (8,470,205)	\$ (22,224,197)	\$ (42,824,533)	\$ (71,642,561)	\$ (92,555,224)
Premium	9,763,407	25,042,054	46,793,428	75,822,798	94,909,077
Claims	17,417,906	45,487,265	86,542,627	142,780,978	181,971,609
L/R	178%	182%	185%	188%	192%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	17,085,963	43,823,595	81,888,500	132,689,897	166,090,886
Losses of Pool	(8,138,262)	(20,560,527)	(38,170,406)	(61,551,480)	(76,674,501)
Savings to Pool	\$ 331,943	\$ 1,663,670	\$ 4,654,127	\$ 10,091,081	\$ 15,880,723
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	19,526,814	50,084,109	93,586,857	151,645,596	189,818,155
Losses of Pool	\$ (8,470,205)	\$ (22,224,197)	\$ (42,824,533)	\$ (71,642,561)	\$ (92,555,224)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -

300% Cap					
Self Funded HIPAA Eligibles; Current FCHA Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (5,956,136)	\$ (16,257,785)	\$ (33,199,730)	\$ (57,382,047)	\$ (76,863,485)
Premium	8,121,234	21,694,874	42,787,598	71,369,055	92,311,045
Claims	13,481,265	36,668,323	73,633,793	125,053,125	164,688,627
L/R	166%	169%	172%	175%	178%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	14,212,160	37,966,029	74,878,297	124,895,847	161,544,329
Losses of Pool	(5,956,136)	(16,257,785)	(33,199,730)	(57,224,769)	(73,719,188)
Savings to Pool	\$ -	\$ -	\$ -	\$ 157,278	\$ 3,144,297
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	16,242,469	43,389,747	85,575,196	142,738,111	184,622,091
Losses of Pool	\$ (5,956,136)	\$ (16,257,785)	\$ (33,199,730)	\$ (57,382,047)	\$ (76,863,485)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -

California Model Analysis - Expected Enrollment Scenario

Assumptions: California model requires carriers to bid a loss ratio; losses above the bid ratio are the carriers' responsibility
 Florida carriers will be interested in this process
 Two analyses - bid loss ratio is 175% and 200%
 Bids will only apply to new members; state retains losses on current FHCA members
 Expected Enrollment Scenarios used

150% Cap					
Self Funded HIPAA Eligibles; Medicare Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (5,010,429)	\$ (11,824,523)	\$ (21,137,573)	\$ (33,286,550)	\$ (41,289,360)
Premium	11,088,628	25,534,978	44,257,747	67,147,645	80,273,084
Claims	14,644,304	34,336,162	60,594,176	93,604,713	113,936,327
L/R	132%	134%	137%	139%	142%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	19,405,099	44,686,212	77,451,057	117,508,380	140,477,898
Losses of Pool	(5,010,429)	(11,824,523)	(21,137,573)	(33,286,550)	(41,289,360)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	\$ 22,177,256	51,069,957	88,515,493	134,295,291	160,546,169
Losses of Pool	(5,010,429)	(11,824,523)	(21,137,573)	(33,286,550)	(41,289,360)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
200% Cap					
Self Funded HIPAA Eligibles; Medicare Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (4,170,485)	\$ (10,279,792)	\$ (19,167,883)	\$ (31,219,569)	\$ (39,851,041)
Premium	11,236,148	26,872,599	48,047,422	74,709,243	91,130,043
Claims	14,277,050	34,766,106	63,290,979	100,200,847	124,446,867
L/R	127%	129%	132%	134%	137%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	19,663,259	47,027,047	84,082,989	130,741,176	159,477,575
Losses of Pool	(4,170,485)	(10,279,792)	(19,167,883)	(31,219,569)	(39,851,041)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	22,472,296	53,745,197	96,094,845	149,418,487	182,260,086
Losses of Pool	(4,170,485)	(10,279,792)	(19,167,883)	(31,219,569)	(39,851,041)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
250% Cap					
Self Funded HIPAA Eligibles; Medicare Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (2,670,042)	\$ (7,076,938)	\$ (14,005,839)	\$ (24,096,495)	\$ (31,958,678)
Premium	9,763,407	25,042,054	46,793,428	75,822,798	94,909,077
Claims	11,617,743	30,340,006	57,723,932	95,234,912	121,375,063
L/R	119%	121%	123%	126%	128%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	17,085,963	43,823,595	81,888,500	132,689,897	166,090,886
Losses of Pool	(2,670,042)	(7,076,938)	(14,005,839)	(24,096,495)	(31,958,678)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	19,526,814	50,084,109	93,586,857	151,645,596	189,818,155
Losses of Pool	(2,670,042)	(7,076,938)	(14,005,839)	(24,096,495)	(31,958,678)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
300% Cap					
Self Funded HIPAA Eligibles; Medicare Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (1,466,875)	\$ (4,047,234)	\$ (8,679,677)	\$ (15,739,356)	\$ (22,022,172)
Premium	8,121,234	21,694,874	42,787,598	71,369,055	92,311,045
Claims	8,992,004	24,457,772	49,113,740	83,410,434	109,847,314
L/R	111%	113%	115%	117%	119%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	14,212,160	37,966,029	74,878,297	124,895,847	161,544,329
Losses of Pool	(1,466,875)	(4,047,234)	(8,679,677)	(15,739,356)	(22,022,172)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	16,242,469	43,389,747	85,575,196	142,738,111	184,622,091
Losses of Pool	(1,466,875)	(4,047,234)	(8,679,677)	(15,739,356)	(22,022,172)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -

California Model Analysis - Expected Enrollment Scenario

Assumptions: California model requires carriers to bid a loss ratio; losses above the bid ratio are the carriers' responsibility
 Florida carriers will be interested in this process
 Two analyses - bid loss ratio is 175% and 200%
 Bids will only apply to new members; state retains losses on current FHCA members
 Expected Enrollment Scenarios used

150% Cap					
All HIPAA Eligible; Current FCHA Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (20,469,338)	\$ (48,278,107)	\$ (85,648,731)	\$ (133,364,563)	\$ (163,620,189)
Premium	18,481,047	42,558,297	73,762,911	111,912,742	133,788,474
Claims	36,592,464	85,797,505	151,409,736	233,894,834	284,698,468
L/R	198%	202%	205%	209%	213%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	32,341,832	74,477,020	129,085,095	195,847,299	234,129,830
Losses of Pool	(16,218,707)	(36,957,622)	(63,324,089)	(95,317,028)	(113,051,551)
Savings to Pool	\$ 4,250,631	\$ 11,320,485	\$ 22,324,642	\$ 38,047,535	\$ 50,568,638
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	\$ 36,962,094	85,116,595	147,525,822	223,825,485	267,576,948
Losses of Pool	(20,469,338)	(47,597,196)	(81,764,817)	(123,295,214)	(146,498,670)
Savings to Pool	\$ -	\$ 680,911	\$ 3,883,914	\$ 10,069,349	\$ 17,121,520

200% Cap					
All HIPAA Eligible; Current FCHA Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (18,763,846)	\$ (46,061,306)	\$ (84,609,881)	\$ (135,408,133)	\$ (169,968,643)
Premium	18,726,913	44,787,664	80,079,037	124,515,406	151,883,405
Claims	35,674,788	86,871,828	158,148,373	250,376,930	310,961,687
L/R	191%	194%	197%	201%	205%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	32,772,098	78,378,412	140,138,315	217,901,960	265,795,959
Losses of Pool	(15,861,155)	(37,567,890)	(66,599,823)	(102,933,163)	(124,802,915)
Savings to Pool	\$ 2,902,690	\$ 8,493,416	\$ 18,010,058	\$ 32,474,970	\$ 45,165,729
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	37,453,826	89,575,328	160,158,075	249,030,811	303,766,810
Losses of Pool	(18,763,846)	(46,061,306)	(84,609,881)	(134,062,014)	(162,773,766)
Savings to Pool	\$ -	\$ -	\$ -	\$ 1,346,119	\$ 7,194,877

250% Cap					
All HIPAA Eligible; Current FCHA Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (14,050,342)	\$ (37,040,328)	\$ (71,374,222)	\$ (119,404,268)	\$ (154,258,706)
Premium	16,272,345	41,736,757	77,989,047	126,371,330	158,181,796
Claims	29,029,843	75,812,108	144,237,711	237,968,296	303,286,014
L/R	178%	182%	185%	188%	192%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	28,476,604	73,039,325	136,480,833	221,149,828	276,818,143
Losses of Pool	(13,497,103)	(34,267,545)	(63,617,344)	(102,585,799)	(127,790,834)
Savings to Pool	\$ 553,238	\$ 2,772,783	\$ 7,756,878	\$ 16,818,468	\$ 26,467,872
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	32,544,691	83,473,515	155,978,095	252,742,660	316,363,592
Losses of Pool	(14,050,342)	(37,040,328)	(71,374,222)	(119,404,268)	(154,258,706)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -

300% Cap					
All HIPAA Eligible; Current FCHA Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (9,860,227)	\$ (27,096,309)	\$ (55,332,883)	\$ (95,636,745)	\$ (128,105,808)
Premium	13,535,391	36,158,123	71,312,663	118,948,425	153,851,742
Claims	22,468,775	61,113,872	122,722,988	208,421,875	274,481,044
L/R	166%	169%	172%	175%	178%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	23,686,934	63,276,715	124,797,161	208,159,745	269,240,549
Losses of Pool	(9,860,227)	(27,096,309)	(55,332,883)	(95,374,614)	(122,865,313)
Savings to Pool	\$ -	\$ -	\$ -	\$ 262,130	\$ 5,240,495
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	27,070,782	72,316,245	142,625,327	237,896,851	307,703,488
Losses of Pool	(9,860,227)	(27,096,309)	(55,332,883)	(95,636,745)	(128,105,808)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -

California Model Analysis - Expected Enrollment Scenario

Assumptions: California model requires carriers to bid a loss ratio; losses above the bid ratio are the carriers' responsibility
 Florida carriers will be interested in this process
 Two analyses - bid loss ratio is 175% and 200%
 Bids will only apply to new members; state retains losses on current FHCA members
 Expected Enrollment Scenarios used

150% Cap					
All HIPAA Eligible; Medicare Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (8,284,048)	\$ (19,707,538)	\$ (35,229,288)	\$ (55,477,584)	\$ (68,815,600)
Premium	18,481,047	42,558,297	73,762,911	111,912,742	133,788,474
Claims	24,407,173	57,226,936	100,990,294	156,007,854	189,893,878
L/R	132%	134%	137%	139%	142%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	32,341,832	74,477,020	129,085,095	195,847,299	234,129,830
Losses of Pool	(8,284,048)	(19,707,538)	(35,229,288)	(55,477,584)	(68,815,600)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	\$ 36,962,094	85,116,595	147,525,822	223,825,485	267,576,948
Losses of Pool	(8,284,048)	(19,707,538)	(35,229,288)	(55,477,584)	(68,815,600)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -

200% Cap					
All HIPAA Eligible; Medicare Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (6,884,141)	\$ (17,132,987)	\$ (31,946,472)	\$ (52,032,615)	\$ (66,418,402)
Premium	18,726,913	44,787,664	80,079,037	124,515,406	151,883,405
Claims	23,795,084	57,943,509	105,484,965	167,001,412	207,411,445
L/R	127%	129%	132%	134%	137%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	32,772,098	78,378,412	140,138,315	217,901,960	265,795,959
Losses of Pool	(6,884,141)	(17,132,987)	(31,946,472)	(52,032,615)	(66,418,402)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	37,453,826	89,575,328	160,158,075	249,030,811	303,766,810
Losses of Pool	(6,884,141)	(17,132,987)	(31,946,472)	(52,032,615)	(66,418,402)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -

250% Cap					
All HIPAA Eligible; Medicare Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (4,383,404)	\$ (11,794,896)	\$ (23,343,064)	\$ (40,160,825)	\$ (53,264,463)
Premium	16,272,345	41,736,757	77,989,047	126,371,330	158,181,796
Claims	19,362,905	50,566,676	96,206,553	158,724,853	202,291,771
L/R	119%	121%	123%	126%	128%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	28,476,604	73,039,325	136,480,833	221,149,828	276,818,143
Losses of Pool	(4,383,404)	(11,794,896)	(23,343,064)	(40,160,825)	(53,264,463)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	32,544,691	83,473,515	155,978,095	252,742,660	316,363,592
Losses of Pool	(4,383,404)	(11,794,896)	(23,343,064)	(40,160,825)	(53,264,463)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -

300% Cap					
All HIPAA Eligible; Medicare Provider Reimbursement Levels					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Losses of Pool	\$ (2,378,125)	\$ (6,745,389)	\$ (14,466,128)	\$ (26,232,260)	\$ (36,703,620)
Premium	13,535,391	36,158,123	71,312,663	118,948,425	153,851,742
Claims	14,986,673	40,762,953	81,856,233	139,017,391	183,078,856
L/R	111%	113%	115%	117%	119%
Bid L/R	175%	175%	175%	175%	175%
Claims of Pool	23,686,934	63,276,715	124,797,161	208,159,745	269,240,549
Losses of Pool	(2,378,125)	(6,745,389)	(14,466,128)	(26,232,260)	(36,703,620)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -
Bid L/R	200%	200%	200%	200%	200%
Claims of Pool	27,070,782	72,316,245	142,625,327	237,896,851	307,703,485
Losses of Pool	(2,378,125)	(6,745,389)	(14,466,128)	(26,232,260)	(36,703,620)
Savings to Pool	\$ -	\$ -	\$ -	\$ -	\$ -

Assessment

HIPAA Self-Funded

Current FCHA Provider Reimbursement Levels

**Florida High Risk Pool
HIPAA Self Funded Eligible at Current FCHA Reimbursement Level
150% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (14,977,254)	\$ (35,116,542)	\$ (61,628,578)	\$ (94,840,486)	\$ (115,335,904)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.09%	0.19%	0.30%	0.41%	0.44%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	2.50	5.73	9.81	14.72	17.47
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	10.41	23.82	40.79	61.24	72.66
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (12,321,603)	\$ (28,966,864)	\$ (51,389,238)	\$ (80,018,738)	\$ (98,172,114)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.08%	0.16%	0.25%	0.35%	0.38%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	2.06	4.72	8.18	12.42	14.87
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	8.57	19.65	34.01	51.67	61.85
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (13,237,465)	\$ (29,381,861)	\$ (45,247,781)	\$ (73,350,986)	\$ (92,686,098)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.08%	0.16%	0.22%	0.32%	0.36%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	2.21	4.79	7.20	11.39	14.04
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	9.21	19.93	29.95	47.36	58.39

**Florida High Risk Pool
HIPAA Self Funded Eligible at Current FCHA Reimbursement Level
200% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (14,483,829)	\$ (35,146,174)	\$ (63,299,428)	\$ (99,828,951)	\$ (123,083,211)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.09%	0.19%	0.31%	0.43%	0.47%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	2.42	5.73	10.07	15.50	18.65
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	10.07	23.84	41.90	64.46	77.54
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (11,298,307)	\$ (27,636,783)	\$ (50,765,928)	\$ (81,244,880)	\$ (101,981,186)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.07%	0.15%	0.25%	0.35%	0.39%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.89	4.51	8.08	12.61	15.45
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	7.86	18.75	33.60	52.46	64.25
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (10,971,330)	\$ (25,425,058)	\$ (40,587,910)	\$ (66,787,654)	\$ (86,692,608)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.07%	0.14%	0.20%	0.29%	0.33%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.83	4.15	6.46	10.37	13.13
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	7.63	17.25	26.86	43.13	54.61

**Florida High Risk Pool
HIPAA Self Funded Eligible at Current FCHA Reimbursement Level
250% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (11,765,790)	\$ (30,094,540)	\$ (56,739,087)	\$ (92,080,371)	\$ (116,327,268)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.07%	0.17%	0.28%	0.40%	0.45%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.97	4.91	9.03	14.30	17.62
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	8.18	20.42	37.55	59.46	73.28
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (8,470,205)	\$ (22,224,197)	\$ (42,824,533)	\$ (71,642,561)	\$ (92,555,224)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.05%	0.12%	0.21%	0.31%	0.36%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.42	3.62	6.81	11.12	14.02
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	5.89	15.08	28.34	46.26	58.31
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (7,905,782)	\$ (19,663,715)	\$ (32,642,036)	\$ (55,501,880)	\$ (74,073,336)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.05%	0.11%	0.16%	0.24%	0.29%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.32	3.21	5.19	8.62	11.22
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	5.50	13.34	21.60	35.84	46.66

**Florida High Risk Pool
HIPAA Self Funded Eligible at Current FCHA Reimbursement Level
300% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (8,486,314)	\$ (22,853,600)	\$ (45,793,530)	\$ (77,505,672)	\$ (100,564,149)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.05%	0.13%	0.22%	0.34%	0.39%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.42	3.73	7.29	12.03	15.24
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	5.90	15.50	30.31	50.05	63.35
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (5,956,136)	\$ (16,257,785)	\$ (33,199,730)	\$ (57,382,047)	\$ (76,863,485)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.04%	0.09%	0.16%	0.25%	0.30%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.00	2.65	5.28	8.91	11.64
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	4.14	11.03	21.97	37.05	48.42
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (5,216,456)	\$ (13,281,744)	\$ (23,436,513)	\$ (41,228,410)	\$ (56,739,493)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.07%	0.11%	0.18%	0.22%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.87	2.17	3.73	6.40	8.60
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	3.63	9.01	15.51	26.62	35.74

Assessment

HIPAA Self-Funded

Medicare Provider Reimbursement Levels

**Florida High Risk Pool
HIPAA Self Funded Eligible at Medicare Provider Reimbursement Level
150% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (5,982,020)	\$ (13,976,398)	\$ (24,487,309)	\$ (37,778,379)	\$ (46,061,027)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.04%	0.08%	0.12%	0.16%	0.18%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.00	2.28	3.90	5.87	6.98
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	4.16	9.48	16.21	24.39	29.02
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (5,010,429)	\$ (11,824,523)	\$ (21,137,573)	\$ (33,286,550)	\$ (41,289,360)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.07%	0.10%	0.14%	0.16%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.84	1.93	3.36	5.17	6.26
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	3.48	8.02	13.99	21.49	26.01
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (5,460,885)	\$ (12,278,813)	\$ (19,165,240)	\$ (31,644,637)	\$ (40,752,887)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.07%	0.09%	0.14%	0.16%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.91	2.00	3.05	4.91	6.17
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	3.80	8.33	12.68	20.43	25.67

**Florida High Risk Pool
HIPAA Self Funded Eligible at Medicare Provider Reimbursement Level
200% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (5,247,139)	\$ (12,709,101)	\$ (22,953,573)	\$ (36,431,370)	\$ (45,200,080)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.07%	0.11%	0.16%	0.17%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.88	2.07	3.65	5.66	6.85
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	3.65	8.62	15.19	23.52	28.48
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (4,170,485)	\$ (10,279,792)	\$ (19,167,883)	\$ (31,219,569)	\$ (39,851,041)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.06%	0.09%	0.14%	0.15%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.70	1.68	3.05	4.85	6.04
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	2.90	6.97	12.69	20.16	25.11
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (4,111,972)	\$ (9,707,516)	\$ (15,862,824)	\$ (26,795,890)	\$ (35,694,594)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.05%	0.08%	0.12%	0.14%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.69	1.58	2.52	4.16	5.41
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	2.86	6.59	10.50	17.30	22.49

**Florida High Risk Pool
HIPAA Self Funded Eligible at Medicare Provider Reimbursement Level
250% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (3,615,259)	\$ (9,227,004)	\$ (17,550,124)	\$ (28,828,716)	\$ (36,848,044)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.02%	0.05%	0.09%	0.13%	0.14%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.60	1.50	2.79	4.48	5.58
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	2.51	6.26	11.62	18.62	23.21
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (2,670,042)	\$ (7,076,938)	\$ (14,005,839)	\$ (24,096,495)	\$ (31,958,678)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.02%	0.04%	0.07%	0.10%	0.12%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.45	1.15	2.23	3.74	4.84
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	1.86	4.80	9.27	15.56	20.13
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (2,540,632)	\$ (6,482,556)	\$ (11,190,370)	\$ (19,794,192)	\$ (27,431,123)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.02%	0.04%	0.05%	0.09%	0.11%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.42	1.06	1.78	3.07	4.16
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	1.77	4.40	7.41	12.78	17.28

**Florida High Risk Pool
HIPAA Self Funded Eligible at Medicare Provider Reimbursement Level
300% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (2,004,906)	\$ (5,359,518)	\$ (10,959,595)	\$ (18,993,429)	\$ (25,193,277)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.01%	0.03%	0.05%	0.08%	0.10%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.33	0.87	1.74	2.95	3.82
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	1.39	3.64	7.25	12.26	15.87
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (1,466,875)	\$ (4,047,234)	\$ (8,679,677)	\$ (15,739,356)	\$ (22,022,172)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.01%	0.02%	0.04%	0.07%	0.08%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.25	0.66	1.38	2.44	3.34
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	1.02	2.75	5.74	10.16	13.87
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (1,325,763)	\$ (3,487,682)	\$ (6,588,604)	\$ (12,359,937)	\$ (18,026,563)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.01%	0.02%	0.03%	0.05%	0.07%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.22	0.57	1.05	1.92	2.73
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	0.92	2.37	4.36	7.98	11.36

Assessment

All HIPAA Eligibles

Current FCHA Provider Reimbursement Levels

**Florida High Risk Pool
All HIPAA Eligible at Current FCHA Provider Reimbursement Level
150% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (24,895,424)	\$ (58,527,570)	\$ (102,714,296)	\$ (158,067,476)	\$ (192,226,507)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.15%	0.32%	0.50%	0.69%	0.74%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	4.16	9.54	16.34	24.54	29.12
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	17.31	39.71	67.98	102.07	121.10
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (20,469,338)	\$ (48,278,107)	\$ (85,648,731)	\$ (133,364,563)	\$ (163,620,189)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.13%	0.27%	0.42%	0.58%	0.63%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	3.42	7.87	13.63	20.71	24.79
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	14.23	32.75	56.69	86.12	103.08
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (13,237,465)	\$ (32,646,512)	\$ (60,429,318)	\$ (97,942,610)	\$ (123,581,464)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.08%	0.18%	0.30%	0.43%	0.48%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	2.21	5.32	9.61	15.21	18.72
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	9.21	22.15	40.00	63.24	77.85

Florida High Risk Pool
All HIPAA Eligible at Current FCHA Provider Reimbursement Level
200% of Standard Individual Rate

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (24,073,048)	\$ (58,576,957)	\$ (105,499,046)	\$ (166,381,584)	\$ (205,138,685)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.15%	0.32%	0.52%	0.72%	0.79%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	4.02	9.55	16.79	25.83	31.08
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	16.74	39.74	69.83	107.44	129.23
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (18,763,846)	\$ (46,061,306)	\$ (84,609,881)	\$ (135,408,133)	\$ (169,968,643)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.12%	0.25%	0.41%	0.59%	0.66%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	3.13	7.51	13.46	21.02	25.75
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	13.05	31.25	56.00	87.44	107.08
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (10,971,330)	\$ (28,250,065)	\$ (54,185,246)	\$ (89,151,427)	\$ (115,590,144)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0	0	0	0	0
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.83	4.61	8.62	13.84	17.51
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	7.63	19.17	35.86	57.57	72.82

**Florida High Risk Pool
All HIPAA Eligible at Current FCHA Provider Reimbursement Level
250% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (19,542,984)	\$ (50,157,566)	\$ (94,565,146)	\$ (153,467,285)	\$ (193,878,779)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.12%	0.28%	0.46%	0.67%	0.75%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	3.26	8.18	15.05	23.83	29.37
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	13.59	34.03	62.59	99.10	122.14
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (14,050,342)	\$ (37,040,328)	\$ (71,374,222)	\$ (119,404,268)	\$ (154,258,706)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.09%	0.20%	0.35%	0.52%	0.59%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	2.35	6.04	11.36	18.54	23.37
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	9.77	25.13	47.24	77.10	97.18
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (7,905,782)	\$ (21,848,572)	\$ (43,568,172)	\$ (74,075,022)	\$ (98,764,447)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.05%	0.12%	0.21%	0.32%	0.38%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.32	3.56	6.93	11.50	14.96
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	5.50	14.82	28.84	47.83	62.22

**Florida High Risk Pool
All HIPAA Eligible at Current FCHA Provider Reimbursement Level
300% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (14,077,190)	\$ (38,089,333)	\$ (76,322,551)	\$ (129,176,120)	\$ (167,606,914)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.09%	0.21%	0.37%	0.56%	0.65%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	2.35	6.21	12.14	20.06	25.39
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	9.79	25.84	50.52	83.41	105.59
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (9,860,227)	\$ (27,096,309)	\$ (55,332,883)	\$ (95,636,745)	\$ (128,105,808)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.06%	0.15%	0.27%	0.42%	0.49%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.65	4.42	8.80	14.85	19.41
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	6.86	18.38	36.62	61.76	80.70
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (5,216,456)	\$ (14,757,493)	\$ (31,278,207)	\$ (55,019,469)	\$ (75,652,657)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.08%	0.15%	0.24%	0.29%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.87	2.41	4.98	8.54	11.46
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	3.63	10.01	20.70	35.53	47.66

Assessment

All HIPAA Eligibles

Medicare Provider Reimbursement Levels

**Florida High Risk Pool
All HIPAA Eligible at Medicare Provider Reimbursement Level
150% of Standard Individual Rate**

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (9,903,366)	\$ (23,293,996)	\$ (40,812,182)	\$ (62,963,966)	\$ (76,768,378)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.06%	0.13%	0.20%	0.27%	0.30%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.65	3.80	6.49	9.78	11.63
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	6.89	15.80	27.01	40.66	48.36
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (8,284,048)	\$ (19,707,538)	\$ (35,229,288)	\$ (55,477,584)	\$ (68,815,600)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.05%	0.11%	0.17%	0.24%	0.27%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.38	3.21	5.61	8.61	10.43
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	5.76	13.37	23.32	35.82	43.35
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (5,460,885)	\$ (13,643,126)	\$ (25,652,597)	\$ (42,334,146)	\$ (54,337,182)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.08%	0.13%	0.18%	0.21%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.91	2.22	4.08	6.57	8.23
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	3.80	9.26	16.98	27.34	34.23

Florida High Risk Pool
All HIPAA Eligible at Medicare Provider Reimbursement Level
200% of Standard Individual Rate

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (8,678,565)	\$ (21,181,835)	\$ (38,255,955)	\$ (60,718,950)	\$ (75,333,467)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.05%	0.12%	0.19%	0.26%	0.29%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.45	3.45	6.09	9.43	11.41
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	6.03	14.37	25.32	39.21	47.46
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (6,884,141)	\$ (17,132,987)	\$ (31,946,472)	\$ (52,032,615)	\$ (66,418,402)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.04%	0.09%	0.16%	0.23%	0.26%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.15	2.79	5.08	8.08	10.06
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	4.79	11.62	21.14	33.60	41.84
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (4,111,972)	\$ (10,786,129)	\$ (21,218,464)	\$ (35,829,074)	\$ (47,592,792)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.06%	0.10%	0.16%	0.18%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.69	1.76	3.38	5.56	7.21
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	2.86	7.32	14.04	23.14	29.98

Florida High Risk Pool
All HIPAA Eligible at Medicare Provider Reimbursement Level
250% of Standard Individual Rate

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (5,958,765)	\$ (15,378,341)	\$ (29,250,206)	\$ (48,047,859)	\$ (61,413,407)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.04%	0.08%	0.14%	0.21%	0.24%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	1.00	2.51	4.65	7.46	9.30
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	4.14	10.43	19.36	31.03	38.69
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (4,383,404)	\$ (11,794,896)	\$ (23,343,064)	\$ (40,160,825)	\$ (53,264,463)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.03%	0.07%	0.11%	0.17%	0.21%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.73	1.92	3.71	6.24	8.07
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	3.05	8.00	15.45	25.93	33.56
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (2,540,632)	\$ (7,202,841)	\$ (14,965,950)	\$ (26,464,772)	\$ (36,574,830)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.02%	0.04%	0.07%	0.12%	0.14%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.42	1.17	2.38	4.11	5.54
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	1.77	4.89	9.91	17.09	23.04

Florida High Risk Pool
All HIPAA Eligible at Medicare Provider Reimbursement Level
300% of Standard Individual Rate

Best Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (3,274,843)	\$ (8,932,529)	\$ (18,265,992)	\$ (31,655,715)	\$ (41,988,795)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.02%	0.05%	0.09%	0.14%	0.16%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.55	1.46	2.91	4.91	6.36
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	2.28	6.06	12.09	20.44	26.45
Probable Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (2,378,125)	\$ (6,745,389)	\$ (14,466,128)	\$ (26,232,260)	\$ (36,703,620)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.01%	0.04%	0.07%	0.11%	0.14%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.40	1.10	2.30	4.07	5.56
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	1.65	4.58	9.57	16.94	23.12
Worst Case Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Gains/Losses					
- New Members	\$ (1,325,763)	\$ (3,875,202)	\$ (8,814,328)	\$ (16,528,172)	\$ (24,035,418)
Assessment Scenario 1					
- Total Health Insurance Premiums	16,063,104,757	18,106,869,443	20,411,492,404	23,010,214,980	25,940,517,960
- Assessment as a % of Premium	0.01%	0.02%	0.04%	0.07%	0.09%
Assessment Scenario 2					
- Total Health Insurance Members	5,985,727	6,133,441	6,285,136	6,440,871	6,600,707
- Assessment per Member	0.22	0.63	1.40	2.57	3.64
Assessment Scenario 3					
- Total Hospital Days	1,438,065	1,474,017	1,510,867	1,548,639	1,587,355
- Assessment per Hospital Day	0.92	2.63	5.83	10.67	15.14

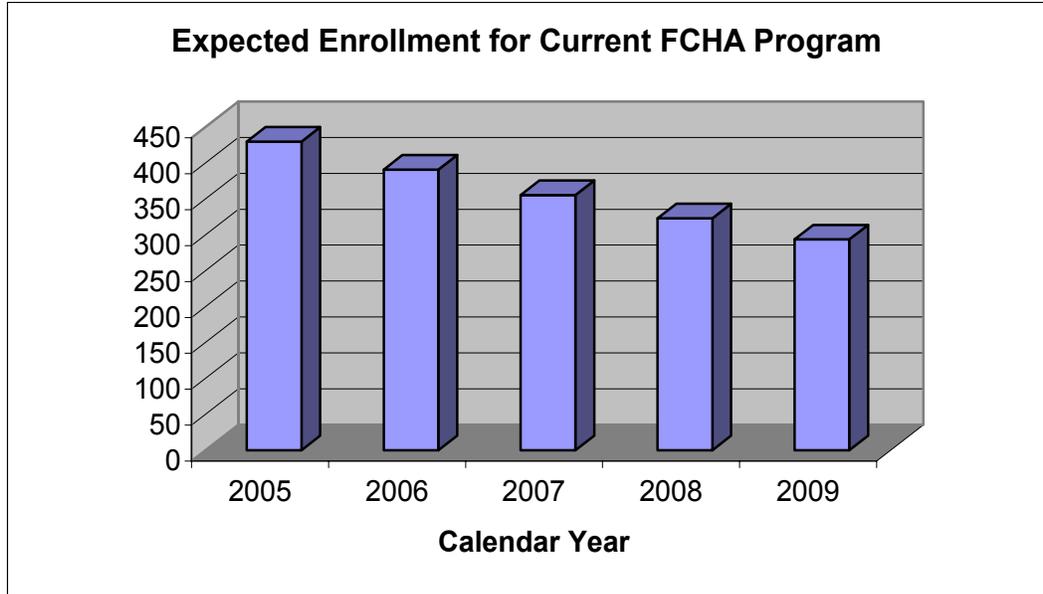
FCHA Analysis

Assumptions

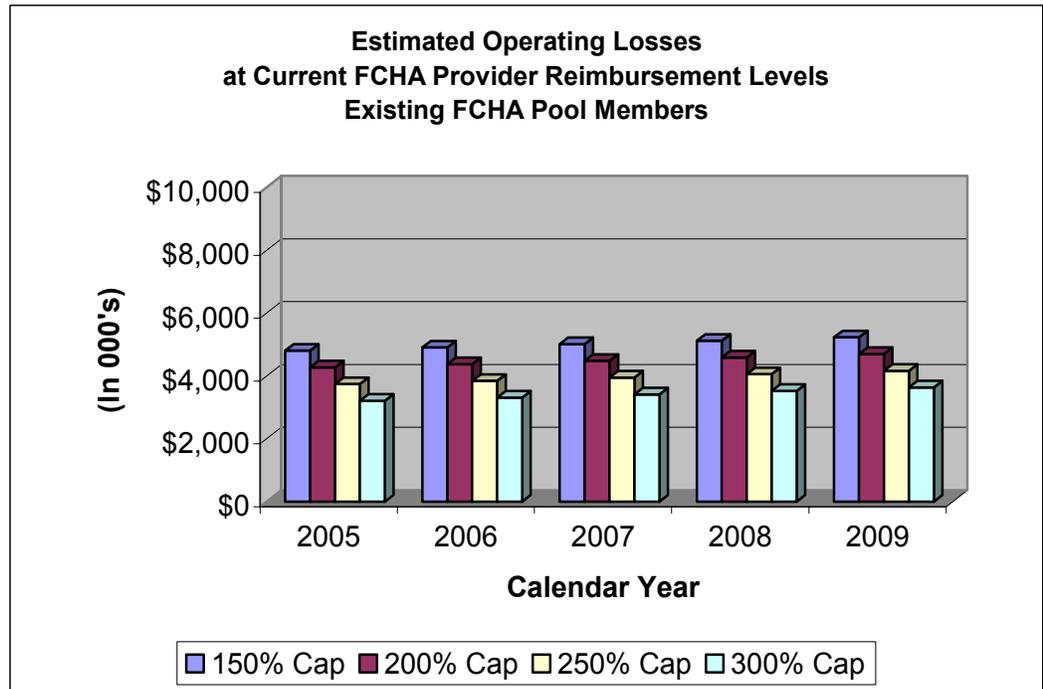
- FCHA members will be “subsumed” into the new pool.
- FCHA members that currently have a Medicare –supplement plan through FCHA will be allowed to stay in the high-risk pool with a Medicare-supplement, even though individuals eligible for Medicare are not deemed eligible for FHIP, the new pool.
- When FCHA members are merged into FHIP, they will be on the same premium basis
- FCHA is able to vary premium, to a limited degree, based upon morbidity. The morbidity loads are 2.00, 2.25 and 2.50. Individuals can only have their loads lowered, not increased. The current average load is 2.30, which translates into FCHA premiums that are 230% of the SRR.
- When FCHA members are merged into FHIP, they will pay the same premium cap that the FHIP members pay. Thus, if the 150% cap is chosen, then FCHA members will enjoy a reduction in premiums, relative to their current cap. If a 300% cap is chosen, FCHA members will experience an increase in premiums, relative to their current cap.
- We assumed a persistency rate of approximately 90%. A persistency analysis of the current pool was performed to develop our assumption.

Results

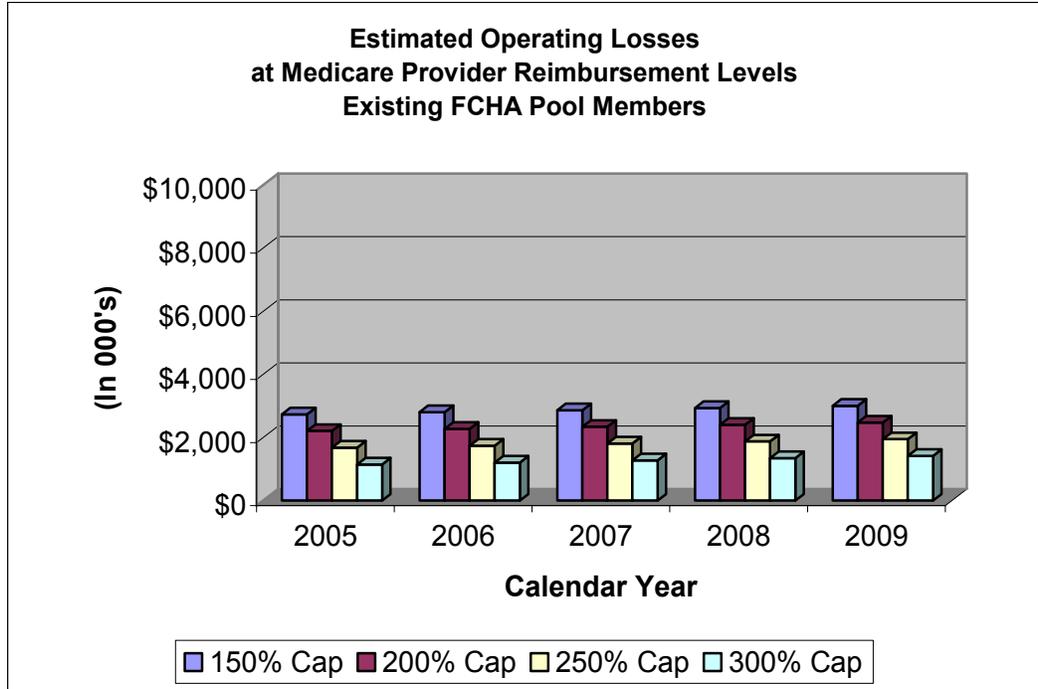
The following charts show the estimated enrollment for the current pool and losses. We employed the same premium and claims trend assumptions for FCHA members to be consistent with the modeling of new FHIP members. FCHA enrollment does not vary by premium cap scenario. There are several reasons for this. First, the FCHA membership is small and can only decrease, therefore enrollment variation for this subgroup will not have a significant impact on the total results. Secondly, the premium levels for current FCHA members vary from 200% to 250% of SRRs. Therefore, for three of the scenarios the FHIP premiums would either be less than or equal to the current FCHA levels for many members.



The following graph shows the anticipated operating losses for current FCHA members. This assumes current FCHA provider reimbursement levels.



Again, if the pool is able to negotiate better discounts, the resulting losses decrease dramatically. The following graph shows the losses of the current pool at discounts similar to Medicare payment levels.



It is our understanding that the FCHA pool’s experience will not be combined with the FHIP for funding purposes.

The following tables contain supporting documentation for the FCHA analysis.

**Florida High Risk Pool
FCHA at Current Provider Reimbursement Levels
150% of Standard Individual Rate**

High Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 3,715	\$ 4,087	\$ 4,495	\$ 4,945	\$ 5,439
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551
Claims	\$ 6,207,892	\$ 6,264,328	\$ 6,321,276	\$ 6,378,742	\$ 6,436,731
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 170,182	\$ 160,899	\$ 152,123	\$ 143,825	\$ 135,980
Loss Ratio	389%	392%	396%	400%	403%
Inherent Morbidity	583%	589%	594%	599%	605%
Gain/Loss of Pool	\$ (4,781,523)	\$ (4,828,676)	\$ (4,876,848)	\$ (4,926,016)	\$ (4,976,160)

Expected Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 3,715	\$ 4,087	\$ 4,495	\$ 4,945	\$ 5,439
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551
Claims	\$ 6,207,892	\$ 6,320,763	\$ 6,435,686	\$ 6,552,698	\$ 6,671,838
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 195,967	\$ 185,278	\$ 175,172	\$ 165,617	\$ 156,583
Loss Ratio	389%	396%	403%	410%	418%
Inherent Morbidity	583%	594%	605%	616%	627%
Gain/Loss of Pool	\$ (4,807,308)	\$ (4,909,490)	\$ (5,014,307)	\$ (5,121,764)	\$ (5,231,870)

Low Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 3,715	\$ 4,087	\$ 4,495	\$ 4,945	\$ 5,439
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551
Claims	\$ 6,207,892	\$ 6,377,198	\$ 6,551,122	\$ 6,729,789	\$ 6,913,329
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 221,752	\$ 209,656	\$ 198,221	\$ 187,409	\$ 177,186
Loss Ratio	389%	399%	410%	422%	433%
Inherent Morbidity	583%	599%	615%	632%	650%
Gain/Loss of Pool	\$ (4,833,093)	\$ (4,990,304)	\$ (5,152,791)	\$ (5,320,646)	\$ (5,493,964)

**Florida High Risk Pool
FCHA at Current Provider Reimbursement Levels
200% of Standard Individual Rate**

High Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 4,953	\$ 5,449	\$ 5,994	\$ 6,593	\$ 7,252
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735
Claims	\$ 6,207,892	\$ 6,264,328	\$ 6,321,276	\$ 6,378,742	\$ 6,436,731
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 170,182	\$ 160,899	\$ 152,123	\$ 143,825	\$ 135,980
Loss Ratio	292%	294%	297%	300%	302%
Inherent Morbidity	583%	589%	594%	599%	605%
Gain/Loss of Pool	\$ (4,249,339)	\$ (4,296,492)	\$ (4,344,664)	\$ (4,393,832)	\$ (4,443,976)

Expected Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 4,953	\$ 5,449	\$ 5,994	\$ 6,593	\$ 7,252
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735
Claims	\$ 6,207,892	\$ 6,320,763	\$ 6,435,686	\$ 6,552,698	\$ 6,671,838
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 195,967	\$ 185,278	\$ 175,172	\$ 165,617	\$ 156,583
Loss Ratio	292%	297%	302%	308%	313%
Inherent Morbidity	583%	594%	605%	616%	627%
Gain/Loss of Pool	\$ (4,275,124)	\$ (4,377,306)	\$ (4,482,123)	\$ (4,589,580)	\$ (4,699,687)

Low Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 4,953	\$ 5,449	\$ 5,994	\$ 6,593	\$ 7,252
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735
Claims	\$ 6,207,892	\$ 6,377,198	\$ 6,551,122	\$ 6,729,789	\$ 6,913,329
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 221,752	\$ 209,656	\$ 198,221	\$ 187,409	\$ 177,186
Loss Ratio	292%	300%	308%	316%	325%
Inherent Morbidity	583%	599%	615%	632%	650%
Gain/Loss of Pool	\$ (4,300,909)	\$ (4,458,120)	\$ (4,620,608)	\$ (4,788,463)	\$ (4,961,780)

**Florida High Risk Pool
FCHA at Current Provider Reimbursement Levels
250% of Standard Individual Rate**

High Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 6,192	\$ 6,811	\$ 7,492	\$ 8,241	\$ 9,065
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919
Claims	\$ 6,207,892	\$ 6,264,328	\$ 6,321,276	\$ 6,378,742	\$ 6,436,731
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 170,182	\$ 160,899	\$ 152,123	\$ 143,825	\$ 135,980
Loss Ratio	233%	235%	238%	240%	242%
Inherent Morbidity	583%	589%	594%	599%	605%
Gain/Loss of Pool	\$ (3,717,155)	\$ (3,764,308)	\$ (3,812,480)	\$ (3,861,649)	\$ (3,911,792)

Expected Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 6,192	\$ 6,811	\$ 7,492	\$ 8,241	\$ 9,065
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919
Claims	\$ 6,207,892	\$ 6,320,763	\$ 6,435,686	\$ 6,552,698	\$ 6,671,838
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 195,967	\$ 185,278	\$ 175,172	\$ 165,617	\$ 156,583
Loss Ratio	233%	238%	242%	246%	251%
Inherent Morbidity	583%	594%	605%	616%	627%
Gain/Loss of Pool	\$ (3,742,941)	\$ (3,845,122)	\$ (3,949,939)	\$ (4,057,397)	\$ (4,167,503)

Low Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 6,192	\$ 6,811	\$ 7,492	\$ 8,241	\$ 9,065
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919
Claims	\$ 6,207,892	\$ 6,377,198	\$ 6,551,122	\$ 6,729,789	\$ 6,913,329
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 221,752	\$ 209,656	\$ 198,221	\$ 187,409	\$ 177,186
Loss Ratio	233%	240%	246%	253%	260%
Inherent Morbidity	583%	599%	615%	632%	650%
Gain/Loss of Pool	\$ (3,768,726)	\$ (3,925,936)	\$ (4,088,424)	\$ (4,256,279)	\$ (4,429,596)

**Florida High Risk Pool
FCHA at Current Provider Reimbursement Levels
300% of Standard Individual Rate**

High Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Annual Risk Premium	\$ 7,430	\$ 8,173	\$ 8,990	\$ 9,889	\$ 10,878
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102
Claims	\$ 6,207,892	\$ 6,264,328	\$ 6,321,276	\$ 6,378,742	\$ 6,436,731
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 170,182	\$ 160,899	\$ 152,123	\$ 143,825	\$ 135,980
Loss Ratio	194%	196%	198%	200%	202%
Inherent Morbidity	583%	589%	594%	599%	605%
Gain/Loss of Pool	\$ (3,184,972)	\$ (3,232,124)	\$ (3,280,297)	\$ (3,329,465)	\$ (3,379,609)

Expected Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 7,430	\$ 8,173	\$ 8,990	\$ 9,889	\$ 10,878
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102
Claims	\$ 6,207,892	\$ 6,320,763	\$ 6,435,686	\$ 6,552,698	\$ 6,671,838
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 195,967	\$ 185,278	\$ 175,172	\$ 165,617	\$ 156,583
Loss Ratio	194%	198%	202%	205%	209%
Inherent Morbidity	583%	594%	605%	616%	627%
Gain/Loss of Pool	\$ (3,210,757)	\$ (3,312,938)	\$ (3,417,755)	\$ (3,525,213)	\$ (3,635,319)

Low Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 7,430	\$ 8,173	\$ 8,990	\$ 9,889	\$ 10,878
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102
Claims	\$ 6,207,892	\$ 6,377,198	\$ 6,551,122	\$ 6,729,789	\$ 6,913,329
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 221,752	\$ 209,656	\$ 198,221	\$ 187,409	\$ 177,186
Loss Ratio	194%	200%	205%	211%	217%
Inherent Morbidity	583%	599%	615%	632%	650%
Gain/Loss of Pool	\$ (3,236,542)	\$ (3,393,752)	\$ (3,556,240)	\$ (3,724,095)	\$ (3,897,413)

**Florida High Risk Pool
FCHA at Medicare Provider Reimbursement Levels
150% of Standard Individual Rate**

High Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 3,715	\$ 4,087	\$ 4,495	\$ 4,945	\$ 5,439
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551
Claims	\$ 4,140,664	\$ 4,178,306	\$ 4,216,291	\$ 4,254,621	\$ 4,293,299
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 170,182	\$ 160,899	\$ 152,123	\$ 143,825	\$ 135,980
Loss Ratio	259%	262%	264%	266%	269%
Inherent Morbidity	389%	393%	396%	400%	403%
Gain/Loss of Pool	\$ (2,714,295)	\$ (2,742,654)	\$ (2,771,863)	\$ (2,801,895)	\$ (2,832,728)

Expected Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 3,715	\$ 4,087	\$ 4,495	\$ 4,945	\$ 5,439
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551
Claims	\$ 4,140,664	\$ 4,215,949	\$ 4,292,602	\$ 4,370,650	\$ 4,450,116
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 195,967	\$ 185,278	\$ 175,172	\$ 165,617	\$ 156,583
Loss Ratio	259%	264%	269%	274%	279%
Inherent Morbidity	389%	396%	403%	411%	418%
Gain/Loss of Pool	\$ (2,740,080)	\$ (2,804,676)	\$ (2,871,223)	\$ (2,939,716)	\$ (3,010,148)

Low Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 3,715	\$ 4,087	\$ 4,495	\$ 4,945	\$ 5,439
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551	\$ 1,596,551
Claims	\$ 4,140,664	\$ 4,253,591	\$ 4,369,598	\$ 4,488,769	\$ 4,611,190
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 221,752	\$ 209,656	\$ 198,221	\$ 187,409	\$ 177,186
Loss Ratio	259%	266%	274%	281%	289%
Inherent Morbidity	389%	400%	411%	422%	433%
Gain/Loss of Pool	\$ (2,765,865)	\$ (2,866,697)	\$ (2,971,268)	\$ (3,079,627)	\$ (3,191,825)

**Florida High Risk Pool
FCHA at Medicare Provider Reimbursement Levels
200% of Standard Individual Rate**

High Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 4,953	\$ 5,449	\$ 5,994	\$ 6,593	\$ 7,252
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735
Claims	\$ 4,140,664	\$ 4,178,306	\$ 4,216,291	\$ 4,254,621	\$ 4,293,299
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 170,182	\$ 160,899	\$ 152,123	\$ 143,825	\$ 135,980
Loss Ratio	280%	196%	198%	200%	202%
Inherent Morbidity	560%	393%	396%	400%	403%
Gain/Loss of Pool	\$ (2,182,111)	\$ (2,210,471)	\$ (2,239,679)	\$ (2,269,711)	\$ (2,300,545)

Expected Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 4,953	\$ 5,449	\$ 5,994	\$ 6,593	\$ 7,252
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735
Claims	\$ 4,140,664	\$ 4,215,949	\$ 4,292,602	\$ 4,370,650	\$ 4,450,116
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 195,967	\$ 185,278	\$ 175,172	\$ 165,617	\$ 156,583
Loss Ratio	280%	198%	202%	205%	209%
Inherent Morbidity	560%	396%	403%	411%	418%
Gain/Loss of Pool	\$ (2,207,896)	\$ (2,272,492)	\$ (2,339,039)	\$ (2,407,532)	\$ (2,477,965)

Low Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 4,953	\$ 5,449	\$ 5,994	\$ 6,593	\$ 7,252
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735	\$ 2,128,735
Claims	\$ 4,140,664	\$ 4,253,591	\$ 4,369,598	\$ 4,488,769	\$ 4,611,190
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 221,752	\$ 209,656	\$ 198,221	\$ 187,409	\$ 177,186
Loss Ratio	280%	200%	205%	211%	217%
Inherent Morbidity	560%	400%	411%	422%	433%
Gain/Loss of Pool	\$ (2,233,681)	\$ (2,334,513)	\$ (2,439,084)	\$ (2,547,443)	\$ (2,659,642)

**Florida High Risk Pool
FCHA at Medicare Provider Reimbursement Levels
250% of Standard Individual Rate**

High Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Risk Premium	\$ 6,192	\$ 6,811	\$ 7,492	\$ 8,241	\$ 9,065
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919
Claims	\$ 4,140,664	\$ 4,178,306	\$ 4,216,291	\$ 4,254,621	\$ 4,293,299
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 170,182	\$ 160,899	\$ 152,123	\$ 143,825	\$ 135,980
Loss Ratio	156%	157%	158%	160%	161%
Inherent Morbidity	389%	393%	396%	400%	403%
Gain/Loss of Pool	\$ (1,649,927)	\$ (1,678,287)	\$ (1,707,495)	\$ (1,737,528)	\$ (1,768,361)

Expected Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 6,192	\$ 6,811	\$ 7,492	\$ 8,241	\$ 9,065
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919
Claims	\$ 4,140,664	\$ 4,215,949	\$ 4,292,602	\$ 4,370,650	\$ 4,450,116
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 195,967	\$ 185,278	\$ 175,172	\$ 165,617	\$ 156,583
Loss Ratio	156%	158%	161%	164%	167%
Inherent Morbidity	389%	396%	403%	411%	418%
Gain/Loss of Pool	\$ (1,675,712)	\$ (1,740,308)	\$ (1,806,856)	\$ (1,875,348)	\$ (1,945,781)

Low Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 6,192	\$ 6,811	\$ 7,492	\$ 8,241	\$ 9,065
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919	\$ 2,660,919
Claims	\$ 4,140,664	\$ 4,253,591	\$ 4,369,598	\$ 4,488,769	\$ 4,611,190
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 221,752	\$ 209,656	\$ 198,221	\$ 187,409	\$ 177,186
Loss Ratio	156%	160%	164%	169%	173%
Inherent Morbidity	389%	400%	411%	422%	433%
Gain/Loss of Pool	\$ (1,701,498)	\$ (1,802,329)	\$ (1,906,900)	\$ (2,015,259)	\$ (2,127,458)

**Florida High Risk Pool
FCHA at Medicare Provider Reimbursement Levels
300% of Standard Individual Rate**

High Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 33	\$ 34	\$ 36	\$ 37	\$ 39
Annual Risk Premium	\$ 7,430	\$ 8,173	\$ 8,990	\$ 9,889	\$ 10,878
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102
Claims	\$ 4,140,664	\$ 4,178,306	\$ 4,216,291	\$ 4,254,621	\$ 4,293,299
Claim Trend	11%	11%	11%	11%	11%
Administrative Expense	\$ 170,182	\$ 160,899	\$ 152,123	\$ 143,825	\$ 135,980
Loss Ratio	130%	131%	132%	133%	134%
Inherent Morbidity	389%	393%	396%	400%	403%
Gain/Loss of Pool	\$ (1,117,744)	\$ (1,146,103)	\$ (1,175,312)	\$ (1,205,344)	\$ (1,236,177)

Expected Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 38	\$ 40	\$ 41	\$ 43	\$ 44
Risk Premium	\$ 7,430	\$ 8,173	\$ 8,990	\$ 9,889	\$ 10,878
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102
Claims	\$ 4,140,664	\$ 4,215,949	\$ 4,292,602	\$ 4,370,650	\$ 4,450,116
Claim Trend	12%	12%	12%	12%	12%
Administrative Expense	\$ 195,967	\$ 185,278	\$ 175,172	\$ 165,617	\$ 156,583
Loss Ratio	130%	132%	134%	137%	139%
Inherent Morbidity	389%	396%	403%	411%	418%
Gain/Loss of Pool	\$ (1,143,529)	\$ (1,208,124)	\$ (1,274,672)	\$ (1,343,164)	\$ (1,413,597)

Low Scenario					
	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
Estimated Pool Enrollment	430	391	355	323	294
Administrative PMPM	\$ 43	\$ 45	\$ 47	\$ 48	\$ 50
Risk Premium	\$ 7,430	\$ 8,173	\$ 8,990	\$ 9,889	\$ 10,878
Premium Trend	10%	10%	10%	10%	10%
Pool Revenue	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102	\$ 3,193,102
Claims	\$ 4,140,664	\$ 4,253,591	\$ 4,369,598	\$ 4,488,769	\$ 4,611,190
Claim Trend	13%	13%	13%	13%	13%
Administrative Expense	\$ 221,752	\$ 209,656	\$ 198,221	\$ 187,409	\$ 177,186
Loss Ratio	130%	133%	137%	141%	144%
Inherent Morbidity	389%	400%	411%	422%	433%
Gain/Loss of Pool	\$ (1,169,314)	\$ (1,270,145)	\$ (1,374,717)	\$ (1,483,075)	\$ (1,595,274)

MERCER OLIVER WYMAN

411 East Wisconsin Avenue, Suite 1600
Milwaukee, WI 53202-4419
414 223 7989