The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Richter, Chair
Senator Smith, Vice Chair

MEETING DATE: Monday, April 25, 2011
TIME: 8:00 —9:30 a.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Richter, Chair; Senator Smith, Vice Chair; Senators Alexander, Bennett, Bogdanoff, Fasano, Hays, Margolis, Negron, Oelrich, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1152** Simmons (Similar CS/H 253)	Limited Liability Companies; Provides that a charging order against a member's limited liability company interest is the sole and exclusive remedy available to enforce a judgment creditor's unsatisfied judgment against a member or member's assignee. Provides an exception for enforcing a judgment creditor's unsatisfied judgment against a judgment debtor or assignee of the judgment debtor of a single-member limited liability company under certain circumstances. Provides legislative intent. Provides for retroactive application. CM 03/16/2011 Favorable JU 03/28/2011 Favorable BI 04/25/2011	
2	**SB 1922** Garcia (Compare CS/H 1125, CS/H 1473, CS/CS/S 1456)	Health Insurance; Revises the types of employers who are eligible to enroll in the Florida Health Choices Program. Authorizes HMOs to sell health maintenance contracts under the program. Requires the OIR to approve risk-bearing products that are sold by vendors. Requires Florida Health Choices, Inc., to approve of certain nonrisk-bearing products. Authorizes personal, identifying information of an applicant or enrollee in the Florida Kidcare program to be disclosed to Florida Health Choices, Inc., for purposes of administering the Florida Health Choices Program, etc. BI 04/25/2011 HR BC	

"An electronic copy of the Appearance Request form is now available to download from any Senate Committee page on the Senate's website, www.flsenate.gov."

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LEGISLATIVE ACTION

Senate . House

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The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment

Delete line 118

and insert:

not merely the rights of an assignee;

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LEGISLATIVE ACTION

Senate . House

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The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment (with title amendment)

Between lines 124 and 125
insert:

(8) In the case of a limited liability company having more than one member, the remedy of foreclosure on a judgment debtor's interest in such limited liability company or against rights to distribution from such limited liability company is not available to a judgment creditor attempting to satisfy the judgment and may not be ordered by a court.

(9) This section does not limit:

(a) The rights of a creditor that has been granted a

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consensual security interest in a limited liability company interest to pursue the remedies available to such secured creditor under other law applicable to secured creditors;

(b) The principles of law and equity which affect fraudulent transfers;

(c) The availability of the equitable principles of alter ego, equitable lien, or constructive trust, or other equitable principles not inconsistent with this section; or

(d) The continuing jurisdiction of the court to enforce its charging order in a manner consistent with this section.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Between lines 11 and 12

insert:

providing that, in the case of a multimember limited liability company, certain remedies are unavailable to a judgment creditor attempting to satisfy a judgment; prohibiting a court from ordering such remedies; providing for construction relating to secured creditor rights, specified principles of law and equity, and continuing enforcement jurisdiction of the court;

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL:	SB 1152
INTRODUCER:	Senator Simmons
SUBJECT:	Limited Liability Companies
DATE:	April 19, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hrdlicka	Cooper	CM	**Favorable**
2.	O'Connor	Maclure	JU	**Favorable**
3.	Matiyow	Burgess	BI	**Pre-meeting**
4.				
5.				
6.				

I. Summary:

In response to a Florida Supreme Court holding about remedies available to a judgment creditor of a single-member limited liability company, SB 1152 amends s. 608.433, F.S. The bill clarifies that the general application of the decision in *Olmstead v. Federal Trade Commission*[1] to single-member limited liability companies does not apply to multiple-member limited liability companies.

The bill provides, with one exception, that a charging order is the "sole and exclusive remedy" by which a judgment creditor of a member or member's assignee may satisfy a judgment from a judgment debtor's interest in a limited liability company or rights to distributions from a limited liability company. The exception arises in situations in which a limited liability company has only one member. The bill provides that the court may order the sale of a member's interest in a single-member limited liability company if the judgment creditor shows that distributions under a charging order will not satisfy the judgment in a reasonable time.

The bill provides that the amendments made to s. 608.433, F.S., are clarifying and apply retroactively.

This bill substantially amends section 608.433, Florida Statutes.

[1] *Olmstead v. Federal Trade Commission*, 44 So. 3d 76 (Fla. 2010),

II. Present Situation:

Limited Liability Companies

Sections 608.401-608.705, F.S., comprise the "Florida Limited Liability Company Act." A limited liability company, or LLC, is a statutorily recognized, "hybrid business entity that offers all of its members limited liability as if they were shareholders of a corporation but treats the entity and its members as a partnership for tax purposes. In other words, a limited liability company is a form of legal entity that has the attributes of both a corporation and a partnership but is not formally characterized as either one."[2]

Members and managers of an LLC are separate from the company itself. Generally, the members and managers of an LLC are not liable, solely by reason of being a member or serving as a manager or managing member, under a judgment, decree, or order of a court, or in any other manner, for a debt, obligation, or liability of the limited liability company. However, this may be expanded or restricted by the provisions of the LLC's articles of organization or operating agreement.[3] Florida law permits single-member LLCs.

Generally, except as otherwise provided in the LLC's articles of organization or operating agreement, no person may be admitted as a member unless a majority-in-interest of the current members consent.[4] A member may assign his or her interest in the LLC, either the whole or a part, but the same general rule for becoming a member applies to the assignee as well.[5] An assignee has no right to participate in the management of the business except as provided in the articles of organization or operating agreement and upon approval of all the members of the LLC, excluding the assigning member. An assignee's interest generally only allows him or her to share in the profits and losses and receive distributions from the LLC.[6]

An assignee may become a member of the LLC only if all the members of the LLC, excluding the assigning member, consent, unless the articles of organization or operating agreement provide otherwise.[7]

According to the Division of Corporations of the Department of State, there are 548,893 active LLCs in Florida.[8] The number of LLC filings has generally increased over the last 10 years. There were 25,566 new business entity filings related to LLCs in 2001, while 138,287 such documents were filed in 2010.

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[2] AMJUR LIMLIACO §1

[3] Section 608.4227, F.S. See also s. 608.4228, F.S., which states that a member or manager shall not be personally liable for monetary damages to the LLC.

[4] Section 608.4232, F.S.

[5] Section 608.432, F.S.

[6] The provisions related to assignments are the same as provisions related to partnerships, whereby if a partner transfers his or her interest, the remaining partners are not required to accept the new partner as an equal for management and voting purposes.

[7] Section 608.433, F.S.

[8] Division of Corporations, Department of State, "Yearly Filings," *available at* http://www.sunbiz.org/corp_stat.html (last visited Mar. 12, 2011). The filing numbers reflect the number of new documents filed beginning January 1 and ending December 31 of each year.

Judgments and Limited Liability Companies

A judgment is an order of the court creating an obligation, such as a debt. Chapter 56, F.S., provides mechanisms for execution of judgments. Section 56.061, F.S., provides that various categories of real and personal property, including stock in corporations, are subject to levy and sale under execution of a court's order or judgment. A member's own interest in an LLC is considered personal property, and is "reasonably understood to fall within the scope of 'corporate stock.'"[9]

Section 608.433(4), F.S., provides for a judgment creditor to apply to a court to charge the LLC membership interest of a member with payment of an unsatisfied amount of judgment owed to the creditor, with interest (otherwise known as a "charging order").[10] "To the extent so charged, the judgment creditor has only the rights of an assignee of such interest."[11] However, the statute also provides that it "does not deprive any member of the benefit of any exemption laws applicable to the member's interest."[12]

A charging order does not give the judgment creditor governance rights with respect to the LLC, because an assignee has no right to participate in the management of the business, unless the articles of organization or operating agreement states otherwise. A judgment creditor, then, would only be able to share in the profits and receive distributions from the LLC.

The theory behind the charging order is that a judgment creditor can be paid from the profits or distributions from the LLC without the disruption of the business caused by inserting another member into the group or the damage caused to other members if the business, or portions of it, was sold to pay the judgment creditor.[13] As a federal bankruptcy court has explained, "a charging order protects the autonomy of the original members, and their ability to manage their own enterprise."[14]

The charging order is not unique to the LLC business structure. Florida's Revised Uniform Partnership Act of 1995, ss. 620.81001-620.9902, F.S., and Florida's Revised Uniform Limited Partnership Act of 2005, ss. 620.1101-620.2205, F.S., similarly provide charging order remedies in partnership and limited partnership law.

A limitation of the charging order remedy is that a creditor cannot recover unless the voting members of the LLC distribute profits. If the LLC does not make a distribution, the judgment creditor is not paid. Particular issues arise when a member of an LLC enters into bankruptcy, is subject to an adjudication of insolvency or appointment of a receiver, or makes an assignment of interest for the benefit of creditors.[15] Section 608.4327, F.S., states that a person ceases to be a

[9] *Olmstead v. Federal Trade Commission*, 44 So. 3d 76, 80 (Fla. 2010).
[10] A "judgment creditor" is a person having a legal right to enforce execution of a judgment for a specific sum of money. Black's Law Dictionary, "judgment creditor" (9th Ed. 2010).
[11] Section 608.433(4), F.S.
[12] *Id.*
[13] *See, generally, City of Arkansas City v. Anderson*, 752 P.2d 673, 681-84 (Kansas 1988) (discussing the charging order at common law and under the Uniform Partnership Act).
[14] *In Re: First Protection, Inc.*, 440 B.R. 821, 830 (9th Cir. BAP (Ariz.) 2010) (citations omitted).
[15] At common law, the purpose of the charging order was to protect non-debtor partners from being forced into partnership with a judgment partner's creditor.

member of an LLC when these situations arise. This is because the economic interests of a creditor or receiver for an insolvent member would not be aligned with the best interest of the LLC.[16] In the case of single-member LLC, there is tension between the interests of the creditors and employees of the LLC and the interests of the judgment creditor of the single member.

Olmstead v. Federal Trade Commission

In *Olmstead v. Federal Trade Commission*, 44 So. 3d 76 (Fla. 2010), the Florida Supreme Court held that Florida's statutory charging order provision is not the exclusive means for a judgment creditor to execute a judgment against the owner of a single-member LLC. The Court held that "a court may order a judgment debtor to surrender all right, title, and interest in the debtor's single-member LLC to satisfy an outstanding judgment."[17]

While the court's holding does not specifically apply to limited liability companies with more than one member, the court's reasoning would likely apply to all limited liability companies.

The Decision in Olmstead

In *Olmstead*, a federal court asked the Florida Supreme Court whether, under Florida law, a court may order a judgment debtor to surrender all "right, title, and interest" in the debtor's single-member LLC to satisfy an outstanding judgment. In the case, the Federal Trade Commission (FTC) alleged Olmstead was operating an "advance-fee credit card scam" and sued for unfair and deceptive trade practices.[18] The FTC prevailed and obtained an order directing Olmstead to surrender all right, title, and interest in his LLC. Olmstead, the judgment debtor and sole member of an LLC, argued that a charging order under s. 608.433(4), F.S., was the sole and exclusive remedy available against his ownership interest in the LLC. He argued that no other remedy was applicable. The FTC argued that other remedies were available under Florida law – and that finding that the statutory charging order was the sole remedy for a single-member LLC would produce absurd results.[19]

The court held that a charging order under s. 608.433(4), F.S., was not the exclusive remedy. The court noted that s. 56.061, F.S., provides that stock in corporations is subject to sale and execution to satisfy a judgment and that because an LLC is a "type of corporate entity," an ownership interest in an LLC is reasonably understood to be corporate stock and subject to execution under the statute.[20] The court rejected arguments that s. 608.433(4), F.S., displaced s. 56.061, F.S. It noted that Florida's partnership and limited partnership statutes contain similar charging order provisions but those provisions provide that the charging order is the exclusive remedy and that specific language relating to an exclusive remedy is not present in the LLC statute.[21] Accordingly, the court said:

[16] Davis, Gardner, and Mary Kendrick, *Single-Member LLC Will Not Shield Debtor's Assets from Judgment Creditor*, 29-Oct Am. Bankr. Inst. J. 52 (2010).
[17] *Olmstead*, 44 So. 3d at 83.
[18] *See Olmstead*, 44 So. 3d at 78.
[19] *See Olmstead*, 44 So. 3d at 77-78.
[20] *Olmstead*, 44 So. 3d at 80.
[21] *See Olmstead*, 44 So. 3d at 81-82.

> Specifically, we conclude that there is no reasonable basis for inferring that the provision authorizing the use of charging orders under section 608.433(4) establishes the sole remedy for a judgment creditor against a judgment debtor's interest in a single-member LLC… Section 608.433(4) does not displace the creditor's remedy available under section 56.061 with respect to a debtor's ownership interest in a single-member LLC.[22]

Olmstead followed a similar holding from a Colorado court in 2003 – *In re Albright*, 291 B.R. 538 (Bkrtcy.D.Colo. 2003). In *Albright*, "the sole-member of a Colorado LLC filed bankruptcy, and the court held that the Chapter 7 trustee became a 'substituted member' and could cause the LLC to sell its real property and distribute the proceeds to the estate."[23] The court stated that the Colorado LLC laws exist to:

> …protect other members of an LLC from having involuntarily to share governance responsibilities with someone they did not choose, or from having to accept a creditor of another member as a co-manager. A charging order protects the autonomy of the original members, and their ability to manage their own enterprise. In a single-member entity, there are no non-debtor members to protect. The charging order limitation serves no purpose in a single member limited liability company, because there are no other parties' interests affected.[24]

However, the Colorado bankruptcy court specifically stated in a footnote that the holding would have been different if there had been other members in the LLC.[25] Colorado's statute on charging orders is similar to the law in Florida.

Criticism of Olmstead

In dissent, Justice Lewis argued that the majority opinion was rewriting the LLC Act to create a remedy not contemplated by the Legislature. He said that a reading of all of ch. 608, F.S., and not merely the provisions cited by the majority, makes clear that the LLC Act displaces ch. 56, F.S.[26] Justice Lewis warned:

> This is extremely important and has far-reaching impact because the principles used to ignore the LLC statutory language under the current factual circumstances apply with equal force to multimember LLC entities and, in essence, today's decision crushes a very important element for all LLCs in Florida. If the remedies available under the LLC Act do not apply here because the phrase "exclusive remedy" is not present, the same theories apply to multimember LLCs and render the assets of all LLCs vulnerable.[27]

The provisions of the LLC Act apply uniformly to all Florida LLCs, regardless of whether the LLC is a single-member LLC or a multiple-member LLC.

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[22] *Olmstead*, 44 So. 3d at 83.
[23] Miller, Elizabeth, *Are the Courts Developing a Unique Theory of Limited Liability Companies or Simply Borrowing from Other Forms?*, 42 Suffolk U. L. Rev. 617, 641-44 (2009).
[24] *In Re Albright*, 291 B.R. at 541 n.7.
[25] *In Re Albright*, 291 B.R. at 540.
[26] *Olmstead*, 44 So. 3d at 83-84 (Lewis, J., dissenting).
[27] *Olmstead*, 44 So. 3d at 84 (Lewis, J., dissenting).

Commenters have explained the concern of some business law practitioners:

> As a result of the dissenting opinion, many practitioners are concerned that a multiple-member Florida LLC arrangement may not provide charging order protection, although that is not what the majority held. … [T]here is a good chance that there will be legislative clarification of this court-created "uncertainty by implication." In the interim, advisors should alert their clients to the exposure and consider bifurcating Florida LLC membership interests into voting and nonvoting interests, converting Florida LLCs to limited partnerships or limited liability limited partnerships, moving Florida LLCs to jurisdictions that have a more stable charging order protection law, or implementing other divestment of management control strategies.[28]

III. Effect of Proposed Changes:

In response to a Florida Supreme Court holding about remedies available to a judgment creditor of a single-member limited liability company, SB 1152 amends s. 608.433, F.S. The bill clarifies that the general application of the *Olmstead* decision to single-member LLCs does not apply to multiple-member LLCs.

Section 1 amends s. 608.433, F.S.

The bill defines a "charging order" as a lien on a judgment debtor's LLC interest or assignee rights. A judgment creditor has only the rights of an assignee of an LLC interest to receive any distributions that the judgment debtor would otherwise have been entitled to, limited to the extent of the judgment including interest.

The bill provides, with one exception, that a charging order is the "sole and exclusive remedy" by which a judgment creditor of a member or member's assignee may satisfy a judgment from a judgment debtor's interest in an LLC or rights to distributions from an LLC. The exception arises in situations in which an LLC has only one member. The bill provides that the court may order the sale of a member's interest in a single-member LLC if the judgment creditor shows that distributions under a charging order will not satisfy the judgment in a reasonable time.

Upon such a showing, the court may order the sale of the interest in the LLC pursuant to a foreclosure sale. The bill provides that the judgment creditor may make such a showing within a reasonable time after entry of the judgment and may do so at the time the judgment creditor applies for entry of the charging order. If the court orders a foreclosure sale, the purchaser at the sale obtains the member's entire interest in the LLC, the purchaser becomes the member of the LLC, and the person whose interest is sold ceases to be a member of the LLC.

Section 2 states that the amendments made to s. 608.433, F.S., are clarifying and apply retroactively.

Section 3 provides that the act takes effect upon becoming law.

[28] Gassman, Alan S., and Christopher J. Denicolo, David L. Koche, and Thomas O. Wells, *After Olmstead: Will a Multiple-Member LLC Continue to Have Charging Order Protection*?, 84-DEC Fla. B.J. 8, 10 (2010).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

This bill provides that it is intended to be clarifying and remedial in nature and shall apply retroactively (see Section 2). Retroactive application of legislation can implicate the due process provisions of the constitution.[29] As a general matter, statutes that do not alter vested rights but relate only to remedies or procedure can be applied retroactively.[30]

The Florida Supreme Court has ruled that statutes enacted soon after a controversy over the meaning of legislation may be considered a legislative interpretation of the original law and not substantive change:

> When, as occurred here, an amendment to a statute is enacted soon after controversies as to the interpretation of the original act arise, a court may consider that amendment as a legislative interpretation of the original law and not as a substantive change thereof. This Court has recognized the propriety of considering subsequent legislation in arriving at the proper interpretation of the prior statute.[31]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill would benefit businesses by providing certainty and predictability to those establishing and maintaining multiple-member LLCs in Florida. Without such a change, businesses may move or create their LLCs in other states where certainty exists. It is not

[29] *See State Department of Transportation v. Knowles*, 402 So. 2d 1155 (Fla. 1981).
[30] *See Metropolitan Dade County v. Chase Federal Housing Corporation*, 737 So.2d. 494 (Fla. 1999). *See also City of Orlando v. Desjardins*, 493 So. 2d 1027, 1028 (Fla. 1986) (citations omitted) ("If a statute is found to be remedial in nature, it can and should be retroactively applied in order to serve its intended purposes.").
[31] *Lowry v. Parole and Probation Commission*, 473 So. 2d 1248, 1250 (Fla. 1985) (internal citations omitted).

known how many, if any, businesses would relocate or not locate in Florida because of the *Olmstead* decision and without this bill becoming law. Also, it is not known how many Florida LLCs, if any, would incur additional costs and change to a different business partnership structure.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
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The Committee on Banking and Insurance (Oelrich) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 408.910, Florida Statutes, is amended to read:

408.910 Florida Health Choices Program.—

(1) LEGISLATIVE INTENT.—The Legislature finds that a significant number of the residents of this state do not have adequate access to affordable, quality health care. The Legislature further finds that increasing access to affordable, quality health care can be best accomplished by establishing a

competitive market for purchasing health insurance and health services. It is therefore the intent of the Legislature to create the Florida Health Choices Program to:

(a) Expand opportunities for Floridians to purchase affordable health insurance and health services.

(b) Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits.

(c) Enable individual choice in both the manner and amount of health care purchased.

(d) Provide for the purchase of individual, portable health care coverage.

(e) Disseminate information to consumers on the price and quality of health services.

(f) Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Corporation" means the Florida Health Choices, Inc., established under this section.

(b) "Corporation's marketplace" means the single, centralized market established by the program which facilitates the purchase of products made available in the marketplace.

(c) ~~(b)~~ "Health insurance agent" means an agent licensed under part IV of chapter 626.

(d) ~~(c)~~ "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, ~~or~~ an exclusive provider organization as

defined in s. 627.6472, a health maintenance organization licensed under part I of chapter 641, or a prepaid limited health service organization or discount medical plan organization licensed under chapter 636.

(e) ~~(d)~~ "Program" means the Florida Health Choices Program established by this section.

(3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health Choices Program is created as a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care. These products include, but are not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. The components of the program include:

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

4. Distribution of premiums to insurers and payments to other eligible vendors.

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

2. Assistance with assessing the benefits and limits of

each product, including information necessary to distinguish between policies offering creditable coverage and other products available through the program.

3. Account information to assist individual participants with managing available resources.

4. Services that promote healthy behaviors.

(d) Recruitment of vendors, including insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.

(e) Certification of vendors to ensure capability, reliability, and validity of offerings.

(f) Collection of data, monitoring, assessment, and reporting of vendor performance.

(g) Information services for individuals and employers.

(h) Program evaluation.

(4) ELIGIBILITY AND PARTICIPATION.—Participation in the program is voluntary and is ~~shall be~~ available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(a) Employers eligible to enroll in the program include:

1. Employers that meet criteria established by the corporation and elect to make their employees eligible for one or more health products offered through the program ~~have 1 to 50 employees~~.

2. Fiscally constrained counties described in s. 218.67.

3. Municipalities having populations of fewer than 50,000 residents.

4. School districts in fiscally constrained counties.

5. Statutory rural hospitals.

(b) Individuals eligible to participate in the program include:

1. Individual employees of enrolled employers.

2. State employees not eligible for state employee health benefits.

3. State retirees.

4. Medicaid ~~reform~~ participants who opt out ~~select the opt-out provision of reform~~.

~~5. Statutory rural hospitals.~~

(c) Employers who choose to participate in the program may enroll by complying with the procedures established by the corporation. The procedures must include, but are not limited to:

1. Submission of required information.

2. Compliance with federal tax requirements for the establishment of a cafeteria plan, pursuant to s. 125 of the Internal Revenue Code, including designation of the employer's plan as a premium payment plan, a salary reduction plan that has flexible spending arrangements, or a salary reduction plan that has a premium payment and flexible spending arrangements.

3. Determination of the employer's contribution, if any, per employee, provided that such contribution is equal for each eligible employee.

4. Establishment of payroll deduction procedures, subject to the agreement of each individual employee who voluntarily participates in the program.

5. Designation of the corporation as the third-party administrator for the employer's health benefit plan.

6. Identification of eligible employees.

7. Arrangement for periodic payments.

8. Employer notification to employees of the intent to transfer from an existing employee health plan to the program at least 90 days before the transition.

(d) All eligible vendors who choose to participate and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health maintenance contracts ~~insurance policies~~, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid limited health service organizations may sell products and services as authorized under part I of chapter 636, and discount medical plan organizations may sell products and services as authorized under part II of chapter 636.

4.~~3.~~ Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

5.~~4.~~ Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6.~~5.~~ Provider organizations, including service networks, group practices, professional associations, and other

incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

7.~~6.~~ Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

A vendor described in subparagraphs 4.-7. ~~3.-6.~~ may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation and is authorized to provide coverage in the relevant geographic area ~~under the provisions of the Florida Insurance Code~~. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

(e) Any risk-bearing product available under subparagraphs (d)1.-4. must be approved by the Office of Insurance Regulation. Any non-risk-bearing product must be approved by the corporation.

(f)~~(e)~~ Eligible individuals may voluntarily continue participation in the program regardless of subsequent changes in job status or Medicaid eligibility. Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures must include, but are not limited to:

1. Submission of required information.

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2. Authorization for payroll deduction.

3. Compliance with federal tax requirements.

4. Arrangements for payment in the event of job changes.

5. Selection of products and services.

(g) ~~(f)~~ Vendors who choose to participate in the program may enroll by complying with the procedures established by the corporation. These procedures may ~~must~~ include, but are not limited to:

1. Submission of required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product offered through the program.

2. Execution of an agreement that ~~to make~~ all risk-bearing products offered through the program are in compliance with the insurance code and are ~~guaranteed-issue policies,~~ subject to preexisting condition exclusions established by the corporation.

3. Execution of an agreement that prohibits refusal to sell any offered non-risk-bearing product to a participant who elects to buy it.

4. Establishment of product prices based on age, gender, family composition, and location of the individual participant, which may include medical underwriting.

5. Arrangements for receiving payment for enrolled participants.

6. Participation in ongoing reporting processes established by the corporation.

7. Compliance with grievance procedures established by the corporation.

(h) ~~(g)~~ Health insurance agents licensed under part IV of

chapter 626 are eligible to voluntarily participate as buyers' representatives. A buyer's representative acts on behalf of an individual purchasing health insurance and health services through the program by providing information about products and services available through the program and assisting the individual with both the decision and the procedure of selecting specific products. Serving as a buyer's representative does not constitute a conflict of interest with continuing responsibilities as a health insurance agent if the relationship between each agent and any participating vendor is disclosed before advising an individual participant about the products and services available through the program. In order to participate, a health insurance agent shall comply with the procedures established by the corporation, including:

1. Completion of training requirements.

2. Execution of a participation agreement specifying the terms and conditions of participation.

3. Disclosure of any appointments to solicit insurance or procure applications for vendors participating in the program.

4. Arrangements to receive payment from the corporation for services as a buyer's representative.

(5) PRODUCTS.—

(a) The products that may be made available for purchase through the program include, but are not limited to:

1. Health insurance policies.

2. Limited benefit plans.

3. Prepaid clinic services.

4. Service contracts.

5. Arrangements for purchase of specific amounts and types

of health services and treatments.

6. Flexible spending accounts.

7. Health maintenance contracts.

(b) Health insurance policies, health maintenance contracts, limited benefit plans, prepaid service contracts, and other contracts for services must ensure the availability of covered services ~~and benefits to participating individuals for at least 1 full enrollment year~~.

(c) Products may be offered for multiyear periods provided the price of the product is specified for the entire period or for each separately priced segment of the policy or contract.

(d) The corporation shall provide a disclosure form for consumers to acknowledge their understanding of the nature of, and any limitations to, the benefits provided by the products and services being purchased by the consumer.

(e) The corporation must determine that making the plan available through the program is in the interest of eligible individuals and eligible employers in the state.

(6) PRICING.—Prices for the products sold through the program must be transparent to participants and established by the vendors. Risk-bearing products approved by the Office of Insurance Regulation must be priced pursuant to state law governing the rates of insurance product ~~based on age, gender, and location of participants~~. ~~The corporation shall develop a methodology for evaluating the actuarial soundness of products offered through the program. The methodology shall be reviewed by the Office of Insurance Regulation prior to use by the corporation. Before making the product available to individual participants, the corporation shall use the methodology to~~

~~compare the expected health care costs for the covered services and benefits to the vendor's price for that coverage. The results shall be reported to individuals participating in the program. Once established, the price set by the vendor must remain in force for at least 1 year and may only be redetermined by the vendor at the next annual enrollment period.~~ The corporation shall annually assess a surcharge for each premium or price set by a participating vendor. The surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives.

(7) MARKETPLACE ~~EXCHANGE~~ PROCESS.—The program shall provide a single, centralized market for purchase of health insurance, health maintenance contracts, and other health products and services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive Internet website. A participant needing personal assistance to select products and services shall be referred to a participating agent in his or her area.

(a) Participation in the program may begin at any time during a year after the employer completes enrollment and meets the requirements specified by the corporation pursuant to paragraph (4)(c).

(b) Initial selection of products and services must be made by an individual participant within 60 days after the date the individual's employer qualified for participation. An individual

who fails to enroll in products and services by the end of this period is limited to participation in flexible spending account services until the next annual enrollment period.

(c) Initial enrollment periods for each product selected by an individual participant must last at least 12 months, unless the individual participant specifically agrees to a different enrollment period.

(d) If an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participant, changes in selected products and services may only be made during the annual enrollment period established by the corporation.

(e) The limits established in paragraphs (b)-(d) apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(8) CONSUMER INFORMATION.—The corporation shall:

(a) Establish a secure website to facilitate the purchase of products and services by participating individuals. The website must provide information about each product or service available through the program.

(b) Inform individuals about other public health care programs.

~~(a) Prior to making a risk-bearing product available~~

~~through the program, the corporation shall provide information regarding the product to the Office of Insurance Regulation. The office shall review the product information and provide consumer information and a recommendation on the risk-bearing product to the corporation within 30 days after receiving the product information.~~

~~1. Upon receiving a recommendation that a risk-bearing product should be made available in the marketplace, the corporation may include the product on its website. If the consumer information and recommendation is not received within 30 days, the corporation may make the risk-bearing product available on the website without consumer information from the office.~~

~~2. Upon receiving a recommendation that a risk-bearing product should not be made available in the marketplace, the risk-bearing product may be included as an eligible product in the marketplace and on its website only if a majority of the board of directors vote to include the product.~~

~~(b) If a risk-bearing product is made available on the website, the corporation shall make the consumer information and office recommendation available on the website and in print format. The corporation shall make late-submitted and ongoing updates to consumer information available on the website and in print format.~~

(9) RISK POOLING.—The program may use ~~shall utilize~~ methods for pooling the risk of individual participants and preventing selection bias. These methods may ~~shall~~ include, but are not limited to, a postenrollment risk adjustment of the premium payments to the vendors. The corporation may ~~shall~~ establish a

methodology for assessing the risk of enrolled individual participants based on data reported annually by the vendors about their enrollees. Distribution ~~Monthly distributions~~ of payments to the vendors may ~~shall~~ be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

(10) EXEMPTIONS.—

(a) Products, other than the risk-bearing products set forth in subparagraph (4)(d)1.-4., ~~Policies~~ sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, as defined in s. 624.01 ~~chapter 641~~, or the mandated offerings or coverages established in part VI of chapter 627 and chapter 641.

(b) The corporation may act as an administrator as defined in s. 626.88 but is not required to be certified pursuant to part VII of chapter 626. However, a third party administrator used by the corporation must be certified under part VII of chapter 626.

(11) CORPORATION.—There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter 112 and chapters 119, 286, and 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

(a) The corporation shall be governed by a 15-member board of directors consisting of:

1. Three ex officio, nonvoting members to include:

a. The Secretary of Health Care Administration or a designee with expertise in health care services.

b. The Secretary of Management Services or a designee with expertise in state employee benefits.

c. The commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.

2. Four members appointed by and serving at the pleasure of the Governor.

3. Four members appointed by and serving at the pleasure of the President of the Senate.

4. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

5. Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations, prepaid service providers, or any other entity, affiliate or subsidiary of eligible vendors.

(b) Members shall be appointed for terms of up to 3 years. Any member is eligible for reappointment. A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(c) The board shall select a chief executive officer for the corporation who shall be responsible for the selection of such other staff as may be authorized by the corporation's operating budget as adopted by the board.

(d) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061. No other compensation is authorized.

(e) There is no liability on the part of, and no cause of action shall arise against, any member of the board or its

employees or agents for any action taken by them in the performance of their powers and duties under this section.

(f) The board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the corporation and carrying out the purposes of this section. The bylaws shall:

1. Specify procedures for selection of officers and qualifications for reappointment, provided that no board member shall serve more than 9 consecutive years.

2. Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.

3. Specify policies and procedures regarding conflicts of interest, including the provisions of part III of chapter 112, which prohibit a member from participating in any decision that would inure to the benefit of the member or the organization that employs the member. The policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

(g) The corporation may exercise all powers granted to it under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this section.

(h) The corporation may establish technical advisory panels consisting of interested parties, including consumers, health

care providers, individuals with expertise in insurance regulation, and insurers.

(i) The corporation shall:

1. Determine eligibility of employers, vendors, individuals, and agents in accordance with subsection (4).

2. Establish procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

3. Arrange for collection of contributions from participating employers and individuals.

4. Arrange for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

5. Establish criteria for disenrollment of participating individuals based on failure to pay the individual’s share of any contribution required to maintain enrollment in selected products.

6. Establish criteria for exclusion of vendors pursuant to paragraph (4)(d).

7. Develop and implement a plan for promoting public awareness of and participation in the program.

8. Secure staff and consultant services necessary to the operation of the program.

9. Establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents, and employers.

10. Provide for the operation of a toll-free hotline to respond to requests for assistance.

11. Provide for initial, open, and special enrollment periods not to exceed 60 days.

12. Establish options for employer participation which may conform with common insurance practices.

~~10. Develop a plan, in coordination with the Department of Revenue, to establish tax credits or refunds for employers that participate in the program. The corporation shall submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2009.~~

(12) REPORT.—Beginning in the 2009-2010 fiscal year, submit by February 1 an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives documenting the corporation's activities in compliance with the duties delineated in this section.

(13) PROGRAM INTEGRITY.—To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

Section 2. Section 409.821, Florida Statutes, is amended to read:

409.821 Florida Kidcare program public records exemption.—

(1) Personal identifying information of a Florida Kidcare program applicant or enrollee, as defined in s. 409.811, held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the

Florida Healthy Kids Corporation is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2)(a) Upon request, such information shall be disclosed to:

1. Another governmental entity in the performance of its official duties and responsibilities;

2. The Department of Revenue for purposes of administering the state Title IV-D program; ~~or~~

3. The Florida Health Choices, Inc., for the purpose of administering the program authorized pursuant to s. 408.910; or

4.~~3.~~ Any person who has the written consent of the program applicant.

(b) This section does not prohibit an enrollee's legal guardian from obtaining confirmation of coverage, dates of coverage, the name of the enrollee's health plan, and the amount of premium being paid.

(3) This exemption applies to any information identifying a Florida Kidcare program applicant or enrollee held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation before, on, or after the effective date of this exemption.

(4) A knowing and willful violation of this section is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 3. Subsection (41) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients

in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or

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particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program

as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(41) The agency shall establish ~~provide for the development of~~ a demonstration project ~~by establishment~~ in Miami-Dade County of a long-term-care facility and a psychiatric facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and collocated ~~colocated~~ with licensed facilities providing a continuum of care. These projects are ~~The establishment of this project is~~ not subject to the provisions of s. 408.036 or s. 408.039.

Section 4. This act shall take effect July 1, 2011.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to Florida Health Choices Program; amending s. 408.910, F.S.; providing and revising definitions; revising eligibility requirements for participation in the Florida Health Choices Program; providing that statutory rural hospitals are eligible as employers rather than participants under the program; permitting specified eligible vendors to sell health maintenance contracts or products and services; requiring certain risk-bearing products offered by

insurers to be approved by the Office of Insurance Regulation; providing requirements for product certification; providing duties of the Florida Health Choices, Inc., including maintenance of a toll-free telephone hotline to respond to requests for assistance; providing for enrollment periods; providing for certain risk pooling data used by the corporation to be reported annually; amending s. 409.821, F.S.; authorizing personal identifying information of a Florida Kidcare program applicant to be disclosed to the Florida Health Choices, Inc., to administer the program; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to establish a demonstration project in Miami-Dade County of a long-term-care facility and a psychiatric facility to improve access to health care by medically underserved persons; providing an effective date.

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LEGISLATIVE ACTION

Senate . House

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The Committee on Banking and Insurance (Oelrich) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 408.910, Florida Statutes, is amended to read:

408.910 Florida Health Choices Program.—

(1) LEGISLATIVE INTENT.—The Legislature finds that a significant number of the residents of this state do not have adequate access to affordable, quality health care. The Legislature further finds that increasing access to affordable, quality health care can be best accomplished by establishing a

competitive market for purchasing health insurance and health services. It is therefore the intent of the Legislature to create the Florida Health Choices Program to:

(a) Expand opportunities for Floridians to purchase affordable health insurance and health services.

(b) Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits.

(c) Enable individual choice in both the manner and amount of health care purchased.

(d) Provide for the purchase of individual, portable health care coverage.

(e) Disseminate information to consumers on the price and quality of health services.

(f) Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Corporation" means the Florida Health Choices, Inc., established under this section.

(b) "Corporation's marketplace" means the single, centralized market established by the program which facilitates the purchase of products made available in the marketplace.

(c) ~~(b)~~ "Health insurance agent" means an agent licensed under part IV of chapter 626.

(d) ~~(c)~~ "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, ~~or~~ an exclusive provider organization as

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defined in s. 627.6472, a health maintenance organization licensed under part I of chapter 641, or a prepaid limited health service organization or discount medical plan organization licensed under chapter 636.

(e) ~~(d)~~ "Program" means the Florida Health Choices Program established by this section.

(3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health Choices Program is created as a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care. These products include, but are not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. The components of the program include:

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

4. Distribution of premiums to insurers and payments to other eligible vendors.

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

2. Assistance with assessing the benefits and limits of

each product, including information necessary to distinguish between policies offering creditable coverage and other products available through the program.

3. Account information to assist individual participants with managing available resources.

4. Services that promote healthy behaviors.

(d) Recruitment of vendors, including insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.

(e) Certification of vendors to ensure capability, reliability, and validity of offerings.

(f) Collection of data, monitoring, assessment, and reporting of vendor performance.

(g) Information services for individuals and employers.

(h) Program evaluation.

(4) ELIGIBILITY AND PARTICIPATION.—Participation in the program is voluntary and is ~~shall be~~ available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(a) Employers eligible to enroll in the program include:

1. Employers that meet criteria established by the corporation and elect to make their employees eligible for one or more health products offered through the program ~~have 1 to 50 employees~~.

2. Fiscally constrained counties described in s. 218.67.

3. Municipalities having populations of fewer than 50,000 residents.

4. School districts in fiscally constrained counties.

5. Statutory rural hospitals.

(b) Individuals eligible to participate in the program include:

1. Individual employees of enrolled employers.

2. State employees not eligible for state employee health benefits.

3. State retirees.

4. Medicaid ~~reform~~ participants who opt out ~~select the opt-out provision of reform~~.

~~5. Statutory rural hospitals.~~

(c) Employers who choose to participate in the program may enroll by complying with the procedures established by the corporation. The procedures must include, but are not limited to:

1. Submission of required information.

2. Compliance with federal tax requirements for the establishment of a cafeteria plan, pursuant to s. 125 of the Internal Revenue Code, including designation of the employer's plan as a premium payment plan, a salary reduction plan that has flexible spending arrangements, or a salary reduction plan that has a premium payment and flexible spending arrangements.

3. Determination of the employer's contribution, if any, per employee, provided that such contribution is equal for each eligible employee.

4. Establishment of payroll deduction procedures, subject to the agreement of each individual employee who voluntarily participates in the program.

5. Designation of the corporation as the third-party administrator for the employer's health benefit plan.

6. Identification of eligible employees.

7. Arrangement for periodic payments.

8. Employer notification to employees of the intent to transfer from an existing employee health plan to the program at least 90 days before the transition.

(d) All eligible vendors who choose to participate and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health maintenance contracts ~~insurance policies~~, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid limited health service organizations may sell products and services as authorized under part I of chapter 636, and discount medical plan organizations may sell products and services as authorized under part II of chapter 636.

4.~~3.~~ Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

5.~~4.~~ Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6.~~5.~~ Provider organizations, including service networks, group practices, professional associations, and other

incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

7.~~6.~~ Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

A vendor described in subparagraphs 4.-7. ~~3.-6~~. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation and is authorized to provide coverage in the relevant geographic area ~~under the provisions of the Florida Insurance Code~~. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

(e) Any risk-bearing product available under subparagraphs (d)1.-4. must be approved by the Office of Insurance Regulation. Any non-risk-bearing product must be approved by the corporation.

(f)~~(e)~~ Eligible individuals may voluntarily continue participation in the program regardless of subsequent changes in job status or Medicaid eligibility. Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures must include, but are not limited to:

1. Submission of required information.


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2. Authorization for payroll deduction.

3. Compliance with federal tax requirements.

4. Arrangements for payment in the event of job changes.

5. Selection of products and services.

(g) ~~(f)~~ Vendors who choose to participate in the program may enroll by complying with the procedures established by the corporation. These procedures may ~~must~~ include, but are not limited to:

1. Submission of required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product offered through the program.

2. Execution of an agreement that ~~to make~~ all risk-bearing products offered through the program are in compliance with the insurance code and are ~~guaranteed-issue policies,~~ subject to preexisting condition exclusions established by the corporation.

3. Execution of an agreement that prohibits refusal to sell any offered non-risk-bearing product to a participant who elects to buy it.

4. Establishment of product prices based on age, gender, family composition, and location of the individual participant, which may include medical underwriting.

5. Arrangements for receiving payment for enrolled participants.

6. Participation in ongoing reporting processes established by the corporation.

7. Compliance with grievance procedures established by the corporation.

(h) ~~(g)~~ Health insurance agents licensed under part IV of

chapter 626 are eligible to voluntarily participate as buyers' representatives. A buyer's representative acts on behalf of an individual purchasing health insurance and health services through the program by providing information about products and services available through the program and assisting the individual with both the decision and the procedure of selecting specific products. Serving as a buyer's representative does not constitute a conflict of interest with continuing responsibilities as a health insurance agent if the relationship between each agent and any participating vendor is disclosed before advising an individual participant about the products and services available through the program. In order to participate, a health insurance agent shall comply with the procedures established by the corporation, including:

1. Completion of training requirements.

2. Execution of a participation agreement specifying the terms and conditions of participation.

3. Disclosure of any appointments to solicit insurance or procure applications for vendors participating in the program.

4. Arrangements to receive payment from the corporation for services as a buyer's representative.

(5) PRODUCTS.—

(a) The products that may be made available for purchase through the program include, but are not limited to:

1. Health insurance policies.

2. Limited benefit plans.

3. Prepaid clinic services.

4. Service contracts.

5. Arrangements for purchase of specific amounts and types


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of health services and treatments.

6. Flexible spending accounts.

7. Health maintenance contracts.

(b) Health insurance policies, health maintenance contracts, limited benefit plans, prepaid service contracts, and other contracts for services must ensure the availability of covered services ~~and benefits to participating individuals for at least 1 full enrollment year~~.

(c) Products may be offered for multiyear periods provided the price of the product is specified for the entire period or for each separately priced segment of the policy or contract.

(d) The corporation shall provide a disclosure form for consumers to acknowledge their understanding of the nature of, and any limitations to, the benefits provided by the products and services being purchased by the consumer.

(e) The corporation must determine that making the plan available through the program is in the interest of eligible individuals and eligible employers in the state.

(6) PRICING.—Prices for the products sold through the program must be transparent to participants and established by the vendors. Risk-bearing products approved by the Office of Insurance Regulation must be priced pursuant to state law governing the rates of insurance product ~~based on age, gender, and location of participants~~. ~~The corporation shall develop a methodology for evaluating the actuarial soundness of products offered through the program. The methodology shall be reviewed by the Office of Insurance Regulation prior to use by the corporation. Before making the product available to individual participants, the corporation shall use the methodology to~~

~~compare the expected health care costs for the covered services and benefits to the vendor's price for that coverage. The results shall be reported to individuals participating in the program. Once established, the price set by the vendor must remain in force for at least 1 year and may only be redetermined by the vendor at the next annual enrollment period.~~ The corporation shall annually assess a surcharge for each premium or price set by a participating vendor. The surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives.

(7) MARKETPLACE ~~EXCHANGE~~ PROCESS.—The program shall provide a single, centralized market for purchase of health insurance, health maintenance contracts, and other health products and services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive Internet website. A participant needing personal assistance to select products and services shall be referred to a participating agent in his or her area.

(a) Participation in the program may begin at any time during a year after the employer completes enrollment and meets the requirements specified by the corporation pursuant to paragraph (4)(c).

(b) Initial selection of products and services must be made by an individual participant within 60 days after the date the individual's employer qualified for participation. An individual

who fails to enroll in products and services by the end of this period is limited to participation in flexible spending account services until the next annual enrollment period.

(c) Initial enrollment periods for each product selected by an individual participant must last at least 12 months, unless the individual participant specifically agrees to a different enrollment period.

(d) If an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participant, changes in selected products and services may only be made during the annual enrollment period established by the corporation.

(e) The limits established in paragraphs (b)-(d) apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(8) CONSUMER INFORMATION.—The corporation shall:

(a) Establish a secure website to facilitate the purchase of products and services by participating individuals. The website must provide information about each product or service available through the program.

(b) Inform individuals about other public health care programs.

~~(a) Prior to making a risk-bearing product available~~


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~~through the program, the corporation shall provide information regarding the product to the Office of Insurance Regulation. The office shall review the product information and provide consumer information and a recommendation on the risk-bearing product to the corporation within 30 days after receiving the product information.~~

~~1. Upon receiving a recommendation that a risk-bearing product should be made available in the marketplace, the corporation may include the product on its website. If the consumer information and recommendation is not received within 30 days, the corporation may make the risk-bearing product available on the website without consumer information from the office.~~

~~2. Upon receiving a recommendation that a risk-bearing product should not be made available in the marketplace, the risk-bearing product may be included as an eligible product in the marketplace and on its website only if a majority of the board of directors vote to include the product.~~

~~(b) If a risk-bearing product is made available on the website, the corporation shall make the consumer information and office recommendation available on the website and in print format. The corporation shall make late-submitted and ongoing updates to consumer information available on the website and in print format.~~

(9) RISK POOLING.—The program may use ~~shall utilize~~ methods for pooling the risk of individual participants and preventing selection bias. These methods may ~~shall~~ include, but are not limited to, a postenrollment risk adjustment of the premium payments to the vendors. The corporation may ~~shall~~ establish a

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methodology for assessing the risk of enrolled individual participants based on data reported annually by the vendors about their enrollees. Distribution ~~Monthly distributions~~ of payments to the vendors may ~~shall~~ be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

(10) EXEMPTIONS.—

(a) Products, other than the risk-bearing products set forth in subparagraph (4)(d)1.-4., ~~Policies~~ sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, as defined in s. 624.01 ~~chapter 641~~, or the mandated offerings or coverages established in part VI of chapter 627 and chapter 641.

(b) The corporation may act as an administrator as defined in s. 626.88 but is not required to be certified pursuant to part VII of chapter 626. However, a third party administrator used by the corporation must be certified under part VII of chapter 626.

(11) CORPORATION.—There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter 112 and chapters 119, 286, and 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

(a) The corporation shall be governed by a 15-member board of directors consisting of:

1. Three ex officio, nonvoting members to include:

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a. The Secretary of Health Care Administration or a designee with expertise in health care services.

b. The Secretary of Management Services or a designee with expertise in state employee benefits.

c. The commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.

2. Four members appointed by and serving at the pleasure of the Governor.

3. Four members appointed by and serving at the pleasure of the President of the Senate.

4. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

5. Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations, prepaid service providers, or any other entity, affiliate or subsidiary of eligible vendors.

(b) Members shall be appointed for terms of up to 3 years. Any member is eligible for reappointment. A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(c) The board shall select a chief executive officer for the corporation who shall be responsible for the selection of such other staff as may be authorized by the corporation's operating budget as adopted by the board.

(d) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061. No other compensation is authorized.

(e) There is no liability on the part of, and no cause of action shall arise against, any member of the board or its

employees or agents for any action taken by them in the performance of their powers and duties under this section.

(f) The board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the corporation and carrying out the purposes of this section. The bylaws shall:

1. Specify procedures for selection of officers and qualifications for reappointment, provided that no board member shall serve more than 9 consecutive years.

2. Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.

3. Specify policies and procedures regarding conflicts of interest, including the provisions of part III of chapter 112, which prohibit a member from participating in any decision that would inure to the benefit of the member or the organization that employs the member. The policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

(g) The corporation may exercise all powers granted to it under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this section.

(h) The corporation may establish technical advisory panels consisting of interested parties, including consumers, health

care providers, individuals with expertise in insurance regulation, and insurers.

(i) The corporation shall:

1. Determine eligibility of employers, vendors, individuals, and agents in accordance with subsection (4).

2. Establish procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

3. Arrange for collection of contributions from participating employers and individuals.

4. Arrange for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

5. Establish criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

6. Establish criteria for exclusion of vendors pursuant to paragraph (4)(d).

7. Develop and implement a plan for promoting public awareness of and participation in the program.

8. Secure staff and consultant services necessary to the operation of the program.

9. Establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents, and employers.

10. Provide for the operation of a toll-free hotline to respond to requests for assistance.


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11. Provide for initial, open, and special enrollment periods not to exceed 60 days.

12. Establish options for employer participation which may conform with common insurance practices.

~~10. Develop a plan, in coordination with the Department of Revenue, to establish tax credits or refunds for employers that participate in the program. The corporation shall submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2009.~~

(12) REPORT.—Beginning in the 2009-2010 fiscal year, submit by February 1 an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives documenting the corporation's activities in compliance with the duties delineated in this section.

(13) PROGRAM INTEGRITY.—To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

Section 2. Section 409.821, Florida Statutes, is amended to read:

409.821 Florida Kidcare program public records exemption.—

(1) Personal identifying information of a Florida Kidcare program applicant or enrollee, as defined in s. 409.811, held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the

Florida Healthy Kids Corporation is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2)(a) Upon request, such information shall be disclosed to:

1. Another governmental entity in the performance of its official duties and responsibilities;

2. The Department of Revenue for purposes of administering the state Title IV-D program; ~~or~~

3. The Florida Health Choices, Inc., for the purpose of administering the program authorized pursuant to s. 408.910; or

4.~~3.~~ Any person who has the written consent of the program applicant.

(b) This section does not prohibit an enrollee's legal guardian from obtaining confirmation of coverage, dates of coverage, the name of the enrollee's health plan, and the amount of premium being paid.

(3) This exemption applies to any information identifying a Florida Kidcare program applicant or enrollee held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation before, on, or after the effective date of this exemption.

(4) A knowing and willful violation of this section is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 3. Subsection (41) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients

in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or

564 particular drugs to prevent fraud, abuse, overuse, and possible
565 dangerous drug interactions. The Pharmaceutical and Therapeutics
566 Committee shall make recommendations to the agency on drugs for
567 which prior authorization is required. The agency shall inform
568 the Pharmaceutical and Therapeutics Committee of its decisions
569 regarding drugs subject to prior authorization. The agency is
570 authorized to limit the entities it contracts with or enrolls as
571 Medicaid providers by developing a provider network through
572 provider credentialing. The agency may competitively bid single-
573 source-provider contracts if procurement of goods or services
574 results in demonstrated cost savings to the state without
575 limiting access to care. The agency may limit its network based
576 on the assessment of beneficiary access to care, provider
577 availability, provider quality standards, time and distance
578 standards for access to care, the cultural competence of the
579 provider network, demographic characteristics of Medicaid
580 beneficiaries, practice and provider-to-beneficiary standards,
581 appointment wait times, beneficiary use of services, provider
582 turnover, provider profiling, provider licensure history,
583 previous program integrity investigations and findings, peer
584 review, provider Medicaid policy and billing compliance records,
585 clinical and medical record audits, and other factors. Providers
586 shall not be entitled to enrollment in the Medicaid provider
587 network. The agency shall determine instances in which allowing
588 Medicaid beneficiaries to purchase durable medical equipment and
589 other goods is less expensive to the Medicaid program than long-
590 term rental of the equipment or goods. The agency may establish
591 rules to facilitate purchases in lieu of long-term rentals in
592 order to protect against fraud and abuse in the Medicaid program

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as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(41) The agency shall establish ~~provide for the development of~~ a demonstration project ~~by establishment~~ in Miami-Dade County of a long-term-care facility and a psychiatric facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and collocated ~~colocated~~ with licensed facilities providing a continuum of care. These projects are ~~The establishment of this project is~~ not subject to the provisions of s. 408.036 or s. 408.039.

Section 4. This act shall take effect July 1, 2011.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health and human services; amending s. 408.910, F.S.; providing and revising definitions; revising eligibility requirements for participation in the Florida Health Choices Program; providing that statutory rural hospitals are eligible as employers rather than participants under the program; permitting specified eligible vendors to sell health maintenance contracts or products and services; requiring certain


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risk-bearing products offered by insurers to be approved by the Office of Insurance Regulation; providing requirements for product certification; providing duties of the Florida Health Choices, Inc., including maintenance of a toll-free telephone hotline to respond to requests for assistance; providing for enrollment periods; providing for certain risk pooling data used by the corporation to be reported annually; amending s. 409.821, F.S.; authorizing personal identifying information of a Florida Kidcare program applicant to be disclosed to the Florida Health Choices, Inc., to administer the program; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to establish a demonstration project in Miami-Dade County of a long-term-care facility and a psychiatric facility to improve access to health care by medically underserved persons; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL:	SB 1922
INTRODUCER:	Senator Garcia
SUBJECT:	Health Insurance
DATE:	April 19, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Pre-meeting**
2.			HR	
3.			BC	
4.				
5.				
6.				

I. Summary:

In 2008, the Florida Legislature created the Florida Health Choices Program (program). The program is designed to provide a centralized marketplace for the sale and purchase of health care products. These products would include, but are not limited to health insurance plans, health maintenance organizations (HMOs) plans, prepaid services, service contracts, and flexible spending accounts. The bill makes the following changes to the program:

- Expands the categories of employees and employers eligible for enrollment;
- Streamlines and clarifies the process by which new products are approved and offered;
- Authorizes HMOs to sell contracts under the program; and
- Requires the Office of Insurance Regulation (OIR) to approve risk-bearing products that are sold by insurers and HMOs.

This bill amends the following sections of the Florida Statutes: 409.821 and 408.910.

II. Present Situation:

Florida Health Choices Program

In 2008, the Florida Legislature created the Florida Health Choices Inc., as a not-for-profit corporation. The corporation is responsible for administering the program and functioning like a third-party administrator (TPA) for employers participating in the program. Products sold as part of the program are exempt from regulation under the Insurance Code and laws governing health maintenance organizations.

Administration of the Program

The corporation is governed by a 15-member board, four members appointed by the Governor, four members appointed by the Senate President, four members appointed by the Speaker of the House of Representatives, and three non-voting members from the following agencies: Agency for Health Care Administration, Department of Management Services, and the Office of Insurance Regulation (OIR). The board members may not include insurers, health insurance agents, health care providers, HMOs, prepaid service providers, or any other entity or affiliate of eligible vendors.

The board may secure staff and consultant services necessary to the operation of the program. A total of $1.5 million in non-recurring funds was appropriated in 2008 from the General Revenue Fund to finance the program. The program is authorized to assess an annual surcharge for each premium or price set by a participating vendor of not more than 2.5 percent of the price to fund administrative services and payments to buyers' representatives or agents.

In the summer of 2011, phase one of the program will be operational. It will offer a central web portal to access and compare multiple insurance products.[1] The initial web-based portal will support a limited number of medical plans and permit a comparison of benefits and costs. The program expects to implement additional features in late 2011 and 2012, including the offering of life insurance and other products.

Eligibility and Enrollment

Small employers (1-50 employees), certain eligible individuals, cities with a population of less than 50,000, fiscally constrained counties, school districts in fiscally constrained counties, and statutory rural hospitals are eligible to enroll. Eligible individuals include individual employees of enrolled employers, state employees ineligible for the state group insurance plan, state retirees, and Medicaid participants who opt-out of the reform program.

Employers are required to establish section 125 plans in order to participate in, and allow their employees to enroll in, the program. This allows both employers and employees to purchase insurance coverage through the program using pre-tax dollars.[2]

Authorized Vendors

The corporation must certify vendors and ensure the validity of their offerings. The following entities are authorized to be eligible vendors of the products and plans:

- Insurers authorized under ch. 624, F.S.,

[1] See http://myfloridachoices.org/about/ (last viewed March 21, 2011).

[2] Section 125 of the Internal Revenue Code (IRC) allows employers to offer a cafeteria plan to employees for payment of qualified benefits. A cafeteria plan is a separate written plan maintained by an employer for employees meeting the specific requirements of section 125. It provides participants an opportunity to receive certain benefits on a pretax basis. Participants in a cafeteria plan must be permitted to choose among at least one taxable benefit (such as cash) and one qualified benefit. A qualified benefit is a benefit that does not defer compensation and is excludable from an employee's gross income under a specific provision of the IRC, without being subject to the principles of constructive receipt. Qualified benefits include but are not limited to accident and health benefits (but not Archer medical savings accounts or long-term care insurance); adoption assistance; dependent care assistance; group-term life insurance coverage; and health savings accounts. A section 125 plan is the only means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice causing the benefits to become taxable. A plan offering only a choice between taxable benefits is not a section 125 plan. *See* http://www.irs.gov/govt/fslg/article/0,,id=112720,00.html. (last viewed April 18, 2011).

- HMOs authorized under ch. 641, F.S.,
- Prepaid health clinics licensed under part II of ch. 641, F.S.,
- Health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers,
- Provider organizations, including services networks, group practices, and professional associations, and
- Corporate entities providing specific health services.

Vendors may not sell products that provide risk-bearing coverage unless those vendors are authorized under a certification of authority issued by the OIR under the Florida Insurance Code. Vendors are required to make all risk-bearing products offered through the program guaranteed-issue policies, subject to preexisting condition exclusions established by the corporation.

Prior to making a risk-bearing product available through the program, the corporation must provide information on the product to the OIR. The OIR has 30 days to review the product and to recommend that it should, or should not, be made available through the program. If the OIR recommends that a risk-bearing product should not be made available, the product may be offered only if a majority of the board vote to include the product.

Pricing; Risk Pooling

Prices for products sold through the program are underwritten based on age, gender, and location of participants. The corporation must develop a methodology for evaluating the actuarial soundness of the product and the methodology is subject to review by the OIR. The corporation must use the methodology to compare the expected costs and benefits of the products, which must be reported to individuals participating in the program. Prices must remain in force for at least one year. The corporation must add a surcharge not to exceed 2.5 percent for each premium or price set by the vendor to generate funding for administrative services provided by the corporation and payments to buyer's representatives (including insurance agents).

The program must utilize methods for pooling the risk of individual participants and preventing selection bias, including a post-enrollment risk adjustment of the premium payments to the vendors. Monthly distributions of payments to the vendors must be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

The Federal Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, "PPACA," P.L. 111-148, as amended by the Reconciliation Act, P.L. 111-152. The PPACA is a broad-based, national approach to reform various aspects of the health care system. The PPACA requires most U.S. citizens and legal residents to obtain health insurance by January 1, 2014.

The PPACA also establishes new requirements on employers and health plans; restructures the private health insurance market; and creates exchanges for individuals and employers to obtain coverage. An exchange is not an insurer; however, it would provide eligible individuals and businesses with access to insurers' plans.

If a state decides to establish an exchange, such exchange must be a governmental agency or nonprofit entity. A state may establish a single exchange or multiple subsidiary exchanges if each serves a distinct geographic area. Exchanges may contract with entities in the individual and small group markets and in benefits coverage if the entity is not an insurer, or with the state Medicaid agency. By 2015, exchanges must be self-sufficient and may charge assessments or user fees. If the U.S. Health and Human Services (HHS) determines by January 1, 2013, that a state has opted out of operating an exchange or that it will not have an exchange operational by January 1, 2014, the HHS shall operate an exchange, either directly or through agreement with a non-profit entity.

Effective January 1, 2014, individual coverage will be available through an "American Health Benefit Exchange" and small businesses with 100 or fewer employees can purchase coverage through a "Small Business Health Options Program" (SHOP) exchange. However, a state may merge the individual and small business exchanges into a single exchange. Businesses with more than 100 employees can purchase coverage in an exchange beginning in 2017.

Florida and 25 other states brought an action in the United States District Court for the Northern District of Florida challenging the constitutionality of PPACA. On January 31, 2011, Judge Roger Vinson found the Act unconstitutional.[3] The court rejected the argument by the United States that the individual mandate is a tax and made it clear that he agreed with the plaintiff's argument that the power the individual mandate seeks to harness "is simply without precedent." On March 3, 2011, Judge Vinson granted a stay of his order on the condition that the federal government seek an immediate appeal and seek an expedited review. The federal government filed the appeal and motion for expedited review to the United State Court of Appeal for the Eleventh Circuit on March 8, 2011.[4] Florida and the other plaintiffs have filed a motion requesting a more condensed briefing and oral argument schedule than requested by the federal government. The Eleventh Circuit responded on March 11, 2011, setting the briefing schedule beginning on April 4, 2011, and ending May 25, 2011.[5]

III. Effect of Proposed Changes:

Section 1 amends section 408.910(2), F.S., relating to Florida Health Choices, Inc.

Definitions
The bill creates definitions for the following terms:

- "Corporation's marketplace" means a single, centralized market established by the program to facilitate the purchase of products certified by the corporation.
- "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plans contract, or HMO contract.

[3] State of Florida, et al. v. United States Department of Health and Human Services, et al., --- F.Supp.2d ----, 2011 WL 285683 (N.D.Fla.).
[4] Case No. 11-11021-HH.
[5] State of Fla., et al. v. U.S. Dept. of Health & Human Serv., Nos. 11-11021-HH & 11-11067-HH, Order on Appellants' Mtn. to Expedite Appeal (11th Cir. March 11, 2011).

- Small employer" means an employer with an average of not more than 50 employees during the preceding calendar year;
  - All employees are counted, including part-time and those not eligible for coverage through the employer;
  - A newly existing employer is allowed to base eligibility on a reasonably expected number of employees; and
  - A small employer is allowed to maintain coverage if his or her number of employees exceed 50.

Eligibility and Administration of the Program
The bill revises the eligibility and enrollment provisions in the following manner:

- Remove the eligibility restriction for employers to have 1 to 50 employees, and allows the employers to meet the criteria as established by the corporation and elect to make their employees to be eligible for more than one or more health plans offered;
- Allows all Medicaid recipients who opt-out of Medicaid to participate in the program rather than only Medicaid reform participants;
- Requires the OIR to approve risk-bearing products that are regulated under ch. 624 or part I of ch. 641, F.S., and are available through the program;
- Clarifies that s. 408.910, F.S., does not preempt the authority of the OIR to regulate the business of insurance in Florida;
- Provides that any non-risk-bearing products other than those specifically subject to OIR's regulation must be approved by the corporation;
- Removes the requirement that the program develop a methodology by which it will evaluate the actuarial soundness of the products and premiums offered by the plan and eliminates the process for the program seek guidance from OIR regarding the approval or denial of inclusion of a plan or product;
- Requires the program to operate a toll-free hotline that will assist enrollees, prospective enrollees, vendors, and other participants;
- Eliminates the plan for tax credits to be made available to participating employers;
- Deletes the one-year enrollment requirement for all types of products; and
- Requires the operation of a toll-free hotline

The bill provides technical, conforming changes, such as including HMOs and their products.

Section 2 amends s. 409.821, F.S., to require the disclosure of personal identifying information about a Florida Kidcare Program applicant or enrollee to the program by the Agency for Health Care Administration, the Department of Children and Families, the Department of Health, or the Florida Healthy Kids Corporation for administration of the program.

Section 3 provides that the bill will take effect July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

In 2008, the Legislature appropriated $1,000,000 in non-recurring General Revenue to the Florida Health Choices, Inc., to implement the program. The program is authorized to assess an annual surcharge for each premium or price set by a participating vendor of not more than 2.5 percent of the price to fund administrative services and payments to buyers' representatives or agents.

The requirement that the program operate a toll-free hotline to respond to requests for assistance regarding the marketplace carries an indeterminate, and possibly significant, fiscal impact. The program will need to purchase hardware and software to establish, operate, and maintain the hotline. Additional staff will also need to be hired and trained. If the program chooses to outsource the operation of the hotline, that action will also carry a fiscal impact on the corporation.

B. Private Sector Impact:

The bill expands the pool of eligible employees and employers that would have access to a variety of products offered by the program.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The bill provides a definition of the term, "small employer," that differs substantially with the definition of a small employer as provided in the Insurance Code. Small employer is defined in s. 627.6699(3)(v), F.S., to mean, in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year the majority of whom were employed in this state, employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of eligible employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single employer. For purposes of this

section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.

The bill provides a definition of "health benefit plan" that differs substantially from the definition in the Insurance Code. The term "health benefit plan" is defined for small group coverage in s. 627.6699(3)(k), F.S., to means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.