FOR CONSIDERATION By the Committee on Health Policy

588-03162A-13 20137144__

A bill to be entitled

An act relating to the Health Choice Plus Program; amending s. 408.910, F.S.; conforming provisions to changes made by the act; creating s. 408.9105, F.S.; creating the Health Choice Plus Program; providing legislative intent; providing definitions; providing eligibility requirements; providing exceptions in specific situations; providing for enrollment in the program; providing for disenrollment in specific situations; providing for reenrollment in specific situations; providing requirements and procedures for use of funds in a health benefits account; authorizing the Florida Health Choices, Inc., to accept funds from various sources to deposit into health benefits accounts, subsidize the costs of coverage, and administer and support the program; requiring the corporation to manage the health benefits accounts and provide the marketplace of options that an enrollee in the program may use; specifying healthy living performance goals; providing for payment for achieving health living performance goals; providing that the Florida Insurance Code is not applicable to the program; providing that coverage under the program is not an entitlement; prohibiting a cause of action against certain entities under certain circumstances; requiring the corporation to submit to the Governor and the Legislature information about the program in its annual report and an evaluation of the effectiveness of the program; providing for a program

review and repeal date; providing an effective date.

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

Section 1. Subsection (1) of 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 markets ~~market~~ for purchasing health insurance and health services. It is therefore the intent of the Legislature to create the Florida Health Choices Program and the Health Choice Plus 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 markets ~~market~~ that stimulate ~~stimulates~~ product innovation, quality improvement, and

efficiency in the production and delivery of health services.

Section 2. Section 408.9105, Florida Statutes, is created to read:

408.9105 Health Choice Plus Program.—

(1) LEGISLATIVE INTENT.—The Legislature recognizes that there are more than 600,000 uninsured residents in this state who have incomes at or below 100 percent of the federal poverty level. Many insurance options are not affordable, and the Legislature intends to provide a benefit program to those individuals who seek assistance with coverage and who assume individual responsibility for their own health care needs. It is therefore the intent of the Legislature to expand the services provided by the Florida Health Choices Program and begin the phase-in of the Health Choice Plus Program starting July 1, 2013. The Health Choice Plus Program must:

(a) Use the existing Florida Health Choices Corporation's infrastructure and governance to manage the program described in this section.

(b) Offer goods and services to individuals who are between 19 to 64 years of age, inclusive.

(c) Establish guidelines for financial participation in the program which allows for enrollees and others to contribute toward a health benefits account.

1. An enrollee shall contribute at least $20 per month toward the health benefits account. This amount may be adjusted annually in the General Appropriations Act.

2. The level of benefit paid into an enrollee's account using state funds is to be determined by the corporation based upon the availability of state, local, and federal funding. The

amount may not exceed $10 per individual per month. This amount may be adjusted annually in the General Appropriations Act.

(d) Implement an employer-based contribution option.

(e) Develop and maintain an education and public outreach campaign for the Health Choice Plus Program.

(f) Provide a secure website to facilitate the purchase of goods and services and to provide public information about the program. The website must also provide information about the availability of insurance affordability programs targeted at this population.

(g) Establish an incentive program that rewards enrollees for achievements in reaching healthy living goals.

(2) DEFINITIONS.—For the Health Choice Plus Program, the following terms are applicable:

(a) "CHIP" means Children's Health Insurance Program as authorized under Title XXI of the Social Security Act.

(b) "Corporation" means Florida Health Choices, Inc., as established under s. 408.910.

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

(d) "Enrollee" means an individual who participates in or receives benefits under the Health Choice Plus Program.

(e) "Program" means the Health Choice Plus Program established under this section.

(f) "Vendor" means an entity that meets the requirements under s. 408.910(4)(d) and is accepted by the corporation.

(g) "Health benefits account" means the account established

for an enrollee at the corporation into which funds may be deposited by the state, the enrollee, other individuals, or organizations for the purchase of health care goods and services on the enrollee's behalf.

(h) "Parent" or "caretaker relative" means an individual who is a relative that has primary custody or legal guardianship of a dependent child and provides the primary care and supervision to that dependent child in the same household. A caretaker relative must be related to the dependent child by blood, marriage, or adoption within the fifth degree of kinship.

(i) "Goods and services" means the individual products offered for sale to an enrollee on the corporation's marketplace or other health care-related items that may be purchased by an enrollee in the private market. An enrollee may purchase these products using funds accumulated in his or her health benefits account.

(j) "Lawful permanent resident" means a non-United States citizen who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. This individual may also be known as a permanent resident alien.

(k) "Patient Protection and Affordable Care Act" or "PPACA" means the federal law enacted as Pub. L. No. 111-148, as further amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and any amendments.

(3) ELIGIBILITY.—

(a) To be eligible for the Health Choice Plus Program, an individual must be a resident of this state and meet all of the following criteria:

1. Be between 19 and 64 years of age, inclusive.

2. Have a modified adjusted gross income that does not exceed 100 percent of the federal poverty level based on the individual's most recent federal tax return, or if the individual did not file a tax return, the individual's most recent monthly income.

3. Be a United States citizen or a lawful permanent resident.

4. Not be eligible for Medicaid.

5. Not be eligible for employer-sponsored insurance coverage. If the enrollee is eligible for employer-sponsored coverage but the cost of that coverage for the enrollee's share for individual coverage would exceed 5 percent of the enrollee's total modified adjusted gross household income or the enrollee's share of family coverage would exceed 5 percent of enrollee's total modified adjusted gross household income, the enrollee is not eligible for employer-sponsored coverage under this section.

6. Not be enrolled in other coverage that meets the definition of essential benefits coverage under PPACA.

(b) In addition to the requirements in paragraph (a), an enrollee must meet the following categorical requirements in order to maintain enrollment in the program:

1. For an enrollee who is also a parent or a caretaker relative, the enrollee must do all of the following:

a. Maintain enrollment in Medicaid or CHIP for any dependent child in the household who is eligible for Medicaid or CHIP and who must be enrolled in Medicaid or CHIP throughout the enrollee's participation in the Health Choice Plus program.

b. Complete a health assessment within the first 3 months

after enrollment at a county health department, federally qualified health center, or other approved health care provider.

c. Schedule and keep at least one preventive visit with a primary care provider within 6 months after enrollment and repeat the preventive visit at least once every 18 months thereafter.

d. Provide proof of employment for at least 20 hours a week or of efforts made to seek employment. In lieu of employment, the enrollee may provide proof of volunteering for at least 10 hours a month at a school or at a nonprofit organization or enrollment as as full-time student at an accredited educational institution. Exceptions to this requirement may be made on a case-by-case basis for medical conditions for the enrollee or if the enrollee is the primary caretaker for a family member who has a chronic and severe medical condition that requires a minimum of 40 hours a week of care.

e. Meet at least two of the healthy living performance goals specified in subsection (7).

2. For an enrollee who is also a childless adult, the enrollee must do all of the following:

a. Provide proof of employment for at least 20 hours a week or of efforts made to seek employment. In lieu of employment, the enrollee may provide proof of volunteering for at least 20 hours a month at a school or at a nonprofit organization or enrollment as a full-time student at an accredited educational institution. Exceptions to this requirement may be made on a case-by-case basis for medical conditions for the enrollee or if the enrollee is the primary caretaker for a family member who has a chronic and severe medical condition that requires a

minimum of 40 hours a week of care.

b. Complete a health assessment within the first 3 months after enrollment at a county health department, federally qualified health center, or other approved health care provider;

c. Schedule and keep at least one preventive visit with a primary care provider within the first 6 months after enrollment and repeat the preventive visit at least once every 18 months thereafter.

d. Meet at least two of the healthy living performance goals specified in subsection (7).

If the enrollee fails to meet the requirements specified in this subsection, the enrollee is disenrolled from the program at the end of the month in which the enrollee has not met the requirements. The enrollee may receive one 30-day extension to comply before cancellation of coverage. If an enrollee's coverage is canceled, the enrollee may not reapply for coverage until the next open enrollment period or 90 days after cancellation of coverage occurs, whichever occurs later. The individual's reenrollment is subject to available funding.

(4) ENROLLMENT.—

(a) Enrollment in the Health Choice Plus Program may occur through the portal of the Florida Health Choices Program, a referral process from the Department of Children and Families, the Florida Healthy Kids Corporation, or the exchange as defined by the federal Patient Protection and Affordable Care Act.

(b) Subject to available funding, the corporation shall establish at least one open enrollment period each year. When the program is full based on available funding, enrollment must

cease.

(c) Eligibility is determined by using electronic means to the fullest extent practicable before requesting any written documentation from an applicant.

(5) HEALTH BENEFITS ACCOUNT.—

(a) A health benefits account is established for each enrollee upon confirmation of eligibility in the program. The corporation shall determine the deposit amount and frequency of deposits based on the availability of funds, the number of enrollees, and other factors.

(b) An enrollee shall make a financial contribution toward his or her own health benefits account in order to maintain enrollment in accordance with paragraph (1)(c).

1. The corporation shall establish disenrollment criteria for failure to pay the required minimum contribution.

2. The disenrollment criteria must include waiting periods of not more than 1 month before reinstatement to the program if the enrollee is still eligible and has paid all required financial obligations.

(c) Subject to appropriations available for this specific purpose, the corporation shall establish a procedure for the deposit of supplemental or bonus funds into an enrollee’s health benefits account if certain healthy living performance goals are achieved. These goals must be established no later than July 1 in each fiscal year and distributed to all enrollees, published on the corporation’s website, and distributed to new enrollees within 30 calendar days after enrollment. For calendar year 2014, the goals must be established no later than October 1, 2013.

1. An enrollee may use funds deposited in a health benefits account to offset other health care costs or to purchase other products and services offered by the marketplace, subject to guidelines established by the corporation and in accordance with federal law.

2. Bonus funds may accumulate in the enrollee's health benefits account for the duration of the program and must automatically expire and return to the corporation upon the termination of the program.

(d) The marketplace is encouraged to use existing community programs and partnerships to deliver services and to include traditional safety net providers for the delivery of services to enrollees, including, but not limited to, rural health clinics, federally qualified health centers, county health departments, emergency room diversion programs, and community mental health centers. A health care entity that receives state funding must participate in the Health Choice Plus Program and offer services or products through the marketplace or to enrollees, as appropriate. An enrollee may be required to make nominal copayments to providers for any nonpreventive services. The corporation may establish the amount of the copayments when applicable.

(e) Except for supplemental funds described under paragraph (c), funds deposited in a health benefits account belong to the enrollee when deposited and are available for health-care-related expenditures, including, but not limited to, physician's fees, hospital costs, prescriptions, insurance premium payments, copayments, and coinsurance. The corporation shall establish a process or contract with another entity for the management of

the funds. The process must ensure the timely distribution and the appropriate expenditure of the state's contributions.

(f) The corporation shall establish a refund process for an enrollee who requests the closure of a health benefits account and the return of any unspent individual contributions. The enrollee may be refunded only those funds that the enrollee or employer has contributed to his or her health benefits account. All other state funds in the enrollee's health benefits account revert to the corporation.

(6) FUNDING.—

(a) The corporation may accept funds from an employer to deposit in an enrollee's health benefits account to supplement funds if such a deposit is not in conflict with other provisions of this section.

(b) The corporation may accept state and federal funds to further subsidize the costs of coverage and to administer the program.

(c) The corporation shall seek other grants and donations to support the program.

(d) An assessment on vendors that participate in the marketplace may be used to fund the administration of the program.

(7) SERVICES.—The corporation shall manage the health benefits accounts and provide a marketplace of options from which an enrollee may also use his or her health benefits account to purchase individual services and products, including, but not limited to, discount medical plans, limited benefit plans, health flex plans, individual health insurance plans, bundled services, or other prepaid health care coverage.

(8) HEALTHY LIVING PERFORMANCE GOALS AND PAYMENT.—

(a) To the extent that funds are made available for this purpose, an enrollee is rewarded for achieving a healthy lifestyle and using preventive health care services appropriately.

(b) Healthy living performance goals for the program include, but are not limited to:

1. Visiting a primary care provider for preventive care, including well-woman exams.

2. Receiving dental preventive exams and cleanings.

3. Maintaining a Body Mass Index (BMI) of less than 25, or if the enrollee's BMI is more than 25 on July 1 of the previous year, reducing the BMI by 5 percent as measured on July 1 of the following year.

4. Maintaining an HDL cholesterol level of no less than 40 mg/dL for men or 50 mg/dL for women, or if an enrollee's HDL cholesterol level is less than these levels, increasing the HDL cholesterol level by at least 5 points.

5. Maintaining an LDL cholesterol level at no more than 130 mg/dL, or if an enrollee's LDL is higher than this level, reducing the LDL cholesterol level by at least 5 points.

6. Maintaining a triglyceride level at no more than 150 mg/dL, or if an enrollee's triglyceride level is higher than this level, reducing the triglyceride level by at least 5 points.

7. For women, obtaining a mammogram, as appropriate. For men, obtaining a prostate exam, as appropriate, based on standards of the United States Preventive Services Task Force.

8. Maintaining blood pressure no higher than 140(systolic)

and 90 (diastolic). Both numbers must be achieved to receive credit for the goal.

9. Obtaining an annual flu shot.

10. Being up to date on adult vaccinations.

11. Ceasing to smoke or showing evidence of participating in a formal smoking cessation program.

12. Demonstrating evidence of an exercise regimen, including an exercise program or other formal training program.

13. Participating and achieving any other goals established by the program.

The program shall post on its website, by July 1 of each fiscal year in which a goal is deemed eligible or ineligible, any other goal that an enrollee is eligible for payment or the elimination of a goal. The corporation shall establish a procedure for the documentation of such goals, timeframes for achievement of the goals if not otherwise provided in this paragraph, and payments of supplemental amounts into an enrollee's health benefits account.

(c) Bonus payments for achieving a healthy living performance goal shall be paid into an enrollee's health benefits account at the end of the quarter in which the goal is achieved. The amount of the payment is based upon the schedule posted by the program on July 1 of that fiscal year.

(9) APPLICABILITY OF INSURANCE CODE.—Coverage offered under this program is not insurance. Any standard forms, website design, or marketing communication developed by the corporation and used by the corporation or any vendor that meets the requirements of s. 408.910(4)(f) is not subject to the Florida

Insurance Code.

(10) LIABILITY.—Coverage under the Health Choice Plus Program is not an entitlement, and a cause of action does not arise against the state, a local governmental entity, any other political subdivision of the state, or the corporation or its board of directors for failure to make coverage under this section available to an eligible person or for discontinuation of any coverage.

(11) PROGRAM EVALUATION.—The corporation shall include information about the Health Choice Plus Program in its annual report under s. 408.910. The corporation shall complete and submit by January 1, 2016, a separate independent evaluation of the effectiveness of the Health Choice Plus Program to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(12) PROGRAM REVIEW.—The Health Choice Plus Program is subject to repeal on July 1, 2016, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 3. This act shall take effect July 1, 2013.