A bill to be entitled

An act relating to the Florida Health Choices Plus Program; amending s. 408.910, F.S.; providing that all employers who meet the requirements of the Florida Health Choices Program are eligible to enroll in the Florida Health Choices Plus Program; requiring participating employers to make a defined contribution with certain conditions; providing that individuals and employees of enrolled employers are eligible to participate in the program; providing that vendors may not refuse to sell any offered product or service to any participant in the program; providing that product prices shall be based on criteria established by the Florida Health Choices, Inc.; providing that certain forms, website design, and marketing communication developed by the Florida Health Choices, Inc., are not subject to the Florida Insurance Code; creating s. 408.9105, F.S.; creating the Florida Health Choices Plus Program; providing definitions; providing eligibility requirements; providing exceptions to such requirements in specific situations; requiring the Department of Children and Families to determine eligibility; providing for enrollment in the program; establishing open enrollment periods; requiring cessation of enrollment under certain circumstances; providing that participation in the program is not an entitlement; prohibiting a cause of action against certain entities under certain circumstances;

requiring an education and outreach campaign; requiring certain joint activities by the Florida Health Choices, Inc., and the Florida Healthy Kids Corporation; providing for a state benefit allowance, subject to an appropriation; requiring an individual contribution; providing for disenrollment in specific situations; allowing contributions from certain other entities; providing requirements and procedures for use of funds; providing for refunds; requiring the corporation to submit to the Governor and Legislature information about the program in its annual report and an evaluation of the effectiveness of the program; creating a task force and providing its mission; establishing membership in the task force and providing for its expiration; amending s. 641.402, F.S.; authorizing prepaid health clinics to offer specified hospital services under certain circumstances; providing appropriations; providing an effective date.

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

Section 1. Subsection (3), paragraphs (a), (b), (c), (e), and (f) of subsection (4), paragraphs (a) and (b) of subsection (5), and paragraph (b) of subsection (7) of section 408.910, Florida Statutes, are amended, and paragraph (c) is added to subsection (10) of that section, to read:

408.910 Florida Health Choices Program.—

(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 and employers 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 and individuals.

(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 and policy, 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, but not limited to, insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and any other health care provider ~~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 shall be available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(a) Employers that meet criteria established by the corporation and elect to make their employees eligible through the program are eligible to enroll in the program ~~include:~~

~~1. Employers that meet criteria established by the corporation and elect to make their employees eligible through the program.~~

~~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 and employees of enrolled employers are 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 participants who opt out~~.

(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.

Any employer contribution must be a defined contribution and the employee must have the option to use any amount of the defined contribution to purchase products and services in the cafeteria plan and to receive any unused portion of the defined contribution as salary.

(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.

2. Authorization for payroll deduction if the individual is employed and the employer agrees to the deduction.

3. Compliance with federal tax requirements.

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

5. Selection of products and services.

(f) Vendors who choose to participate in the program may enroll by complying with the procedures established by the corporation. These procedures ~~may~~ 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 to comply with requirements established by the corporation.

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

4. Communication of product and service prices, established by the vendor ~~Establishment of product prices based on age, gender, 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.

(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. Health maintenance contracts.

3. Limited benefit plans.

4. Prepaid clinic services.

5. Service contracts.

6. Arrangements for purchase of any specific amounts and types of health services and treatments.

7. Flexible spending accounts.

(b) Health insurance policies, health maintenance

contracts, limited benefit plans, prepaid service contracts, and other contracts for services must ensure the availability of contracted ~~covered~~ services.

(7) THE MARKETPLACE 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.

(b) Initial selection of products and services must be made during the applicable open ~~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.

(10) EXEMPTIONS.—

(c) Any standard form, website design, or marketing communication developed by the corporation and utilized by the corporation or any vendor participating in the program is not subject to the Florida Insurance Code, as defined in s. 624.01.

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

408.9105 Florida Health Choices Plus Program.—

(1) PROGRAM.-The Florida Health Choices Plus Program is established within the Florida Health Choices Program established under s. 408.910 to assist uninsured Floridians to gain access to affordable health coverage, products, and services.

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

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

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

(c) "Department" means the Department of Children and Families.

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

(e) "Household" means the group or the individual whose income is considered in determining eligibility for the program. The term "household" has the same meaning as provided in s. 36B(d)(2) of the Internal Revenue Code of 1986.

(f) "Marketplace" means the single, centralized market established by the corporation which offers and facilitates the purchase of health coverage, products, and services.

(g) "Parent" or "caretaker relative" means an individual who has primary custody or legal guardianship of a dependent child under the age of 19, provides the primary care and supervision to that dependent child in the same household, and is related to the dependent child by blood, marriage, or adoption within the fifth degree of kinship.

(h) "Patient Protection and Affordable Care Act" means the federal law enacted as Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and regulations issued thereunder.

(i) "Program" means the Florida Health Choices Plus Program established under this section.

(j) "Qualified alien" means an alien as defined in s. 431 of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.

(3) ELIGIBILITY.-

(a) A Florida resident who meets the following criteria is eligible to participate in the program. An eligible resident must be:

1. Nineteen to 64 years of age, inclusive;

2. A United States citizen or a qualified alien;

3. Uninsured and ineligible for Medicaid; and

4.a. A parent or caretaker relative, or the spouse of a parent or caretaker relative living in the same household; or

b. A person who receives payments from, who is determined eligible for, or who was eligible for but lost cash benefits from the federal program known as the Supplemental Security Income program whose household income does not exceed 100 percent of the federal poverty level based on the most recent federal tax return, or, if a tax return was not filed, the most recent monthly income.

(b) To maintain eligibility, enrollees eligible under subparagraph (a)4. must provide proof to the department of engagement in work activities consistent with the requirements

for temporary cash assistance, as defined in s. 414.0252, pursuant to s. 414.045.

(c) The department shall establish and maintain a process for determining eligibility of individuals for coverage under the program. The department shall use the same simplified application process and income determination methods used for Medicaid and CHIP pursuant to the Patient Protection and Affordable Care Act. The department shall refer eligible applicants to the program. The eligibility determination process must include an initial determination of eligibility and a redetermination or reverification of eligibility every 12 months. Enrollees are obligated to report changes in income which could affect eligibility to the department within 30 days after the change. The department, in consultation with the corporation, shall develop procedures for redetermining or reverifying eligibility which will enable a family to easily update any change in circumstances which could affect eligibility.

(4) ENROLLMENT.-

(a) Subject to available funding, the corporation shall establish two 30-day open enrollment periods each fiscal year. The first open enrollment period shall commence March 31, 2014. Enrollment in the program may occur through the portal of the Florida Health Choices Program or by referral from the Department of Children and Families, the Florida Healthy Kids Corporation, or the health insurance exchange established in this state pursuant to the Patient Protection and Affordable Care Act.

(b) Eligible individuals shall be enrolled on a first-come, first-served basis using the date the application is received. The corporation shall cease enrollment when projected expenditures equal the available funding.

(c) Participation in the program is not an entitlement. No cause of action shall arise against the corporation, the state, or any political subdivision of the state for determination of ineligibility, failure to enroll, or failure to make a state contribution for any person in the program.

(d) The corporation shall develop and maintain an education and public outreach campaign for the program. The corporation shall provide choice counseling for enrollees, including information about available products and services and participating vendors, and information necessary to enable enrollees to compare those products and services. The corporation's website must also provide information about the availability of Medicaid, CHIP, and federally subsidized coverage in the health insurance exchange established in this state pursuant to the Patient Protection and Affordable Care Act. The corporation and the Florida Healthy Kids Corporation shall engage in joint marketing of and cross-promotion efforts for their health coverage programs for children and parents.

(5) CARE ACCOUNTS.-

(a) Subject to annual appropriation, each enrollee shall receive $2,000 to fund a Contribution Amount for Responsible Expenditures (CARE) account to purchase health coverage, products, and services in the marketplace.

(b) As a condition of eligibility, each enrollee shall

make a monthly individual contribution of $25, or another amount as otherwise provided in the General Appropriations Act, to the enrollee's CARE account. The corporation shall disenroll an individual who fails to pay the individual contribution. Disenrollment procedures shall include a 1-month grace period. An individual who is disenrolled may reenroll at the next open enrollment period, if that individual is still eligible, subject to availability of funding.

(c) An enrollee may make additional contributions to his or her CARE account to increase the enrollees' purchasing power, if desired.

(d) An enrollee's employer may make contributions to the enrollee's CARE account on behalf of the enrollee.

(e) Governmental entities, political subdivisions, or charitable organizations, as defined in s. 736.1201, may make contributions to the program which shall be used to enhance enrollees' CARE accounts.

(f) An enrollee may use contributions for any product available in the marketplace. An enrollee who is eligible under subparagraph (3)(a)4. must purchase a product or service, or a combination of products and services, that includes both preventive and catastrophic coverage or hospital care. The corporation shall provide a secure website to compare and facilitate the selection of products and services and provide public information about the program. Unused funds in the enrollee's CARE account may be used to fund health savings accounts for expenditure on qualified medical expenses as defined in s. 213(d) of the Internal Revenue Code. An enrollee

who is eligible for Supplemental Security Income benefits under subparagraph (3)(a)5. may use funds contributed to the health savings account for Medicare-related premiums and cost-sharing. Unused balances in an enrollee's health savings account may be carried forward to the next year if the enrollee is continuously enrolled in the program. An enrollee may maintain unused funds in his or her CARE account for additional purchases in the marketplace.

(g) The corporation shall receive the contributions and manage their use for individual enrollees. The corporation may establish and manage an operating fund for the purposes of addressing the corporation's unique cash-flow needs and facilitating the fiscal management of the corporation. The corporation may accumulate and maintain a cash balance reserve in its operating fund equal to no more than 25 percent of its annualized operating expenses. The corporation must ensure the timely distribution and appropriate expenditure of contributions. The corporation shall establish health savings accounts for unused contributions. The corporation shall establish a process to refund unused CARE and health savings account funds in the event an enrollee disenrolls from the program. The corporation shall first refund individual contribution amounts. Refunds to employers, political subdivisions, and charitable organizations shall be based on a pro rata share of the funds remaining after the individual contribution amounts are refunded. Remaining state contribution amounts shall revert to the state. Upon dissolution of the program, any remaining cash balances of state funds shall revert

to the General Revenue Fund or such other state funds consistent with the appropriated funding, as provided by law.

(6) PROGRAM EVALUATION; TASK FORCE.—

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

(b) The Florida Health Care Market Task Force is created within the Legislature. The mission of the task force is to study and make recommendations on:

1. Strategies for allowing state employees to participate in the Florida Health Choices Program using a defined contribution.

2. Methods for increasing the capacity of our current health care workforce to serve more patients by allowing advanced registered nurse practitioners and physician assistants to practice more independently.

3. Options for reducing federal control of the Medicaid program and for building a medical assistance program customized for Florida's needs.

(c) The task force shall be composed of seven members. Three members shall be appointed by the President of the Senate, three members shall be appointed by the Speaker of the House of Representatives, and a chair shall be appointed jointly by the President of the Senate and the Speaker of the House of

Representatives. The task force shall submit a report to the President of the Senate and the Speaker of the House of Representatives by January 1, 2014.

(d) The task force expires February 1, 2014.

Section 3. Subsection (4) of section 641.402, Florida Statutes, is amended to read:

641.402 Definitions.—As used in this part, the term:

(4) "Prepaid health clinic" means any organization authorized under this part which provides, either directly or through arrangements with other persons, basic services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services which subscribers might reasonably require to maintain good health. A ~~However, No~~ clinic that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services may not ~~shall~~ be a prepaid health clinic, unless the clinic also meets the requirements of part I of this chapter. Any prepaid health clinic that applies for and obtains a health care provider certificate pursuant to part III of this chapter, meets the surplus requirements of s. 641.225, and meets all other applicable requirements of part I of this chapter may obtain a certificate of authority under s. 641.21. A prepaid health clinic that receives a certificate of authority pursuant to s. 641.21 has the same rights and responsibilities as an entity certified under part I of this chapter.

Section 4. The sum of $18,863,753 in recurring funds is appropriated from the General Revenue Fund to the Agency for

Health Care Administration for the 2013-2014 fiscal year for the purpose of implementing the provisions contained in this act.

Section 5. The sum of $6,124,421 in nonrecurring funds is appropriated from the General Revenue Fund to the Agency for Health Care Administration for the 2013-2014 fiscal year for the purpose of contracting with Florida Health Choices, Inc., as created in s. 408.910(11), Florida Statutes, for the purpose of implementing the provisions of this act.

Section 6. This act shall take effect July 1, 2013.