A bill to be entitled
An act relating to the Health Choices Plus program;
amending s. 408.910; providing that all employers who
meet the requirements of the Florida Health Choices
Program are eligible to enroll in the program;
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 Florida Health Choices;
providing that certain forms, website design, and
marketing communication developed by Florida Health
Choices shall not be subject to the Florida Insurance
Code; creating s. 408.9105; creating the Health
Choices Plus Program; providing definitions; providing
eligibility requirements; providing exceptions 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 Corporation
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 the
Legislature information about the program in its
annual report and an evaluation of the effectiveness
of the program; creating a task force; establishing
membership; amending s. 641.402, F.S.; authorizing
prepaid health clinic plans to offer hospital services
under certain circumstances; providing an effective
date.

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

Section 1. Paragraph (a) of subsection (3), paragraphs
(a), (b), (e), and (f) of subsection (4), paragraph (b) of
subsection (5), paragraph (b) of subsection (7), and subsection
(10) of section 408.910, Florida Statutes, are amended 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 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.


4. Medicaid participants who opt out.
(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 services.

(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.

(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.

(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 during the applicable open enrollment period. 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.

(10) EXEMPTIONS.—

(a) Products, other than the products set forth in subparagraphs (4)(d)1.-4., sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, as defined in s. 624.01 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.

(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 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 Children's Health Insurance Program as authorized under Title XXI of the Social Security Act.

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

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

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

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

(f) "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 section 36B(d)(2) of the Internal Revenue Code of 1986.

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


(j) "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.

(3) ELIGIBILITY.-

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

1. Be 19 to 64 years of age, inclusive; and
2. Be a United States citizen or a qualified alien; and
3. Be uninsured and ineligible for Medicaid; and
4. Be a parent or caretaker relative, or the spouse of a parent or caretaker relative living in the same household, of a child under age 18 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; or

5. Be 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 4. must provide proof to the department of engagement in work activities consistent with s. 445.024 and 45 C.F.R. 261.2.

(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 of the change. The department, in consultation with the corporation, shall develop procedures for redetermining or reverifying eligibility which 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 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 will 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 will make a monthly individual contribution of $25, or as otherwise provided in the General Appropriations Act, to the CARE account. The corporation shall disenroll individuals who fail to pay the individual contribution. Disenrollment procedures shall include a one-month grace period. Individuals who are disenrolled may reenroll at the next open enrollment period, if still eligible, subject to availability of funding.

(c) Enrollees may make additional contributions to their CARE accounts to increase their purchasing power, if desired.

(d) Enrollees’ employers may make contributions to the enrollees’ CARE account on behalf of enrollees.

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

(f) Enrollees may use the contributions for any product available in the marketplace. Enrollees 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 to provide
public information about the program. Unused funds in the enrollees’ CARE accounts may be used to fund health savings accounts for expenditure on qualified medical expenses as defined in Section 213(d) of the Internal Revenue Code. Enrollees eligible under paragraph (3)(a)5. may use funds in the health savings account for Medicare-related premiums and cost-sharing. Enrollees may maintain unused funds in the 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 in the operating fund at any given time a cash balance reserve equal to no more than 25 percent of its annualized operating expenses. The corporation must ensure the timely distribution and appropriate expenditure of the contributions. The corporation shall establish health savings accounts for unused contributions. The corporation shall establish a refund process for an enrollee who disenrolls from the program to return any unused individual or employer contributions. The enrollee may be refunded only those funds that the enrollee has contributed; the employer may be refunded only those funds that the employer has contributed. Remaining state contribution amounts 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 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 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 Florida Legislature. The mission of the task force is to study and make recommendations on:

1. Strategies for allowing state employees to participate in Florida Health Choices 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; and
3. Options for reducing federal control of the Medicaid program and for building a medical assistance program customized for Florida’s needs.

The task force shall be comprised of seven members: three members appointed by the President of the Senate; three members appointed by the Speaker of the House of Representatives; and a chairman 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

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Speaker of the House of Representatives by January 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. 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 shall be a prepaid health clinic, unless it meets the qualifications of this part. Any prepaid health clinic that applies for and obtains a health care provider certificate pursuant to part III of this chapter and meets the surplus requirements of s. 641.225, and meets all other applicable requirements of this part may provide or contract for, either directly or indirectly, inpatient hospital services and hospital inpatient physician services.

Section 4. This act shall take effect July 1, 2013.