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 Committee on Appropriations

BILL: SPB 7144

INTRODUCER: For Consideration by Committee on Health Policy

SUBJECT: Health Choice Plus Program

DATE: April 2, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Submitted as Committee Bill**
2.				
3.				
4.				
5.				
6.				

I. Summary:

SPB 7144 creates a new health care services program, the Health Choice Plus (HCP) program within the Florida Health Choices Corporation (Corporation). The Corporation will phase-in the HCP program and be responsible for its on-going oversight, including the delivery of services, management of contracts and collection of enrollee or employer contributions.

The HCP is created as an alternative health benefits program for uninsured, low income Floridians with incomes at or below 100 percent of the federal poverty level meeting other designated eligibility criteria. Enrollees and the state will jointly fund health benefits accounts, to the extent funds are appropriated annually in the General Appropriations Act, that are managed by the corporation. Enrollees may utilize funds in those accounts to purchase a range of health care products from the corporation's marketplace or to offset other out of pocket health care costs. At a minimum, enrollees must contribute $20 per month and the state will contribute no more than $10 per month. These amounts may be adjusted annually in the General Appropriations Act.

Continued enrollment in HCP is contingent upon several factors, including but not limited to, an enrollee health assessment within the first 3 months of enrollment, continued payment of the monthly contribution requirement, and the enrollee's employment or full-time school enrollment. Exceptions to full-time employment may be made for an enrollee's medical condition or where the enrollee is the primary caregiver for a relative with a chronic medical condition that requires at least 40 hours of care per week. Supplemental payments may also be deposited to an enrollee's health benefits account for successful achievement of optional healthy living goals, subject to a specific appropriation for this purpose. Enrollment in the program must cease once full and is based upon the availability of funds.

The program is subject to automatic repeal on July 1, 2016, unless re-enacted by the Legislature.

SPB 7144 has a significant state fiscal impact of an estimated $15,275,000 for state fiscal year 2013-2014.

The bill is effective July 1, 2013.

The bill amends s. 408.910, F.S. and creates s. 408.9105, F.S.

II. Present Situation:

Florida provides health insurance coverage options to low income Floridians through a variety of programs utilizing state and federal funds. As of February 28, 2013, more than 3.2 million individuals received coverage through some Medicaid eligibility category.[1] Enrollment in the Florida Kidcare program (non-Medicaid funded components) for the same time period was an additional 256,721 children.[2]

Florida's Medicaid program is expected to expend $21 billion for the state fiscal year 2012-2013, to provide coverage to its enrollees making it fifth largest in the nation for expenditures.[3] The Medicaid program is jointly funded between the state and federal governments; 52.73 percent of the costs for health care services are paid by federal funds and 42.27 percent is state share in the current fiscal year. Funding for the Florida Kidcare program's Title XXI components has an enhanced federal match of 70.66 percent for federal fiscal year 2012-13.[4]

According to the most recent data from the American Community Survey (ACS) of the federal Census Bureau, an estimated 4 million Floridians are uninsured.[5] Of that number according to the ACS data, 594,000 are children.[6] Dividing Florida's uninsured by income level, more than 1.6 million adults are under 139 percent of the federal poverty level (FPL) according to statistics for 2010-2011.[7] Lower income adults, those below 100 percent of the FPL, number at 1.1 million of the 1.9 million for that same time period.[8]

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[1] Agency for Health Care Administration, *Report of Medicaid Eligibles*, http://ahca.myflorida.com/Medicaid/about/pdf/age_assistance_category_130228.pdf (last visited Mar. 17, 2013).
[2] Agency for Health Care Administration, *Florida KidCare Enrollment Report – February 2013*, (copy on file with the Senate Health Policy Committee).
[3] Agency for Health Care Administration, Presentation to House Health and Human Services Committee, *Florida Medicaid: An Overview - December 5, 2012*, http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2714&Session=2013&DocumentType=Meeting Packets&FileName=HHSC_Mtg_ 12-5-12_ONLINE.pdf (last visited Mar. 17, 2013).
[4] Florida KidCare Coordinating Council, *2013 Annual Report and Recommendations*, p. 5, (January 2013), http://www.floridakidcare.org/council/reports/2013_KCC_Report.pdf (last visited Mar. 17, 2013).
[5] Office of Economic and Demographic Research, Florida Legislature, *Economic Analysis of PPACA and Medicaid Expansion*, Presentation to Senate Select Committee on Patient Protection and Affordable Care Act (Mar. 4, 2013), http://www.floridakidcare.org/council/reports/2013_Recommendations.pdf (last visited Mar. 17, 2013).
[6] Id.
[7] Kaiser Family Foundation, statehealthfacts.org, *Health Insurance Coverage of the Non-Elderly (0-64) with Incomes up to 139% of FPL (2010-2011)*, http://www.statehealthfacts.org/profileind.jsp?ind=849&cat=3&rgn=11&cmprgn=1 (last visited Mar. 17, 2013).
[8] Id.

Eligibility for the Medicaid program is based on a number of factors, including age, household or individual income, and assets. The Department of Children and Families (DCF) determines eligibility for the Medicaid program but the Agency for Health Care Administration (AHCA) is the single state Medicaid agency under s. 409.963, F.S., and has the lead responsibility for the overall program.[9]

Recipients in the Medicaid program receive their benefits through several different delivery systems depending on their individual situation. Delivery systems currently include fee for service providers, prepaid dental plans, provider service networks, and Medicaid managed care plans. In July 2006, the AHCA implemented the Medicaid Managed Care Pilot Program as directed by the 2005 Legislature through s. 409.91211, F.S. The pilot program operates under an 1115 Research and Demonstration Waiver approved by the Centers for Medicare and Medicaid Services (CMS). The pilot program was initially authorized for Broward and Duval counties with expansion to Baker, Clay and Nassau the following year.

Under the current pilot program, most Medicaid recipients in the five pilot counties (Broward, Duval, Baker, Clay and Nassau counties) are required to receive their benefits through either health maintenance organizations (HMOs), provider service networks (PSNs) or a specialty plan. In addition to the minimum benefits package, plans may provide enhanced services such as over the counter benefits, preventive dental care for adults, and health and wellness benefits.

Medicaid Statewide Managed Medical Care Program

In 2011, the Legislature passed HB 7107, creating the Statewide Medicaid Managed Care (SMMC) Program as ch. 409, part IV, F.S. The SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits, for the delivery of primary and acute care as well as long-term care services. The SMMC has two components: the Long Term Care Managed Care program and the Managed Medical Assistance (MMA) program.

The AHCA has primary responsibility for the management and operations of the state's Medicaid program. To implement these two programs and receive federal Medicaid funding, the AHCA was required to seek federal authorization through two different Medicaid waivers from CMS. The first component authorized was the LTC Managed Care Program's 1915(b) and (c) waiver. Approval was granted on February 1, 2013.

The LTC Managed Care Program will serve Medicaid-eligible recipients who are also determined to require a nursing facility level of care. Medicaid recipients who qualify will receive all of their long-term care services from the long term care managed care plan.

Implementation of the LTC Managed Care Program started July 1, 2012, with completion expected by October 1, 2013. The AHCA released an Invitation to Negotiate (ITN) on June 29,

[9] Agency for Health Care Administration, *Welcome to Medicaid!*, http://ahca.myflorida.com/Medicaid/index.shtml (last visited Mar. 17, 2013).

2012, and on January 15, 2013, notices of contract awards to managed care plans under that ITN were announced.

For the medical assistance component, the AHCA sought to modify the existing Medicaid Reform 1115 Demonstration waiver with the CMS to expand the program statewide. The AHCA initiated the SMMC project in January 2012 and released a separate ITN to competitively procure managed care plans on a statewide basis on December 28, 2012. Bids were due to the AHCA on March 29, 2013, and awards are expected to be announced on September 16, 2013.

Plans can supplement the minimum benefits in their bids and offer enhanced options. The number of plans to be selected by region is prescribed under s. 409.974, F.S. Specialty plans that serve specific, targeted populations based on age, medical condition and diagnosis are also included under the SMMC program. Under s. 409.967, F.S., accountability provisions for the managed care plans specify several conditions or requirements including emergency care and physician reimbursement standards, access and credentialing requirements, encounter data submission guidelines, grievance and resolutions, and medical loss ratio calculations.

Statewide implementation of SMMC is expected to be completed by October 1, 2014. Final approval of the necessary Medicaid waiver by the federal government has not yet been received; however, on February 20, 2013, the AHCA and the CMS reached an "Agreement in Principle" on the proposed plan.

Under SMMC, all persons meeting applicable eligibility requirements of Title XIX of the Social Security Act must be enrolled in a managed care plan. Medicaid recipients who (a) have other creditable care coverage, excluding Medicare, (b) reside in residential commitment facilities operated through the Department of Juvenile Justice, group care facilities operated by the DCF, and treatment facilities funded through DCF Substance Abuse and Mental Health Program; (c) are eligible for refugee assistance; or (d) residents of a developmental disability center, may voluntarily enroll in the SMMC program. If they elect not to enroll, they will be served through the Medicaid fee for service system.

Cover Florida and Florida Health Choices

In 2008, the Florida Legislature created two programs simultaneously to address the issue of Florida's uninsured: Cover Florida Health Access Program and the Florida Health Choices Program.[10] The two programs offered two unique methods of addressing Florida's uninsured population.

Cover Florida Health Access Program

Cover Florida is designed to provide affordable health care options for uninsured residents between the ages of 19 and 64 and who met other criteria under s. 408.9091, F.S. The AHCA and the Office of Insurance Regulation (OIR) have joint responsibility for the program and were directed to issue an Invitation to Negotiate (ITN) to secure plans for the delivery of services by

[10] *See* Chapter Law 2008-32.

July 1 2008. An ITN was released July 2, 2008, and as a result of that ITN, 2-year contracts were executed with two statewide plans and four regional plans.11

The Cover Florida plans are not subject to the Florida Insurance Code and chapter 641, relating to HMOs. Two plan options were required for development: plans with catastrophic coverage and plans without catastrophic coverage. Plans without catastrophic coverage were required to include other benefit options such as:[12]

- Incentives for routine preventive care;
- Office visits for diagnosis and treatment of illness or injury;
- Behavioral health services;
- Durable medical equipment and prosthetics; and,
- Diabetic supplies.

Plans that did include catastrophic coverage were to include all of the benefits above, plus have options for these additional benefits:[13]

- Inpatient hospital stays;
- Hospital emergency care services;
- Urgent care services; and,
- Outpatient facility services, outpatient surgery, and outpatient diagnostic services.

All plans are guarantee issue policies and are required to include prescription drug benefits. Plans could also require limits on services and cap benefits and copayments.

To be eligible, the enrollee must be:

- Resident of Florida;
- Ages 19 to 64;
- Not covered by private insurance or eligible for public insurance, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements; and,
- Uninsured for at least the prior 6 months, with exceptions for persons who lose coverage within the past 6 months under certain conditions.

As of December 17, 2010, no insurers or HMOs offered any new policies under Cover Florida.[14] The six insurers selected by the state in 2009 to participate in Cover Florida ceased enrollment in

[11] Agency for Health Care Administration, *Cover Florida Health Care Access Program Annual Report (March 2013), p. 1,* *http://ahca.myflorida.com/MCHQ/Managed_Health_Care/CHMO/docs/CoverFLReport-Mar2013.pdf* (last visited Mar. 22, 2013).
[12] *See* s. 409.9091(4)(6)(a).
[13] *See* s. 409.9091(4)(a)(7).
[14] Department of Financial Services, *Cover Florida Health Care Access Program Defined*, http://www.myfloridacfo.com/consumers/insurancelibrary/insurance/l_and_h/cover_florida/cover_florida_-_defined.htm (last visited Mar. 22, 2013).

2011 due to lack of participation by both insurers and participants.[15] Currently, 1,997 enrollees participate in two plans and both plans will terminate those policies in 2014.[16]

Florida Health Choices Program

The Florida Health Choices Program (Program) is created as a private, non-profit, corporation under s. 408.917, F.S., and is led by a 15-member board of directors. The Program is designed as a single, centralized marketplace for the purchase of health products including, but not limited to, health insurance plans, HMO plans, prepaid services, services contracts, and flexible spending accounts. Policies sold as part of the program are exempt from regulation under the Insurance Code and laws governing HMOs. The following entities are authorized to be eligible vendors under the Program:

- Insurers authorized under ch. 624, F.S.;
- HMOs authorized under ch. 641, F.S.;
- Prepaid health clinics licensed under ch. 641, part II, 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 service networks, group practices, and professional associations; and,
- Corporate entities providing specific health services.

The Program is authorized to collect premiums and other payments from employers. The law further specifies who may participate as either an employer or an individual. Employers eligible to enroll include:[17]

- Employers that meet criteria established by the corporation and elect to make their employees eligible;
- Fiscally constrained counties described in s. 218.67, F.S.;
- Municipalities having populations of fewer than 50,000 residents;
- School districts in fiscally constrained counties; or,
- Statutory rural hospitals.

Individuals eligible to participate include:[18]

- Individual employees of enrolled employers;
- State employees not eligible for state employee health benefits;
- State retirees; or,
- Medicaid participants who opt out.

For phase one of Florida Health Choices' launch in 2013, the Marketplace will serve small businesses with 2 to 50 employees.[19] The initial list of vendors will include plans from Florida

[15] South Florida Business Journal, Brian Bandell, http://www.bizjournals.com/southflorida/print-edition/2011/03/25/cover-florida-health-plan-program.html?s=print, Mar. 25, 2011, (last visited Mar. 22, 2013).
[16] *Supra* note 11, at 2.
[17] *See* s. 408.910(4)(a), F.S.
[18] *See* s. 408.910(4)(b), F.S.

Blue, Florida Health Care Plans, Argus Dental and Liberty Dental.[20] The pilot will last 6 months and then the Program will evaluate adding other services.[21]

Patient Protection and Affordable Care Act (PPACA)

In March 2010, the Congress passed and the President signed the PPACA.[22] Under the PPACA, one of the key components required the states to expand Medicaid to a minimum national eligibility threshold of 133 percent of the FPL or as it is sometimes expressed 138 percent of the FPL with the automatic 5 percent income disregard applied, effective January 1, 2014.[23] While the funding for the newly eligible under this expansion would be initially funded at 100 percent federal funds for the first 3 calendar years, the states would gradually be required to pay a share of the costs, starting at 5 percent in calendar year 2017 before leveling off at 10 percent in 2020.[24] States that refused to expand to the new national eligibility threshold faced the loss of *all* of their federal Medicaid funding.[25]

Florida, along with 25 other states challenged the constitutionality of the law. In *NFIB v. Sebelius*, the Supreme Court found the enforcement provisions of the Medicaid expansion unconstitutional.[26] As a result, states could voluntarily expand their Medicaid populations to 133 percent of the FPL and receive the enhanced federal match, but could not be required to do so for the population defined as newly eligible in the law, which was interpreted to be only the adult population (childless adults aged 19 - 64).[27] States were unable to receive the enhanced federal matching fund for partial Medicaid expansions.[28]

While finding the adult expansion of Medicaid optional, subsequent federal guidance has also emphasized state flexibility in how states expand coverage to those defined as the newly eligible population. In a letter to the National Governors Association January 14, 2013, Health and Human Services Secretary Sebelius reminded states of their ability to design flexible benefit packages without the need for waivers and the alternative benefit plans available.[29] This letter had been preceded by the Frequently Asked Questions document on Exchange, Market Reforms

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[19] Florida Health Choices, *2012 Annual Report*, p. 4, http://myfloridachoices.org/wp-content/uploads/2011/03/FHC-AnnualReport-2012_v4a.pdf (last visited Mar. 22, 2013).
[20] Florida Health Choices, *Florida Health Choices Announces Initial Offerings*, (Feb. 22. 2013) http://myfloridachoices.org/florida-health-choices-announces-initial-offerings/ (last visited Mar. 25, 2013).
[21] *Supra* Note 19 at 3.
[22] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).
[23] 42 U.S.C. s. 1396a(10).
[24] 42 U.S.C. s. 1396d(y)(1).
[25] 42 U.S.C. s. a1396c
[26] *See supra* note 1.
[27] Department of Health and Human Services, *Secretary Sebelius Letter to Governors, July 10, 2012*, http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf (last visited Mar. 16, 2013).
[28] Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid (December 10, 2012)*, p.12, http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf (last visited April 1, 2013).
[29] *Letter to National Governor's Association from Secretary Sebelius*, January 14, 2013 (copy on file with Senate Health Policy Committee).

and Medicaid on December 10, 2012, that discussed promotion of personal responsibility wellness benefits and state flexibility to design benefits.[30]

A State Medicaid Director Letter on November 20, 2012 (ACA #21), further addressed state options for the adult Medicaid expansion group and the alternative benefit plans available under Section 1937 of the Social Security Act.[31] Under Section 1937, state Medicaid program have the option of providing certain groups with benchmark or benchmark equivalent coverage based on four products: (1) the standard Blue Cross/Blue Shield Preferred Provider option offered to federal employees; (2) state employee coverage that is generally offered to all state employees; (3) the commercial HMO with the largest insured, non-Medicaid enrollment in the state or (4) Secretary approved coverage.[32] For children under the age of 21, the coverage must include the Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT). Other aspects of the essential health benefit requirements of the PPACA, as discussed further below, may also be applicable, depending on the benefit package utilized.

In addition to the Medicaid expansion component, the federal reform law imposes a mandate on individuals to buy insurance, or pay a penalty. Currently, many uninsured individuals are eligible for Medicaid or Kidcare coverage, but are not enrolled. The existence of the federal mandate to purchase insurance will result in many eligibles coming forward and enrolling in Medicaid who had not previously chosen to do so. While these eligibles are currently entitled to Medicaid coverage, their participation will result in increased costs and would not likely have occurred without the catalyst of the federal legislation.

To obtain insurance coverage, the PPACA authorized the state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges. These exchanges are to be administered by governmental agencies or non-profit organizations and be ready to accept applications for coverage beginning October 1, 2013, for January 1, 2014, coverage dates. The exchanges, at a minimum, must:[33]

- Certify, re-certify and de-certify plans participating on the exchange;
- Operate a toll-free hotline;
- Maintain a website;
- Provide plan information and plan benefit options;
- Interact with the state's Medicaid and CHIP programs and provide information on eligibility and determination of eligibility for these programs;
- Certify individuals who gain exemptions from the individual responsibility requirement; and,
- Establish a navigator program.

The initial guidance from the Department of Health and Human Services in November 2010 set forward a number of principles and priorities for the exchanges. Further guidance was issued on

[30] *See Supra* note 28, at 15-16.
[31] Centers for Medicare and Medicaid Services, *State Medicaid Director Letter: Essential Health Benefits in the Medicaid Program* (November 20, 2012), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf (last visited Mar. 17, 2013).
[32] *See supra* note 31, at 2.
[33] Centers for Medicare and Medicaid Services, Initial Guidance to States on Exchanges, November 18, 2010, http://cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html (last visited Mar. 16, 2013).

May 16, 2012, detailing the proposed operations of the federally facilitated exchanges for those states that elected not to implement a state-based, separate system. On November 16, 2012, Florida Governor Rick Scott notified the Health and Human Services Secretary, Kathleen Sebelius, that Florida had too many unanswered questions to commit to a state-based exchange under PPACA for the first enrollment period on January 1, 2014.[34]

The PPACA also includes a tax penalty for those individuals that do not have qualifying health insurance coverage beginning January 1, 2014. The penalty is the greater of $695 per year up to a maximum of three times that amount per family or 2.5 percent of household income. The penalty, however, is phased in and exemptions may be granted for financial hardships such as those that may have been eligible under a Medicaid expansion in states that did not opt in, religious objections, American Indians and undocumented immigrants, incarcerated individuals, and lack of access to affordable coverage.[35] Qualifying coverage may be obtained through an employer, the federal or state exchanges created under the PPACA or private individual or group coverage meeting the minimum essential benefits coverage standard.

Employers with more than 50 full-time employees also share a financial responsibility under the PPACA. Employers with more than 50 full-time employees that do not offer coverage meeting the essential benefits coverage standard and who have at least one employee receive a premium tax credit will be assessed a fee of $2,000 per full-time employee, after the 30th employee.[36] If an employer does offer coverage and an employee receives a premium tax credit, the employer is assessed the lesser of $3,000 per employee receiving the credit or $2,000 per each employee after the 30th employee.[37]

Premium credits and other cost sharing subsidies are available to United States citizens and legal immigrants within certain income limits for coverage purchased through the exchanges. Legal immigrants with incomes at or below 100 percent of the FPL who are not eligible for Medicaid during their first 5 years are eligible for premium credits.[38] Premium credits are set on a sliding scale based on the percent of the FPL for the household and reduce the out of pocket costs incurred by individuals and families.

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[34] *Letter from Governor Rick Scott to Health and Human Services Secretary Kathleen Sebelius,* November 16, 2012 http://www.flgov.com/2012/11/16/letter-from-governor-rick-scott-to-u-s-secretary-of-health-and-human-services-kathleen-sebelius/ (last visited Mar. 16, 2013).
[35] 26 U.S.C. s. 36(B)(c).
[36] Kaiser Family Foundation, *Summary of New Health Reform Law,* Last Modified April 15, 2011, http://www.kff.org/healthreform/upload/8061.pdf (last viewed Mar. 16, 2013).
[37] Kaiser Family Foundation, *Summary of New Health Reform Law,* Last Modified April 15, 2011, http://www.kff.org/healthreform/upload/8061.pdf (last viewed Mar. 16, 2013).
[38] 26 U.S.C. s. 36B(c).

The amount for premium tax credits, as a percentage of income, are set in section 36B of the Internal Revenue Code follows[39]:

Premium Tax Credits	
Income Range	**Premium Percentage Range** (% of income)
Up to 133% FPL	2%
133% to 150%	3% - 4%
150% to 200%	4% - 6.3%
200% to 250%	6.3% - 8.05%
250% to 300%	8.05% - 9.5
300% to 400%	9.5%

Subsidies for cost sharing are also applicable for those between 100 percent of the FPL and 400 percent of the FPL.[40] For 2013, 100 percent of the FPL equates to the following by family size:[41]

2013 Federal Poverty Guidelines – 100% FPL	
Family Size	Maximum Annual Income
1	$11,490
2	$15,510
3	$19,530
4	$23,550

The cost sharing credits reduce the out of pocket amounts incurred by individuals on essential health benefits and will also impact the actuarial value of a health plan. Actuarial value reflects the average share of covered benefits paid by the insurer or health plan. For example, if the actuarial value of a plan is 90 percent, the health plan is paying 90 percent of the costs and the enrollee 10 percent. Under the PPACA, the maximum amount of cost sharing under this component range from 94 percent for those between 100 percent of the FPL to 150 percent FPL to 70 percent for those between 250 percent of the FPL and 400 percent of the FPL.

Select Committee on Patient Protection and Affordable Care Act

In December 2012, Florida Senate President Don Gaetz formed the Select Committee on PPACA to launch a comprehensive assessment on the impact of the law on Florida, evaluate the state's options under the law, and to make recommendations to the full Senate membership on any actions necessary to mitigate cost increases, preserve a competitive insurance market, and protect Florida's consumers.[42] The Select Committee received public testimony, expert presentations

[39] 26 U.S.C. s. 36B(c).
[40] Kaiser Family Foundation, *Summary of New Health Reform Law*, Last Modified April 15, 2011, http://www.kff.org/healthreform/upload/8061.pdf (last viewed Mar. 16, 2013).
[41] *See* Annual Update of the HHS Poverty Guidelines, 78 Fed. Reg. 5182, 5183 (January 24, 2013) https://www.federalregister.gov/articles/2013/01/24/2013-01422/annual-update-of-the-hhs-poverty-guidelines#t-1 (last visited Mar. 29, 2013).
[42] *See* Florida Senate, *Patient Protection and Affordable Care Act*, http://www.flsenate.gov/topics/ppaca (last visited: April 1, 2013).

and staff reports over nine meetings before it developed three specific recommendations relating to the development of a health care exchange, coverage for certain state employees and the expansion of Medicaid. On Medicaid, the Select Committee voted 7-4 to recommend to the full Senate to not expand Medicaid under the current state plan or pending waivers.[43] Following that vote, two alternative proposals for coverage of the population under 138 percent of the FPL that utilize the private insurance market were put forward for further discussion and debate.[44]

III. Effect of Proposed Changes:

Section 1 revises the legislative intent for the Florida Health Choices program to recognize the Health Choice Plus Program (HCP).

Section 2 creates s. 408.9105, F.S., and a new program called Health Choice Plus (HCP). The HCP program is managed by the Florida Health Choices Corporation (Corporation) under its existing infrastructure and governance and provides a benefit program to uninsured Floridians under 100 percent of the FPL. The bill establishes health benefit accounts for enrollees with financial contributions from the enrollee, the state, subject to available appropriations, and other sources such as the enrollee's employer; and provides a marketplace for enrollees to purchase health care goods and services utilizing funds from the health benefits account. Examples of products that may be purchased include, but are not limited to, discount medical plans, limited benefit plans, health flex plans, individual health insurance plans, bundled services or other prepaid health care coverage.

Under SPB 7144, definitions and their application to HCP are provided for the following:

- CHIP;
- Corporation;
- Corporation's marketplace;
- Enrollee;
- Program;
- Vendor;
- Health benefits account;
- Lawful permanent resident;
- Parent or caretaker relative;
- Goods and services; and,
- Patient Protection and Affordable Care Act.

The bill provides specific criteria for initial eligibility for HCP and conditions for continued enrollment. To be eligible, SPB 7144 requires that the individual meet the following conditions:

- Be a resident of Florida;
- Be between the ages of 19 and 64;

[43] Florida Senate Select Committee on Patient Protection and Affordable Care Act, *Letter to Senate President Don Gaetz on Medicaid Recommendation* http://www.flsenate.gov/usercontent/topics/ppaca/03-12-13MedicaidRecommendation.pdf (last visited: April 1, 2013).
[44] Id.

- Have a modified adjusted gross income of less than 100 percent of the FPL based on the individual's last tax return or other documentation;
- Be a United States citizen or a lawful permanent resident;
- Not be eligible for Medicaid;
- Not be eligible for employer sponsored coverage (with some exceptions); and,
- Meet on-going criteria based on whether or not the enrollee meets the definition of a childless adult or parent/relative caretaker.

SPB 7144 requires HCP to establish guidelines for financial participation by enrollees. At a minimum, an enrollee is required to contribute $20 per month towards his or her health benefit account. The enrollee contribution amount may be adjusted annually through the General Appropriations Act. The amount paid into the account by the state will be determined by the corporation based on the availability of state, local or federal funding. SPB 7144 provides that it may not exceed $10 per enrollee per month; however, this amount may be adjusted annually in the General Appropriations Act. HCP is also directed to implement an employer based contribution option. An employer may contribute towards an employee's health benefits account, including making the entire payment amount, at any time.

The bill directs HCP to develop and maintain an education and public outreach campaign and to provide a secure website that provides information and facilitates the purchase of goods and services. Information must also be provided about other insurance affordability programs.

To enroll in HCP, the bill provides that HCP must hold at least one open enrollment period per year, subject to available funding. Eligibility must be determined utilizing electronic means to the fullest extent possible. Once the program is full, enrollment will cease. Under subsection (3) of s. 408.9105, F.S., enrollment may occur through the Florida Health Choices portal, a referral from the DCF, the Florida Healthy Kids Corporation, or the exchange, as defined under the PPACA.

Once eligibility is confirmed, the bill directs the corporation to determine the amount of funds that will be deposited into each enrollee's account based upon the availability of funds and other factors. Enrollees must make a financial contribution to their health benefits account in order to maintain enrollment and the corporation is required to establish disenrollment criteria for non-payment of those minimum contributions. A maximum waiting period of 1 month prior to reinstatement to HCP for non-payment of any required payment may be imposed.

SPB 7144 requires the establishment of an optional incentives program for the achievement of healthy living goals. The program will establish annual healthy living goals, as provided under section (8)(b), and provide supplemental payments into an enrollee's health benefits account for meeting those goals, subject to the availability of funds.

The Corporation must establish the goals each fiscal year and publish the goals, procedures and timeframes for the achievement of those optional goals by July 1 and distribute to new enrollees within 30 calendar days after enrollment. The bill directs HCP to publish goals for the 2014 calendar year by October 1, 2013. Bonus funds may accumulate in an enrollee's account until program termination.

SPB 7144 provides that continued enrollment in HCP and receipt of state contributions on the enrollee's behalf is contingent upon the enrollee obtaining a health assessment from a county health department, federally qualified health center or other approved health care provider within the first 3 months of enrollment, making the required financial contribution, and meeting the categorical eligibility requirements.

The following additional criteria apply based on the enrollee's category of eligibility:

Criteria	**Childless Adult**	**Parent\Relative Caretaker**
Any dependent child in the household must be enrolled in Medicaid or CHIP, if eligible		X
Proof of 20 hours of employment or effort to seek employment; or, in lieu of employment volunteer hours at school or non-profit or enrollment as full-time student	X Volunteer hours - 20	X Volunteer hours – 10
Health Assessment in first 3 months	X	X
One preventive visit in first 6 months, repeat every 18 months thereafter	X	X

Failure to meet the ongoing eligibility criteria will result in the enrollee's disenrollment. One 30 day extension may be granted by HCP to comply. If disenrolled, the enrollee may not re-apply for coverage until the next open enrollment period or 90 days, whichever occurs later.

Subsection (5)(d) encourages the marketplace to utilize existing community programs and partnerships to deliver services, including but not limited to rural health clinics, federally qualified health centers, county health departments, emergency room diversion programs and community mental health centers. Any health care entity that receives state funding is required to participate in HCP and to offer services or products through the marketplace or directly to enrollees, as appropriate. Providers may charge nominal copayments for these services. The Corporation may establish the amount of allowable copayments when applicable.

Funds deposited into an enrollee's health benefits account may be used by the enrollee to offset health care costs or to purchase other health care services offered in the marketplace. Except for supplemental funds deposited under subsection (5)(c), funds deposited in an enrollee's account belong to the enrollee and are available for health care related expenditures. The bill provides under subsection (8)(c) that the optional bonus payments will be paid into the enrollee's account at the end of the quarter in which the goal was completed.

SPB 7144 requires the corporation to establish a refund process for enrollees who request the closure of their health benefits accounts and the return of any unspent individual contributions. Enrollees may only be refunded any funds that the enrollee or employer has contributed to their health benefits account. All other state funds revert to the corporation.

Under subsection (6), HCP is authorized to accept funds from employers to deposit into their employees' health benefits accounts, when not in conflict with any other provisions of this

act. The corporation is also permitted to accept state and federal funds or to seek other grants to help administer HCP. An assessment on vendors may be utilized to fund administration.

SPB 7144 specifically excludes the HCP from the Florida Insurance Code and affirms that coverage under HCP is not insurance. The bill under subsection (10), designates the coverage as a non-entitlement and affirms that 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 available to eligible persons or for the discontinuation of any coverage under HCP.

The bill requires the corporation to include information about the program into its regular annual report. A separate evaluation of HCP is also required under subsection (11) and is due to the Governor and Legislature by January 1, 2016.

A program sunset clause is provided in subsection (12) repealing the program effective July 1, 2016 unless saved from repeal through re-enactment by the Legislature.

Section 3 provides an effective date of July 1, 2013.

Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

IV. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill contemplates the corporation contracting with private providers of health care services and products to deliver health care benefits to an additional population of currently uninsured individuals who may or may not be seeking health care services now. Physicians, hospitals and other health care providers may be impacted by additional individuals seeking out health care coverage and there may be a higher demand for such services once implemented.

Additionally, those safety net and other providers who serve this same population and are not receiving compensation or are receiving reduced compensation for those services from those individuals may have an additional avenue for revenue.

C. Government Sector Impact:

The bill requires enrollees to receive certain health assessments from county health departments, federally qualified health centers and other approved health care providers within the first 3 months of enrollment as a condition of continued enrollment. For those county health departments with primary care services, there could be an increased demand for their services as individuals seek to comply with this requirement.

In addition to the increased demand for services, the program includes state contributions to the health benefit accounts on a monthly basis and incentives for achievement on optional healthy living performance goals based on an initial enrollment of 60,000 members for 12 months. No federal funds are expected for this program.

The following is the estimated state fiscal impact for 60,000 members over 12 months:

		PMPM Enrollee	PMPM State	Annual State PMPM	TOTAL
Health Benefits Account Funds		$20.00	$10.00	$120.00	$7,200,000
Incentives $25 Each Healthy Living Goal					
100% Achieve 2	$3,000,000				$3,000,000
25% Achieve 3	$1,125,000				$1,125,000
5% Achieve 4	$300,000				$300,000
2% Achieve 5	$150,000				$150,000
Administration (FHC)	$1,500,000				$1,500,000
Direct Services (Community and safety net provider supplement for HBAs)	$2,000,000				$2,000,000
Grand Total:					$15,275,000

V. Technical Deficiencies:

None.

VI. Related Issues:

The Florida Health Choices Corporation will be receiving and reviewing medical records and personal health information of enrollees in the Health Choice Plus program. The exemption from public records under s. 408.910(14) F.S., only applies to the Florida Health Choices Corporation and enrollees and participants of the Florida Health Choices program. An exemption for the Health Choice Plus program would be appropriate to ensure that medical records and personal

information of enrollees and applicants to the program would remain confidential and exempt from s. 119.07(1), F.S. and s. 24(a), Art. 1 of the State Constitution.

VII. 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.