FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

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BILL #: CS/HB 905	**COMPANION BILL:** SB 1034 (Martin)
TITLE: Florida Health Choices Program	**LINKED BILLS:** None
SPONSOR(S): Yarkosky	**RELATED BILLS:** SB 1034 (Martin)

Committee References

Health Care Facilities & Systems
16 Y, 0 N, As CS

SUMMARY

Effect of the Bill:

PCS for HB 905 creates the Florida Employee Health Choices Program, and creates the Florida Employee Health Choices, Inc., to administer the Program. The Program will administer a statewide online exchange for the purchase of individual health insurance coverage in the context of Individual Coverage Health Reimbursement Arrangements (ICHRAs) established by employers for their employees. Under the bill, the Department of Management Services DMS will provide administrative support for the corporation until 2028, when the bill requires the corporation to be self-sustaining. The bill requires the corporation to competitively procure a vendor to build and operate the exchange platform, and requires the corporation to establish policies and procedures for including health policies in the exchange and managing premium contributions for the products available there.

Fiscal or Economic Impact:

The bill will have an indeterminate negative fiscal impact on DMS for the administrative support of the corporation until 2018, including but not limited to, the work to issue and evaluate the competitive procurement for the platform vendor.

The bill may have a positive economic impact on small and medium-sized employers and their employees, if the program expands their ability to access affordable health care coverage.

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ANALYSIS

EFFECT OF THE BILL:

Individual Coverage Health Reimbursement Arrangements

An Individual Coverage Health Reimbursement Arrangement (ICHRA) is a health insurance model that allows employers to reimburse their employees for health insurance premiums or qualified medical expenses, on a tax-free basis. ICHRAs are commonly used with an online exchange, or marketplace, where employees may purchase individual health coverage products for later reimbursement by their employers.

State statutory authority is not required for employers to use ICHRAs, as the individual policies available for reimbursement in the exchange would already be regulated under the Florida Insurance Code. Private entities may currently offer exchanges for these products; however, the state has not established such a marketplace as a government function.

Florida Employee Health Choices Program

The PCS for HB 905 authorizes employers to offer ICHRAs to their employees by creating the Florida Employee Health Choices Program (Program). The Program creates a centralized platform for employees enrolled in ICHRAs to purchase individual health insurance plans. The bill uses the statutory structure of a pre-existing, similar, now-

defunct program (the Florida Health Choices Program) in s. 408.910, F.S., as the base for the Program, and modifies the language to fit the federal criteria for ICHRAs.

The bill creates the Florida Employee Health Choices, Inc., (corporation) to manage the Florida Employee Health Choices Program. The Department of Management Services (DMS) oversees the corporation's creation and administration until January 1, 2028; after this date, the corporation must be self-sustaining. (Section 1)

Corporation Governance

The bill requires DMS, in its administrative support role, to facilitate the formation of the corporation and provide other such administrative assistance as may be needed by the board for its statutory functions.

The bill establishes a governance structure for the corporation, in a board of directors comprised of eight-members who serve three-year terms. Members may be reappointed, granted they do not serve more than nine consecutive years. The Governor will appoint three members, the President of the Senate two members, the Speaker of the House of Representatives two members, and the Secretary of the Department of Management Services, or a designee, will serve as an ex officio, non-voting, member. The DMS designee must have experience in state employee benefits and procurement practices.

The bill requires the board to establish bylaws to govern itself, including:

- Procedures for selecting the corporation's officers;
- Qualifications for reappointing members;
- Procedures for selecting the corporation's chief executive officer;
- An annual meeting for Program participants to express feedback;
- Procedures to adopt an annual budget; and
- Procedures to address conflicts of interest and public disclosure of conflicts of interest.

The bill authorizes reimbursement for travel expenses, subject to the standards for travel reimbursement for state employees in s. 112.061, F.S. Travel expenses must be paid for from corporation funds; not state funds.

The bill provides liability protection for board members, and their employees or agents, for actions taken in the performance of their duties in administering the program.

Program Administration

The bill requires the corporation to administer the Program, including enrolling and assisting employers, assisting individuals with information about products, recruiting health plan vendors, certifying plan vendor eligibility, and monitoring plan performance. To that end, the bill requires the corporation to create policies and procedures, including:

- Criteria for Program participation;
- Procedures for determining eligibility for employers, employees, plan vendors, and health insurance agents;
- Procedures to ensure vendors are licensed to sell health insurance policies or health maintenance contracts and do not use deceptive or predatory practices;
- Processes for collecting employer and individual contributions, premium payments and other payments based on the employee's chose insurance plan; and
- Policies for an employee's disenrollment for the employee's failure to pay premiums.

The bill requires the corporation to create a plan to promote the Program and establish a toll-free hotline to assist employers and employees. The bill also authorizes the corporation to evaluate additional options for employers to participate in the Program, and implement them, if they conform with common insurance practices.
Platform Procurement

The bill requires DMS to conduct the procurement of the platform vendor. Within 90 days of the corporation's formation, DMS must issue an invitation to negotiate (ITN) to procure that vendor, as directed by the board. The bill requires DMS to include the requirement that bidders demonstrate the ability to establish a fully operational platform in time for open enrollment by January 1, 2027. The platform vendor must be able to accommodate initial enrollment periods, open enrollment periods and special enrollment periods.

DMS must evaluate and score the bids, and enter into negotiations at the board's direction. DMS must also make recommendations to the board related to the contract award, but will not make the final award decision. The bill requires the corporation to award the platform contract within 180 days of DMS issuing the ITN.

Public Records Exemption

Current law includes a public records exemption for the prior Florida Health Choices Program. That exemption applies to personal identifying information of plan enrollees or participants; client and customer lists of buyer representatives held by the original Florida Health Choices corporation; and proprietary, confidential business information held by the original Florida Health Choices corporation.

The bill reenacts the existing public records exemption to apply to the new Florida Employee Health Choices Program established by the bill.

The bill makes numerous conforming changes. (Sections 2, 3, and 4)

The bill provides an effective date of July 1, 2025. (Section 5)

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

The bill will have an indeterminate negative fiscal impact on DMS for the administrative support of the corporation until 2028, including, but not limited to, the work to issue and evaluate the competitive procurement for the platform vendor. This impact may be absorbable by the department.

PRIVATE SECTOR:

The bill may have a positive economic impact on small and medium-sized employers and their employees, if the Program expands their ability to access affordable health care coverage.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Health Reimbursement Arrangements

Health reimbursement arrangements or accounts (HRAs) are employer-funded health benefits that allow employers to reimburse employees for medical expenses and health plan premiums on a tax-free basis for both the employer and the employee.[1] HRAs can be paired with a traditional health insurance policy or health plan.

With an HRA, the employer determines an amount to contribute for each employee, or class of employees. An employee cannot make contributions to the account.
The employer then determines what medical expenses are eligible for reimbursement under the arrangement, which might include expenses not typically paid for by an insurance coverage policy, such as expenses the patient

[1] See, 26 U.S.C. §§ 105, 106, 213.

must cover out-of-pocket to meet a deductible, coinsurance, copayments, services not covered by the main health coverage policy such as dental or vision services, or medical supplies.

The employee can use the HRA funds to be reimbursed for those allowed medical expenses. Reimbursements made through ICHRAs are exempt from federal income and payroll taxes for both employers and employees.

The Internal Revenue Service (IRS) first recognized HRAs as employer-funded plans and granted their tax-free status in 2002. However, the Patient Protection and Affordable Care Act (PPACA) of 2010 introduced market regulatory changes affecting group health plans, including HRAs. Specifically, PPACA deemed employer payment plans that reimbursed employees for individual health insurance premiums non-compliant with PPACA requirements.[2] Under PPACA, an employer could not establish an HRA for employees to use to pay premiums for individual policies and maintain the tax-free status of the employer contribution.

Individual Coverage Health Reimbursement Arrangements

In 2019, the federal Departments of the Treasury, Labor, and Health and Human Services adopted a final rule that expanded the usability of HRAs. These regulations aimed to allow HRAs to be integrated with individual health insurance coverage, thereby providing more flexibility for employers and employees. The rule established the framework for Individual Coverage Health Reimbursement Arrangements (ICHRAs), permitting employers to offer these arrangements starting January 1, 2020.[3]

An ICHRA is a health insurance model that allows employers of any size to reimburse their employees for health insurance premiums or qualified medical expenses. Unlike a traditional HRA, an ICHRA cannot be offered in connection with a group health plan and are not group health insurance coverage, but does have the tax advantages of group health insurance coverage: reimbursements are tax-free for both the employer and employee. This authorization counters the provisions of PPACA that would prevent tax-free treatment of HRA used to pay premiums, if structured according to the rule.

Employer Participation

An employer using an ICHRA sets a monthly or annual contribution the employer will make to the ICHRA for each employee; federal law imposes no maximum or minimum amount for the contribution. An employee then selects an individual health coverage policy through an exchange, such as the federal PPACA Marketplace or a private exchange, or directly from an insurance company. The individual health plan selected by the employee must be in compliance with the coverage and regulatory requirements of PPACA. After selecting a plan, the employee enrolls in the individual policy through the exchange and submits claims for reimbursement of eligible expenses to the employer. The employer then reimburses employees from the ICHRA funds.

The employee cannot contribute to the ICHRA; however, when selecting a plan for which ICHRA funds will be used, the employee is not limited by the amount of the ICHRA funds. The employee can choose an individual plan that may cost more, annually, than the employer's ICHRA allowance. The ICHRA is used to reimburse the employee up to the amount of the allowance.

If an employee chooses to no longer be covered by an ICHRA, the employee will not be reimbursed for any medical care expenses that are incurred after the ICHRA has received notice of the cancellation or termination.

Employee Participation

[2] *See,* Internal Revenue Service, Notice 2015-17; Notice 2013-54; Internal Revenue Bulletin 2013-40, 287, Sept. 30, 2013.
[3] *See,* 26 CFR Parts 1 and 54; 29 CFR Parts 2510 and 2590; 45 CFR Parts 144-147 and 155.

The federal rule allows employers to offer ICHRAs to all employees or to only some classes of employees, but prohibits offering a group health policy to employees who are also offered an ICHRA. Employers may vary their reimbursement allowances by class of employee, and the rule defines the types of employee classes employers can use. Employers can also vary the coverage based on whether the covered individual is an employee or a dependent.

Because the ICHRA allowance is essentially a pledge to pay on behalf of the employer, the employer retains ownership of the allowance, and may determine how unspent amounts are handled. The IRS rule authorizes employers to allow unspent amounts, or a portion of unspent amounts, to carry over from year to year, at the employer's discretion. Employees cannot retain unspent amounts.

Health Coverage Exchanges

A health coverage exchange is an online platform, or marketplace, populated by health plan offerings where individual consumers can compare plans and purchase coverage. Exchange operators fund the functions by charging fees to participate; fees may be charged to the insurers or HMOs which offer products on an exchange, or to the employers or individual coverage purchasers.

PPACA Exchange

PPACA established a federal program to subsidize health insurance coverage for people with incomes from 133 percent to 400 percent of the federal poverty level.[4] To facilitate the use of PPACA-created federal subsidies for health coverage, PPACA required each state to establish a state exchange to host plans offering products for use with the subsidy.[5] Many states declined to comply[6], and the federal government established a federal exchange, called the Health Insurance Marketplace.[7]

The federal Marketplace hosts individual policies for purchase by individual (or family) consumers; it has no nexus with employer-sponsored coverage, under PPACA.[8]

Florida Health Choices Program

In 2008, the legislature established the Florida Health Choices program as health coverage exchange available to small employers. The program created a single, centralized marketplace for the sale and purchase of various products that enable individuals to pay for health care, and created the Florida Health Choices Corporation to administer the program. The program complied with Sec. 125 of the Internal Revenue Code regarding cafeteria plans, which enabled the employers' contributions and the employees' contributions to be made using pre-tax dollars.

Under this program, several types of employers were eligible to use the marketplace as their employer-sponsored health plan:

- Employers with 1-50 employees;

[4] 26 U.S.C. 36B. The federal poverty level (FPL) is $32,000 for a family of four; 138% of the FPL is $44,367 for a family of four; 400% of the FPL is $128,600 for a family of four. PPACA subsidies are scaled to income level. U.S. Dept. of Health and Human Services, 2025 Poverty Guidelines for the 48 Contiguous States and the District of Columbia, available at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines (last visited March 23, 2025).
[5] 42 U.S.C. 18031.
[6] 20 states established state-based marketplaces; three have state-based exchanges on the federal platform; and 28 states use the federal marketplace. KFF, State Health insurance Marketplace Types, 2014-2025, available at https://www.kff.org/affordable-care-act/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited March 23, 2025).
[7] The exchange is available at https://www.healthcare.gov/ (last visited March 23, 2025).
[8] However, employers subject to the mandated coverage offering under PPACA are penalized if one of their employees goes to the marketplace and obtains subsidized coverage. See, 26 U.S.C. 4980H.

- Fiscally constrained counties;
- Municipalities with populations less than 50,000; and
- School districts in fiscally constrained counties.

Employees authorized to purchase coverage included:

- Employees of employers choosing the marketplace as the employer-sponsored health plan;
- State employees not eligible for state employee health benefits;
- State retirees;
- Medicaid recipients who choose to use their Medicaid benefits to purchase coverage in the marketplace; and
- Employees of statutory rural hospitals.

Products authorized for inclusion in the program marketplace included insurance and HMO policies and contracts, limited benefit policies, prepaid clinic service providers and contracts and provider organization contracts, among other products.

The program struggled to attract enough enrollees and enough products to support a diverse marketplace and be self-sustaining. Ultimately, the enactment of PPACA and the creation of its federal exchange for individual coverage eclipsed the program, despite the different target populations (employer-based individual coverage populations under Florida Health Choices and individual, non-employment based coverage under the PPACA exchange). Upon the 2017 gubernatorial veto of a $250,000 appropriation for marketing[9], the board dismantled the program and the corporation.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Health Care Facilities & Systems Subcommittee	16 Y, 0 N, As CS	3/27/2025	Calamas	Calamas
THE CHANGES ADOPTED BY THE COMMITTEE:	Click or tap here to enter text.			

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.

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[9] Fiscal Year 2017-2018 General Appropriations Act, Conference Report on SB 2500, Line 166.