A bill to be entitled

An act relating to the Florida Health Choices Program; amending s. 408.910, F.S.; renaming the "Florida Health Choices Program" as the "Florida Employee Health Choices Program"; revising legislative findings and intent; revising definitions; revising the purpose and components of the program; revising eligibility and participation requirements for vendors under the program; revising the types of health insurance products that are available for purchase through the program; deleting certain pricing transparency requirements to conform to changes made by the act; revising the structure of the insurance marketplace process under the program; deleting the option for risk pooling under the program; deleting exemptions from certain requirements of the Florida Insurance Code under the program; renaming the corporation administering the program as "Florida Employee Health Choices, Inc."; revising membership of the board of directors; authorizing the corporation to exercise certain powers; revising duties of the board and the corporation; revising the fiscal year in which the corporation's annual report is due; amending ss. 409.821, 409.9122, and 409.977, F.S.; conforming provisions to changes made by the act; providing an

effective date.

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

Section 1. Section 408.910, Florida Statutes, is amended to read:

408.910 Florida Employee Health Choices Program.—

(1) LEGISLATIVE INTENT.—The Legislature finds that a significant number of employers and employees in ~~the residents of~~ this state do not have adequate access to affordable, quality health insurance that meets their needs ~~care~~. The Legislature further finds that individual coverage health reimbursement arrangements offer a novel way for employers of any size to give health care contributions directly to employees to empower them to choose their own health plan in a broad marketplace based on individual financial needs and health factors. The Legislature further finds that increasing access to affordable, quality health care through individual coverage health reimbursement arrangements can be best accomplished by establishing a competitive marketplace ~~market~~ for employees who receive employer premium contributions through individual coverage health reimbursement arrangements ~~purchasing health insurance and health services~~. It is therefore the intent of the Legislature to create the Florida Employee Health Choices Program to do the following:

(a) Expand opportunities for employers and employees ~~Floridians~~ to access ~~purchase~~ affordable health insurance in this state ~~and health services~~.

(b) Create a platform that streamlines the purchase of individual coverage for employees enrolled in individual coverage health reimbursement arrangements ~~Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits~~.

(c) Enable individual choice in both the manner and amount of health care purchased.

(d) Provide for the purchase of individual, portable health care coverage.

(e) Disseminate information to employers and employees about individual coverage health reimbursement arrangements ~~consumers on the price and quality of health services~~.

(f) Sponsor a competitive marketplace ~~market~~ that stimulates product innovation, quality improvement, and efficiency in the production and delivery of individual health insurance plans to employees enrolled in individual coverage health reimbursement arrangements ~~health services~~.

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

(a) "Corporation" means ~~the~~ Florida Employee Health Choices, Inc., established under this section.

(b) "Corporation's marketplace" means the ~~single,~~ centralized market established by the program which ~~that~~

facilitates the purchase of products made available in the marketplace.

(c) "Health insurance agent" means an agent licensed under part IV of chapter 626.

(d) "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy ~~or a group health insurance policy~~, a preferred provider organization as defined in s. 627.6471, an exclusive provider organization as defined in s. 627.6472, or a health maintenance organization licensed under part I of chapter 641~~, or a prepaid limited health service organization or discount plan organization licensed under chapter 636~~.

(e) "Program" means the Florida Employee Health Choices Program established by this section.

(3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Employee Health Choices Program is created as a ~~single,~~ centralized marketplace ~~market~~ for the sale and purchase of individual health insurance plans by employees enrolled in an individual coverage health reimbursement arrangement ~~various products that enable individuals 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.

(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~~, 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 insurers and~~,~~ health maintenance organizations~~, prepaid clinic service providers, provider service networks, and other 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 eligible to enroll in the program include those employers that meet criteria established by the corporation and elect to make their employees eligible through the program.

(b) Individuals eligible to participate in the program include:

1. Individual employees of enrolled employers.

2. Other individuals that meet criteria established by the corporation.

(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.

(d) All eligible vendors who choose to participate and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies~~, limited benefit policies, other risk-bearing coverage, and other products or services~~.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health maintenance contracts~~, limited benefit policies, other risk-bearing products, and other~~

~~products or services~~.

~~3. Prepaid limited health service organizations may sell products and services as authorized under part I of chapter 636, and discount plan organizations may sell products and services as authorized under part II of chapter 636.~~

~~4. Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.~~

~~5. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.~~

~~6. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.~~

~~7. Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.~~

~~A vendor described in subparagraphs 3.-7. may not sell products~~

~~that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation and is authorized to provide coverage in the relevant geographic area. Otherwise~~ Eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

(e) Eligible individuals may participate in the program voluntarily. 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.

3. Compliance with federal tax requirements.

4. Arrangements for payment.

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 product or service to a participant who elects to buy it.

4. ~~Establishment of product prices based on applicable criteria.~~

~~5.~~ Arrangements for receiving payment for enrolled participants.

5.~~6.~~ Participation in ongoing reporting processes established by the corporation.

6.~~7.~~ Compliance with grievance procedures established by the corporation.

(g) Health insurance agents licensed under part IV of chapter 626 are eligible to voluntarily participate as buyers' representatives. A buyer's representative acts on behalf of an individual purchasing health insurance and health services through the program by providing information about products and services available through the program and assisting the individual with both the decision and the procedure of selecting specific products. Serving as a buyer's representative does not constitute a conflict of interest with continuing responsibilities as a health insurance agent if the relationship between each agent and any participating vendor is disclosed before advising an individual participant about the products and

services available through the program. In order to participate, a health insurance agent shall comply with the procedures established by the corporation, including:

1. Completion of training requirements.

2. Execution of a participation agreement specifying the terms and conditions of participation.

3. Disclosure of any appointments to solicit insurance or procure applications for vendors participating in the program.

4. Arrangements to receive payment from the corporation for services as a buyer's representative.

(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 and~~.~~

~~2.~~ health maintenance contracts.

~~3. Limited benefit plans.~~

~~4. Prepaid clinic services.~~

~~5. Service contracts.~~

~~6. Arrangements for purchase of 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 covered 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.~~

(6) SURCHARGE ~~PRICING~~.~~—Prices for the products and services sold through the program must be transparent to participants and established by the vendors.~~ The corporation shall annually assess a surcharge for each premium or price set by a participating vendor. The surcharge may not be more than 2.5 percent of the price and must ~~shall~~ be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives.

(7) ~~THE~~ MARKETPLACE PROCESS.—The program shall provide a ~~single,~~ centralized marketplace ~~market~~ for access to ~~purchase of~~ health insurance and~~,~~ health maintenance contracts by an employee enrolled in an individual coverage health reimbursement arrangement~~, 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 must ~~shall~~ be made available through printed material and an interactive Internet website. A participant needing personal assistance to select products and services must ~~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 by an individual participant within the applicable open 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.~~

(8) CONSUMER INFORMATION.—The corporation shall:

(a) Establish a secure website to facilitate the purchase of products and services by participating individuals. The website must provide information about each product or service available through the program.

(b) Inform individuals about other public health care programs.

(9) ~~RISK POOLING.—The program may use methods for pooling the risk of individual participants and preventing selection bias. These methods may include, but are not limited to, a postenrollment risk adjustment of the premium payments to the vendors. The corporation may establish a methodology for assessing the risk of enrolled individual participants based on data reported annually by the vendors about their enrollees. Distribution of payments to the vendors may be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.~~

~~(10)~~ EXEMPTION ~~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 forms, website design, or marketing communication developed by the corporation and used by the corporation, or any vendor that meets the requirements of paragraph (4)(f) is not subject to the Florida Insurance Code, as established in s. 624.01.~~

(10) CORPORATION.—There is created Florida Employee Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter 112 and chapters 119, 286, and 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program. The Department of Management Services shall facilitate the formation of the corporation and provide administrative support for the corporation until January 1, 2029. The corporation must be self-sustaining and no longer require administrative assistance from the Department of

Management Services by January 1, 2029.

(a) The corporation shall be governed by an eight-member board of directors. Board members shall be appointed for terms of up to 3 years and shall be eligible for reappointment. A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment. Board members may not include an individual who is affiliated with or employed by an eligible vendor or a subsidiary of an eligible vendor. Board members shall serve without compensation, but are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided in s. 112.061. The membership of the board shall consist of:

1. Three members appointed by the Governor.

2. Two members appointed by the President of the Senate.

3. Two members appointed by the Speaker of the House of Representatives.

4. The Secretary of Management Services or a designee with expertise in state employee benefits and procurement, as an ex officio nonvoting member.

(b) The corporation may exercise all powers granted to it under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of

value to be held, used, and applied for the purposes of this section.

(c) There is no liability on the part of, and a cause of action may not arise against, any member of the board or its employees or agents for any action taken by them in exercising their powers and performing their duties under this section.

(d) The board shall develop and adopt bylaws and other corporate procedures necessary for the operation of the corporation and carrying out the purposes of this section. At a minimum, the bylaws must:

1. Specify procedures for selection of officers and qualifications for reappointment, provided that a board member may not serve more than 9 consecutive years.

2. Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.

3. Specify policies and procedures regarding conflicts of interest, including part III of chapter 112, which prohibit a member from participating in any decision that would inure to the benefit of the member or the organization that employs the member. The policies and procedures must also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

4. Specify procedures for adopting an annual budget.

5. Specify procedures for selecting a chief executive

officer for the corporation who shall be responsible for securing staff and consultant services necessary for the operation of the program as may be authorized by the corporation's operating budget.

(e) The corporation shall establish policies and procedures for application, enrollment, plan administration, performance monitoring, and consumer education, and other policies and procedures necessary for the operation of the program, including, but not limited to:

1. Criteria for participation in the program and procedures for determining the eligibility of employers, vendors, individuals, and health insurance agents and employers to participate in the program.

2. Exclusion of vendors pursuant to paragraph (4)(d).

3. Collection of contributions from participating employers and individuals.

4. Payment of premiums and other appropriate disbursements based on the selections of products and services by participating individuals.

5. Disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

(f) The corporation shall procure a vendor to facilitate a platform that streamlines the purchase of individual coverage for employees enrolled in individual coverage health

reimbursement arrangements.

1. Within 90 days after the formation of the corporation, the department shall, as directed by the board, issue an invitation to negotiate to procure the vendor. Responsive bidders must demonstrate the ability to establish a platform fully operational for open enrollment by January 1, 2028, and provide for initial, open, and special enrollment periods.

2. The department shall evaluate and score the procurement bids, enter into negotiations at the direction of the board, and make recommendations to the board related to the contract award. The corporation shall select the vendor and execute the contract within 180 days after the issuance of the invitation to negotiate.

(g) The corporation shall develop and implement a plan for promoting public awareness of and participation in the program and shall establish a toll-free hotline to respond to requests for assistance from employers and plan enrollees.

(h) The corporation may evaluate and implement additional options for employer participation which conform with common insurance practices.

~~(11) CORPORATION.—There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter 112 and chapters 119, 286, and 617. The purpose of the corporation is to administer the program created in this section~~

~~and to conduct such other business as may further the administration of the program.~~

~~(a) The corporation shall be governed by a 15-member board of directors consisting of:~~

~~1. Three ex officio, nonvoting members to include:~~

~~a. The Secretary of Health Care Administration or a designee with expertise in health care services.~~

~~b. The Secretary of Management Services or a designee with expertise in state employee benefits.~~

~~c. The commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.~~

~~2. Four members appointed by and serving at the pleasure of the Governor.~~

~~3. Four members appointed by and serving at the pleasure of the President of the Senate.~~

~~4. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.~~

~~5. Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations, prepaid service providers, or any other entity, affiliate or subsidiary of eligible vendors.~~

~~(b) Members shall be appointed for terms of up to 3 years. Any member is eligible for reappointment. A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment.~~

~~(c) The board shall select a chief executive officer for the corporation who shall be responsible for the selection of such other staff as may be authorized by the corporation's operating budget as adopted by the board.~~

~~(d) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061. No other compensation is authorized.~~

~~(e) There is no liability on the part of, and no cause of action shall arise against, any member of the board or its employees or agents for any action taken by them in the performance of their powers and duties under this section.~~

~~(f) The board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the corporation and carrying out the purposes of this section. The bylaws shall:~~

~~1. Specify procedures for selection of officers and qualifications for reappointment, provided that no board member shall serve more than 9 consecutive years.~~

~~2. Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.~~

~~3. Specify policies and procedures regarding conflicts of interest, including the provisions of part III of chapter 112, which prohibit a member from participating in any decision that would inure to the benefit of the member or the organization~~

~~that employs the member. The policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.~~

~~(g) The corporation may exercise all powers granted to it under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this section.~~

~~(h) The corporation shall:~~

~~1. Determine eligibility of employers, vendors, individuals, and agents in accordance with subsection (4).~~

~~2. Establish procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.~~

~~3. Arrange for collection of contributions from participating employers and individuals.~~

~~4. Arrange for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.~~

~~5. Establish criteria for disenrollment of participating individuals based on failure to pay the individual's share of~~

~~any contribution required to maintain enrollment in selected products.~~

~~6. Establish criteria for exclusion of vendors pursuant to paragraph (4)(d).~~

~~7. Develop and implement a plan for promoting public awareness of and participation in the program.~~

~~8. Secure staff and consultant services necessary to the operation of the program.~~

~~9. Establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents, and employers.~~

~~10. Provide for the operation of a toll-free hotline to respond to requests for assistance.~~

~~11. Provide for initial, open, and special enrollment periods.~~

~~12. Evaluate options for employer participation which may conform with common insurance practices.~~

(11)~~(12)~~ REPORT.—Beginning in the 2027-2028 ~~2009-2010~~ fiscal year, the corporation shall submit by February 1 an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives documenting the corporation's activities in compliance with the duties delineated in this section.

(12)~~(13)~~ PROGRAM INTEGRITY.—To ensure program integrity and to safeguard the financial transactions made under the

auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

(13) ~~(14)~~ EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—

(a) *Definitions.*—For purposes of this subsection, the term:

1. "Buyer's representative" means a participating insurance agent as described in paragraph (4)(g).

2. "Enrollee" means an employer who is eligible to enroll in the program pursuant to paragraph (4)(a).

3. "Participant" means an individual who is eligible to participate in the program pursuant to paragraph (4)(b).

4. "Proprietary confidential business information" means information, regardless of form or characteristics, that is owned or controlled by a vendor requesting confidentiality under this section; that is intended to be and is treated by the vendor as private in that the disclosure of the information would cause harm to the business operations of the vendor; that has not been disclosed unless disclosed pursuant to a statutory provision, an order of a court or administrative body, or a private agreement providing that the information may be released

to the public; and that is information concerning:

a. Business plans.

b. Internal auditing controls and reports of internal auditors.

c. Reports of external auditors for privately held companies.

d. Client and customer lists.

e. Potentially patentable material.

f. A trade secret as defined in s. 688.002.

5. "Vendor" means a participating insurer or other provider of services as described in paragraph (4)(d).

(b) *Public record exemptions.*—

1. Personal identifying information of an enrollee or participant who has applied for or participates in the Florida Employee Health Choices Program is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

2. Client and customer lists of a buyer's representative held by the corporation are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

3. Proprietary confidential business information held by the corporation is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(c) *Retroactive application.*—The public record exemptions provided for in paragraph (b) apply to information held by the corporation before, on, or after the effective date of this

exemption.

(d) *Authorized release.*—

1. Upon request, information made confidential and exempt pursuant to this subsection must ~~shall~~ be disclosed to:

a. Another governmental entity in the performance of its official duties and responsibilities.

b. Any person who has the written consent of the program applicant.

c. The Florida Kidcare program for the purpose of administering the program authorized in ss. 409.810-409.821.

2. Paragraph (b) does not prohibit a participant's legal guardian from obtaining confirmation of coverage, dates of coverage, the name of the participant's health plan, and the amount of premium being paid.

(e) *Penalty.*—A person who knowingly and willfully violates this subsection commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 2. Paragraph (a) of subsection (2) of section 409.821, Florida Statutes, is amended to read:

409.821 Florida Kidcare program public records exemption.—

(2)(a) Upon request, such information shall be disclosed to:

1. Another governmental entity in the performance of its official duties and responsibilities;

2. The Department of Revenue for purposes of administering

the state Title IV-D program;

3. ~~The~~ Florida Employee Health Choices, Inc., for the purpose of administering the program authorized pursuant to s. 408.910; or

4. Any person who has the written consent of the program applicant.

Section 3. Subsection (3) of section 409.9122, Florida Statutes, is amended to read:

409.9122 Medicaid managed care enrollment; HIV/AIDS patients; procedures; data collection; accounting; information system; medical loss ratio.—

(3) The agency shall develop a process to enable any recipient with access to employer-sponsored health care coverage to opt out of all eligible plans in the Medicaid program and to use Medicaid financial assistance to pay for the recipient's share of cost in any such employer-sponsored coverage. Contingent on federal approval, the agency shall also enable recipients with access to other insurance or related products that provide access to health care services created pursuant to state law, including any plan or product available pursuant to the Florida Employee Health Choices Program or any health exchange, to opt out. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a plan for that recipient.

Section 4. Subsection (4) of section 409.977, Florida Statutes, is amended to read:

409.977 Enrollment.—

(4) The agency shall develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage. The agency shall also enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under the Florida Employee Health Choices Program, or any health exchange, to opt out. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient. The agency shall require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient. The agency may exceed this amount for a high-cost patient if it determines it would be cost effective to do so. The agency shall annually, beginning June 30, 2026, submit an annual report on the program to the

Legislature including, but not limited to, the level of participation; participant demographics, income levels, type of employer-based coverage, and amount of health care utilization; and a cost-effectiveness analysis both in the aggregate and on an individual patient basis.

Section 5. This act shall take effect July 1, 2026.