Appropriations Committee

Friday, April 19, 2013
9:00 AM – 1:00 PM
212 Knott Building

Meeting Packet

Will Weatherford
Speaker

Seth McKeel
Chair

The Florida House of Representatives

Appropriations Committee

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AGENDA

Friday, April 19, 2013
212 Knott Building
9:00 AM – 1:00 PM

I. Call to Order/Roll Call

II. Opening Remarks by Chair McKeel

III. Consideration of the following bills:

CS/HB 279 Rental of Homestead Property by Finance & Tax Subcommittee, Hood

HB 7169 Florida Health Choices Plus Program by Select Committee on PPACA (Patient Protection and Affordable Care Act), Cummings, Hudson

IV. Closing Remarks and Adjournment

221 The Capitol, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 717-4810 Fax: (850) 488-9633

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 279 Rental of Homestead Property
SPONSOR(S): Finance & Tax Subcommittee, Hood, Jr. and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 342

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Tax Subcommittee	13 Y, 0 N, As CS	Tarich	Langston
2) Local & Federal Affairs Committee	16 Y, 0 N	Lukis	Rojas
3) Appropriations Committee		Voyles SV	Leznoff

SUMMARY ANALYSIS

CS/HB 279 allows the rental of homestead property, for up to 30 days per calendar year, without the property being considered abandoned as a homestead, for ad valorem tax purposes, or otherwise negatively affecting the homestead status of the property. However, if homestead property is rented for more than 30 days in a calendar year, the property is considered abandoned as a homestead, and homestead-related ad valorem tax benefits will be lost.

This bill substantially amends s. 196.061, F.S.

The Revenue Estimating Conference has estimated the bill will increase property tax revenues by $4.1 million in Fiscal Year 2013-14.

This bill has an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES

Present Situation

Exemptions and Property Classifications

The Florida Constitution requires that all property be assessed at just value (i.e., market value) for ad valorem tax purposes.[1] However, ss. 3, 4, and 6, Art. VII of the State Constitution, provide for specific assessment limitations, property classifications and exemptions. After the property appraiser has considered any assessment limitation or use classification affecting the just value of a property, the assessed value is determined. The assessed value is then reduced by any applicable exemptions to produce the taxable value.[2] Available exemptions include homestead exemptions and exemptions for property used for education, religious, or charitable purposes.[3]

Homestead Exemption

Every person who maintains his or her permanent residence[4] on property to which he or she holds legal and equitable title is eligible for a $25,000 homestead tax exemption applicable to all ad valorem tax levies, including school districts.[5] An additional $25,000 homestead exemption applies to homesteads that have an assessed value greater than $50,000 and up to $75,000, excluding ad valorem taxes levied by schools.[6]

Changes Affecting Save Our Homes

After any change in ownership, as provided by general law, homestead property must be assessed at just value as of January 1 of the following year. Changes, additions, reductions, and improvements to homestead property are assessed as provided by general law, but after the initial assessment, these items are subject to the Save Our Homes assessment limitation. If the homestead use of the property is terminated, the property is assessed at just value.

Loss of Homestead Status through Rental

Section 196.061, F.S., provides guidance on homestead status, rentals of the homestead and its abandonment as follows:

- Rental of all or substantially all of a dwelling previously claimed to be a homestead for tax purposes constitutes abandonment of the dwelling as a homestead.[7]
- Abandonment continues until the dwelling is physically occupied by the owner.
- The abandonment of the homestead after January 1 of any year shall not affect the homestead exemption for tax purposes for that particular year so long as the property was not rented in two consecutive years.

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[1] Fla. Const. Art. VII, s. 4.
[2] See s. 196.031, F.S.
[3] Fla. Const. Art. VII, ss. 3 and 6.
[4] Pursuant to s. 196.012(18), F.S., "permanent residence" means that place where a person has his or her true, fixed, and permanent home and principal establishment to which, whenever absent, he or she has the intention of returning. Intention to establish a permanent residence in Florida is a factual determination to be made, in the first instance, by the property appraiser.
[5] Fla. Const. Art. VII, s. 6.
[6] *Id.*
[7] Ch. 2012-193, s. 18, Laws of Fla., introduced the "all or substantially all of a" dwelling language. Owners sometimes rented the majority of a dwelling but retained possession of a closet or similar limited space in an effort to retain a homestead exemption.

- The provisions of s. 196.061, F.S., do not apply to a member of the Armed Forces of the United States whose service in such forces is the result of a mandatory obligation imposed by the federal Selective Service Act, or who volunteers for service as a member of the Armed Forces of the United States.

Florida courts have traditionally emphasized that a determination of homestead abandonment is made on a case-by-case basis.[8] In particular, courts conduct a factual inquiry as to whether the owner's rental activity constituted abandonment of the homestead.[9]

A 2010 Florida Bar Journal article summarized many of the issues related to homesteads and rentals.[10] The authors trace the historical understanding that property owners who rent their entire dwelling for long periods of time forfeit the homestead tax exemption:

> The underlying rationale for the termination of homestead due to long-term rentals is that the owner's long-term rental activity, coupled with his or her implied absence from the property, signifies the owner's *intent* to reside elsewhere. Therefore, the owner's departure and residence elsewhere, coupled with the conversion of his or her home into a commercially oriented use (a rental), reveals an "intent" to abandon the homestead.[11] (emphasis added)

The Bar Journal article continues on to contemplate an alternative rental circumstance:

> By contrast, there are occasions when property owners do not intend to abandon their residence through rental. For example, numerous Floridians rent out their homes for short periods of time and may even remain on the premises during the course of these rentals.[12]

Examples of these types of short term rentals include those associated with annual sporting events, arts festivals, college graduations, or business-related symposiums and conventions.

Tax Liens Imposed for Persons Improperly Claiming a Homestead Exemption

If a property appraiser determines that a person who was not entitled to a homestead exemption was granted the exemption for any year within the prior 10 years, the property appraiser is required to serve a notice of tax lien against property owned by the person.[13] The tax lien subjects the property to back taxes, a penalty of 50 percent of the unpaid taxes for each year, plus 15 percent interest per year. However, if the exemption was granted as the result of a clerical error, the person receiving the exemption is not assessed penalties or interest. Before a lien is filed, the owner is given 30 days to pay the taxes, penalties, and interest.[14]

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[8] Mark A. Rothberg and Kara L. Cannizzaro, *The Loss of Homestead Through Rental,* The Florida Bar (January, 2010, Volume 84, No.1) *available at http://www.floridabar.org/DIVCOM/JN/JNJournal01.nsf/c0d731e03de9828d852574580042ae7a/bd15816cc01b9b018525769b00679e0a!OpenDocument.*

[9] *See generally Poppell v. Padrick*, 117 So. 2d 435 (Fla. 2d DCA 1959); *Jacksonville v. Bailey*, 30 So. 2d 529 (Fla. 1947).

[10] Mark A. Rothberg and Kara L. Cannizzaro, *The Loss of Homestead Through Rental,* The Florida Bar Journal (January, 2010, Volume 84, No.1) *available at http://www.floridabar.org/DIVCOM/JN/JNJournal01.nsf/c0d731e03de9828d852574580042ae7a/bd15816cc01b9b018525769b00679e0a!OpenDocument.*

[11] *Id.* Section 196.012(13), F.S., defines "real estate used and owned as a homestead" to mean real property to the extent provided in s. 6(a), Art. VII of the State Constitution, but less any portion used for commercial purposes. Property rented for more than 6 months is presumed to be used for commercial purposes.

[12] *Id.*

[13] Section 196.161(1)(b), F.S.

[14] See s. 196.161(1)(b), F.S.

Effect of Proposed Changes

- The bill amends s. 196.061, F.S., to allow the rental of homestead property for up to 30 days per calendar year without the property being considered abandoned or affecting the homestead status of the property with no limitations on the number of years rentals are allowed. However, if the property is rented for more than 30 days in a calendar year, the property is considered abandoned as a homestead and the property will lose its homestead status even if the rental is not for two consecutive years.

B. SECTION DIRECTORY:

Section 1: Amends s. 196.061, F.S., by making some minor technical and grammatical changes and replacing the clause "if this provision is not used for 2 consecutive years. The provisions of" with "unless the property is rented for more than 30 days per calendar year."

Section 2: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The Revenue Estimating Conference has estimated the bill will increase property tax revenues by $4.1 million in Fiscal Year 2013-14.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Property owners who have a homestead exemption will be able to rent their dwellings for up to 30 days a year and retain the homestead status of their property and any applicable Save our Homes assessment limitation. As a result, an indeterminate number of additional short-term rental opportunities may become available to homestead owners who decide to rent their properties up to 30 days. Property owners that rent their homes for more than 30 days could lose their homestead exemption even if the rental is not for two consecutive years. As a result, their tax liability increases.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The county/municipality mandates provision of s. 18, Art. VII of the State Constitution, may apply because this bill reduces local government authority to raise revenue by reducing *ad valorem* tax bases compared to that which would exist under current law. However, this bill appears to qualify under the exemption for bills that have an "insignificant fiscal impact" and therefore a two-thirds vote is not required.[15]

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 28, 2012, the Finance and Tax Subcommittee adopted an amendment that removed a provision from current law that triggered the disallowance of homestead exemption when the property was rented in 2 consecutive years.

This analysis has been updated to reflect the above amendment.

[15] Fla. Const. Art. VII, s. 18(d).

A bill to be entitled

An act relating to the rental of homestead property; amending s. 196.061, F.S.; revising criteria under which rental of such property is allowed for tax exemption purposes and not considered abandoned; providing an effective date.

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

Section 1. Section 196.061, Florida Statutes, is amended to read:

196.061 Rental of homestead to constitute abandonment.—

(1) The rental of all or substantially all of a dwelling previously claimed to be a homestead for tax purposes shall constitute the abandonment of such dwelling as a homestead, and the abandonment continues ~~shall continue~~ until the ~~such~~ dwelling is physically occupied by the owner. However, such abandonment of the ~~such~~ homestead after January 1 of any year does not affect the homestead exemption for tax purposes for that particular year unless the property is rented for more than 30 days per calendar year. ~~if this provision is not used for 2 consecutive years. The provisions of~~

(2) This section does ~~do~~ not apply to a member of the Armed Forces of the United States whose service ~~in such forces~~ is the result of a mandatory obligation imposed by the federal Selective Service Act or who volunteers for service as a member of the Armed Forces of the United States. Moreover, valid military orders transferring such member are sufficient to

maintain permanent residence~~,~~ for the purpose of s. 196.015~~,~~ for the member and his or her spouse.

Section 2. This act shall take effect July 1, 2013.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Hood offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 196.061, Florida Statutes, is amended to read:

196.061 Rental of homestead to constitute abandonment.—

(1) The rental of all or substantially all of a dwelling previously claimed to be a homestead for tax purposes shall constitute the abandonment of such dwelling as a homestead, and the abandonment continues ~~shall continue~~ until the ~~such~~ dwelling is physically occupied by the owner. However, such abandonment of the ~~such~~ homestead after January 1 of any year does not affect the homestead exemption for tax purposes for that particular year unless the property is rented for more than 30 days per calendar year ~~if this provision is not used~~ for 2 consecutive years. ~~The provisions of~~

(2) This section does ~~do~~ not apply to a member of the

Armed Forces of the United States whose service ~~in such forces~~ is the result of a mandatory obligation imposed by the federal Selective Service Act or who volunteers for service as a member of the Armed Forces of the United States. Moreover, valid military orders transferring such member are sufficient to maintain permanent residence~~,~~ for the purpose of s. 196.015~~,~~ for the member and his or her spouse.

Section 2. This act shall take effect July 1, 2013.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to the rental of homestead property; amending s. 196.061, F.S.; revising criteria under which rental of such property is allowed for tax exemption purposes and not considered abandoned; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7169 PCB SPPACA 13-03 Florida Health Choices Plus Program
SPONSOR(S): Select Committee on PPACA (Patient Protection and Affordable Care Act), Cummings and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Select Committee on PPACA (Patient Protection and Affordable Care Act)	11 Y, 6 N	Shaw	Calamas
1) Appropriations Committee		Pridgeon	Leznoff

SUMMARY ANALYSIS

The Florida Health Choices (FHC) program is a single, centralized marketplace for the sale and purchase of health care coverage products and services including, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. The Legislature created FHC in 2008 to assist small employers needing more coverage and contribution options for their employees.

The PCB uses the infrastructure of FHC to implement the Florida Health Choices Plus Program (FHC Plus). The program is not an entitlement, but will assist uninsured Floridians to gain access to affordable health coverage, products and services. Parents and Social Security Income-eligible disabled adults with incomes under 100% of poverty who are not eligible for Medicaid are eligible. Enrollees in FHC Plus will receive $2,000 to fund a contribution amount for responsible expenditures (CARE) account to purchase health coverage, products and services in the FHC Plus marketplace. Each enrollee must make a monthly individual contribution of $25 to the account, and may make additional contributions to increase their buying power. Employers, local governments, and charitable organizations may also make contributions. In addition, non-disabled enrollees must meet the same work requirements as TANF enrollees.

Enrollees may use their CARE accounts to buy any product available in the FHC Plus marketplace; parents must purchase preventive and catastrophic coverage or hospital care. Disabled enrollees may use their CARE accounts account for Medicare-related premiums and cost-sharing. Remaining funds may be deposited in a health savings account created by the program for out-of-pocket medical expenses.

The bill requires the Department of Children and Families to conduct eligibility determinations and redeterminations for the program, using the same process as for Medicaid and the Children's Health Insurance Program. FHC Plus will have two 30-day open enrollment periods each fiscal year with the first open enrollment commencing on March 31, 2014. FHC must annually report to the Legislature on the program's status.

The bill also expands the current FHC program by allowing all individuals and employers to participate FHC in as long as program criteria are met. The bill exempts standard forms, website designs, and marketing communications developed and used by FHC from regulation under the Florida Insurance Code.

A prepaid health clinic is a health plan that provides health care services to groups and individuals on a prepaid per capita or prepaid aggregate fixed-sum basis, and is dually regulated by the Agency for Health Care Administration and the Office of Insurance Regulations. Prepaid health clinics are not permitted to cover hospital services. The bill amends prepaid health clinic laws to allow them to cover hospital services, if certain criteria are met. This may increase the diversity of options in FHC for FHC Plus enrollees.

The bill creates the Florida Health Care Market Task Force within the Legislature to study and make recommendations on: strategies for allowing state employees to participate in FHC with a defined contribution; methods for increasing the capacity of our current health care workforce, particularly advanced registered nurse practitioners and physician assistants; and options for reducing federal control of the Medicaid program. The task force will consist of seven members, three appointed by the Senate President, three by the Speaker of the House of Representatives and a chair appointed jointly. The bill requires the task force to submit a report to the President and Speaker by January 1, 2014.

The bill has a recurring fiscal impact on state government for CARE account contributions of $18,883,753 in recurring General Revenue and $6,124,421 in nonrecurring general revenue for costs for the FHC to administer the program. The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA")[1], as amended by the Health Care and Education Reconciliation Act of 2010[2]. The law contains comprehensive changes to the entire health care system in the United States. Most of the PPACA provisions take effect in 2014; however, many changes are phased in, starting from the day the bill was signed on March 23, 2010 and continuing through 2019.

Specifically, PPACA:

- Requires most U.S. citizens and legal residents to obtain health insurance coverage or pay a penalty;
- Substantially expands Medicaid;
- Establishes new requirements for employers and health plans;
- Restructures the private health insurance market;
- Creates health insurance exchanges for individuals and employers to obtain coverage;
- Sets minimum standards for health coverage offered in the health insurance exchange; and
- Provides premium tax credits and cost-sharing subsidies for eligible individuals that obtain coverage through the health insurance exchange.

Individual Mandate

Effective in 2014, PPACA provides that health insurance coverage will be mandatory for almost all U.S. citizens.[3] Individuals who are required to file a tax return, but do not have "minimal essential coverage," will pay a tax[4] to the U.S. government with enforcement by the Internal Revenue Service.[5] "Minimal essential coverage" includes: Medicaid, Medicare, CHIP, and other government programs; employer-sponsored plans; and individual market plans.[6]

The annual tax for failure to have minimal essential coverage will be the greater of:

- a flat dollar amount per individual; or
- a percent of the individual's taxable income.[7]

The tax increases over time: $95 or 1% in 2014; $325 or 2% in 2015 and $695 or 2.5% in 2016. After 2016, the tax increase is indexed to inflation and rounded to the next lowest multiple of $50.[8] The tax for a child is one half of the adult tax.

Exemptions for mandatory health insurance coverage will be granted to American Indians, to those objecting to the mandatory provision for religious reasons, to individuals without health insurance for

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[1] P.L. 111-148, 124 Stat. 119 (2010)
[2] P.L. 111-152, 124 Stat. 1029 (2010)
[3] 26 U.S.C. s. 5000A
[4] 26 U.S.C. s. 5000A(b)(1) refers to the payment as a "penalty" ; however, the Supreme Court of the United States has found the payment to be a tax. *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012).
[5] 26 U.S.C. s . 5000A(b)(1)
[6] 26 U.S.C. s. 5000A(f)(1)
[7] 26 U.S.C. s. 5000A(c)
[8] Id.

less than three months, to individuals in prison, and for cases of extreme financial hardship.[9] Individuals who would be eligible for Medicaid but for a state's choice not to expand Medicaid eligibility are also exempt from the individual mandate.[10]

Exchanges

A health insurance exchange is intended to create organized and competitive market for health insurance by offering a choice of plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them.[11]

PPACA requires that a health insurance exchange be established in each state. Individuals and small businesses will be able to use the exchange to purchase health insurance coverage that meets the minimum essential coverage provisions of PPACA. The exchanges must begin open enrollment on October 1, 2013, for coverage effective January 1, 2014. The exchange is not an insurer; instead, it will provide eligible individuals and businesses access to qualified health plans.

Each plan sold on the exchange must include "essential health benefits" as defined by PPACA and as compared to an existing benchmark plan set in each state. The essential health benefits are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Each plan must be one of following actuarial value "metal levels":

- Bronze: 60% actuarial value[12]
- Silver: 70% actuarial value
- Gold: 80% actuarial value
- Platinum: 90% actuarial value

In addition to enrolling individuals in qualified health plans, the exchange may also determine eligibility for Medicaid and the Child Health Insurance Program (CHIP). The exchange will also determine if an individual is eligible for advance premium tax credits and cost-sharing reductions.

Individuals with household income between 100% and 400% of the federal poverty level are eligible to receive an advance premium tax credit if "affordable coverage"[13] is not available through an employer.

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[9] 26 U.S.C. s. 5000A(e)

[10] Propose Rule; Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions; 45 CRF Parts 155 and 156; 78 FR 7328 (February 1, 2013)

[11] The Kaiser Foundation, What Are Health Insurance Exchanges? (May 2009); available at www.kff.org/healthreform/upload/7908.pdf.

[12] Actuarial value is calculated by computing the ratio of total expected payments by the plan for essential health benefits and cost-sharing rules with the total costs of the essential health benefits the standard population is expected to incur. For example, a health plan with an actuarial value of 80 percent would be expected to pay an average of 80 percent of a standard population's expected medical expenses for the EHB. Individuals covered by the plan would then be expected to pay the remaining 20 percent, on average, through cost sharing such as deductibles, co-pays, and co-insurance.

[13] To be considered "affordable", the employee portion of the self-only premium for the employer's lowest cost coverage may not exceed 9.5 percent of the employee's household income. 26 U.S.C. s. 36B.

2013 Federal Poverty Guidelines				
Family size	100%	138%	200%	400%
1	$11,490	$15,856	$22,980	$45,960
2	$15,510	$21,406	$30,420	$62,040
3	$19,530	$26,951	$39,060	$78,120
4	$23,550	$32,499	$47,100	$94,200

The amount of the tax credit that an individual can receive is based on the premium for the second lowest cost silver plan in the exchange and area where the person is eligible to purchase coverage.

The amount of the tax credit varies with income so the premium that a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income as follows:

Income Level	Premium as a Percent of Annual Income	Annual Premium Amount Range (Individual)
Up to 138% FPL	2% of income	Under $317
138-150% FPL	3 – 4% of income	$475-$689
150-200% FPL	4 – 6.3% of income	$689-$1447
200-250% FPL	6.3 – 8.05% of income	$1447-$2312
250-300% FPL	8.05 – 9.5% of income	$2312-$3274
300-400% FPL	9.5% of income	$3274-$4366

Cost-sharing subsidies prevent lower income individuals from having high out-of-pocket costs at the point of service. PPACA provides for reduced cost sharing for families with incomes at or below 250% of poverty by making them eligible to enroll in health plans with higher actuarial values.

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for 3.2 million eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. The current federal share is 58.67% with the state paying 41.33%.[14] AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs. Florida Medicaid is expected to spend $21 billion in FY 2012-13, with about $6,324 average annual expenditure per recipient. Florida has the fourth largest Medicaid population in the nation and Florida Medicaid is the fifth largest expenditures in the country.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states: Some populations are entitled to enroll in the program; and enrollees are entitled to certain benefits.

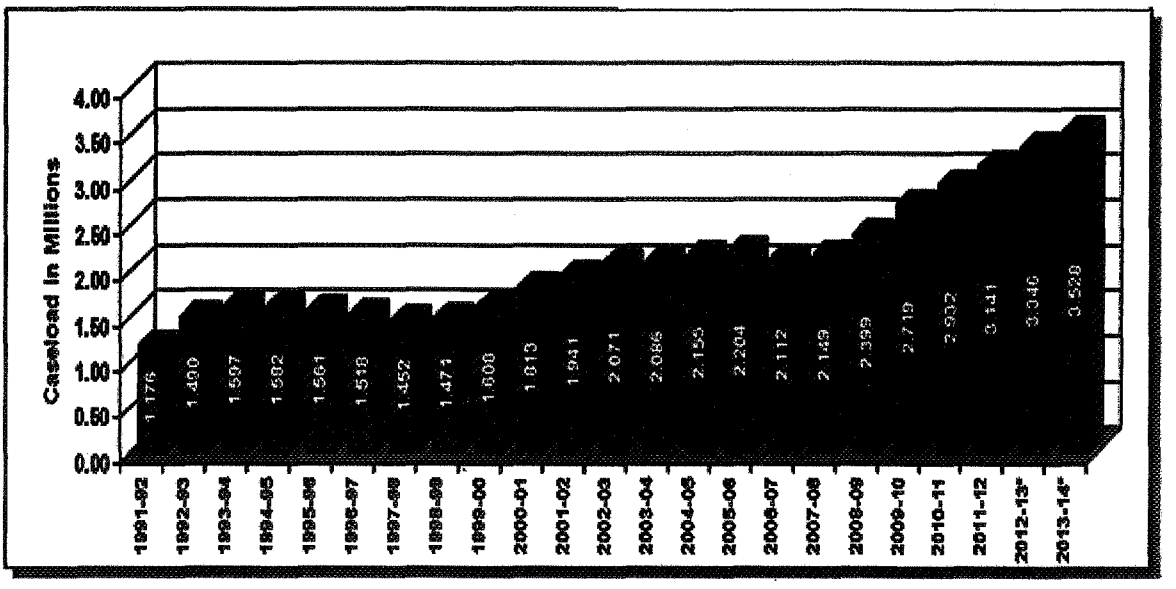
[14] Social Services Estimating Conference (SSEC), March 7, 2013, FMAP for FY 2013-14.

The federal government sets the minimum mandatory populations to be included in every state Medicaid program. States can add eligibility groups, with federal approval. Once these optional groups are part of the Medicaid program the entitlement applies to them as well.

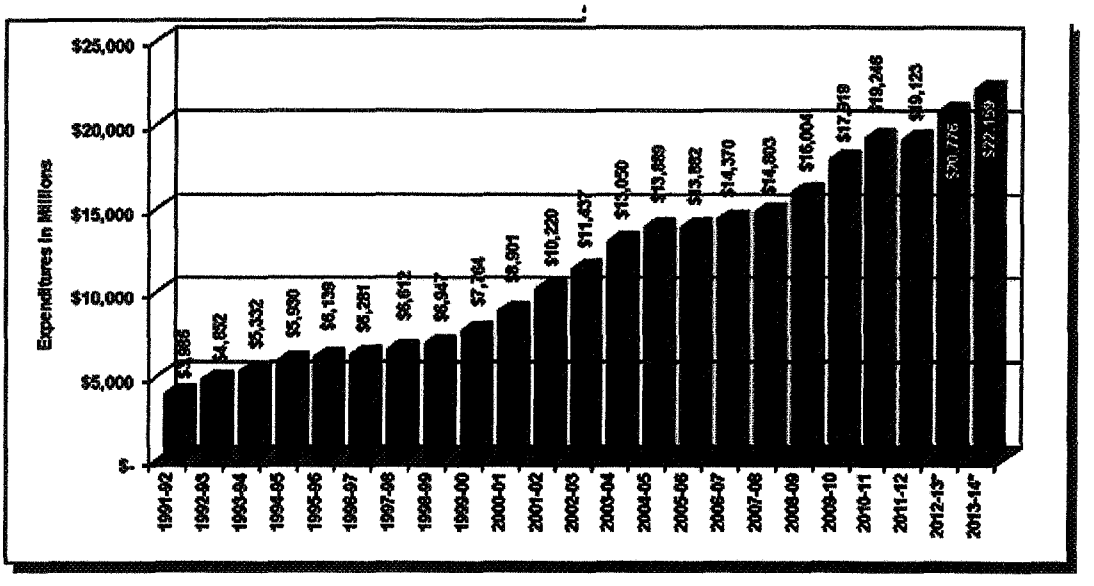
The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[15] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[16]

Florida's Medicaid costs have increased significantly since its inception, due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures. The growth in Florida's Medicaid population and expenditures is shown in the graphs below.[17]

Growth and Projected Growth in Medicaid Caseload 1991-2014



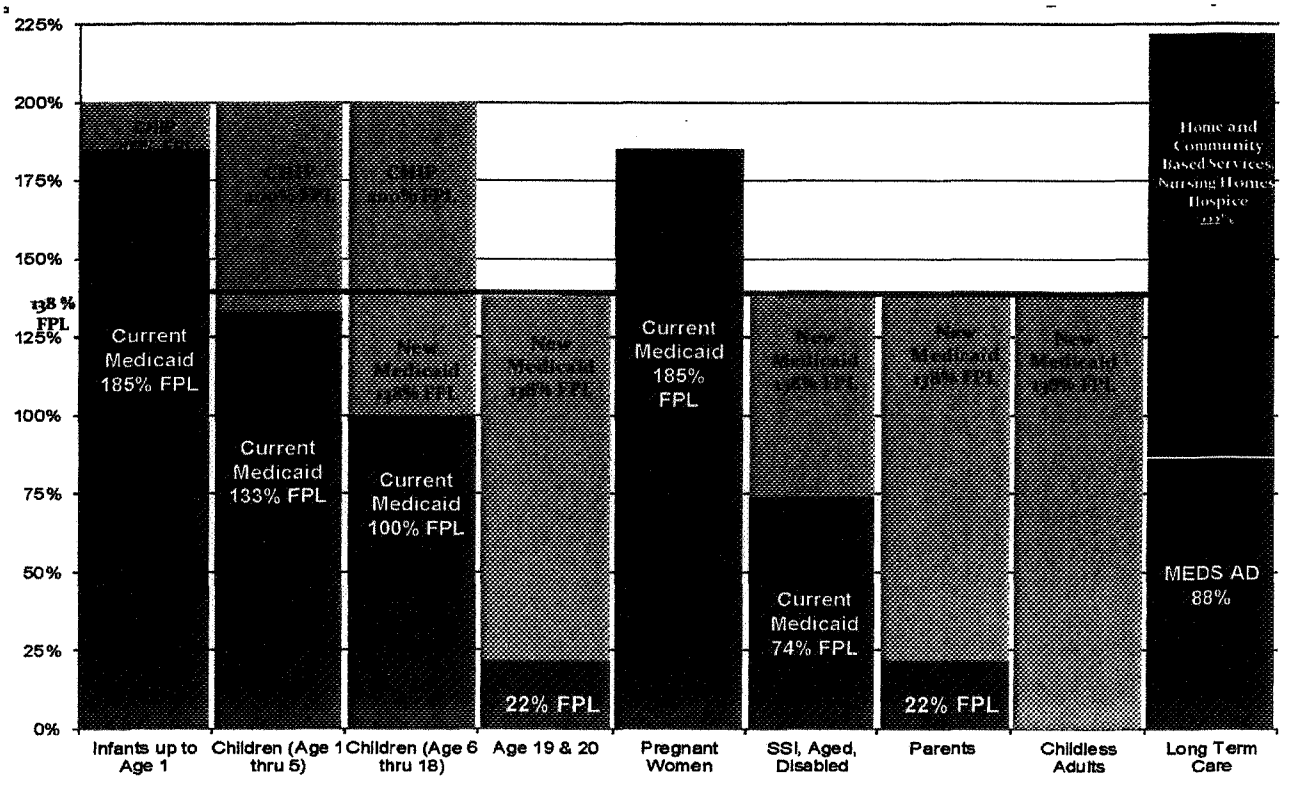
Growth and Projected Growth in Medicaid Expenditures 1991-2014



[15] S. 409.905, F.S.
[16] S. 409.906, F.S.
[17] Agency for Health Care Administration: Medicaid Services Eligibility Subsystem Reports and 2012 Caseload Social Services Estimating Conferences; Medicaid Services Budget Forecasting System Reports and 2012 Social Services Estimating Conference.

PPACA's Medicaid Provisions

Medicaid currently focuses on covering low-income children, pregnant women, and adults who are elderly or have a disability. The PPACA increases the mandatory population to all adults, regardless of whether they are disabled or elderly, up to 138 percent of the poverty level. The chart below shows both the current Medicaid eligibility groups (dark gray) and the PPACA expansion groups (light gray).



PPACA provides that the federal government will pay an enhanced federal share, or Federal Medical Assistance Percentage (FMAP), for the expansion population as follows:

100% CY 2015
100% CY 2016
95% CY 2017
94% CY 2018
93% CY 2019
90% CY 2020 and beyond

PPACA made expansion, like all other federal Medicaid requirements, a condition of receiving federal matching funds. Failure to comply with the mandatory PPACA expansion would cause a state to risk losing federal funding for the entire program.

National Federation of Independent Business v. Sebelius

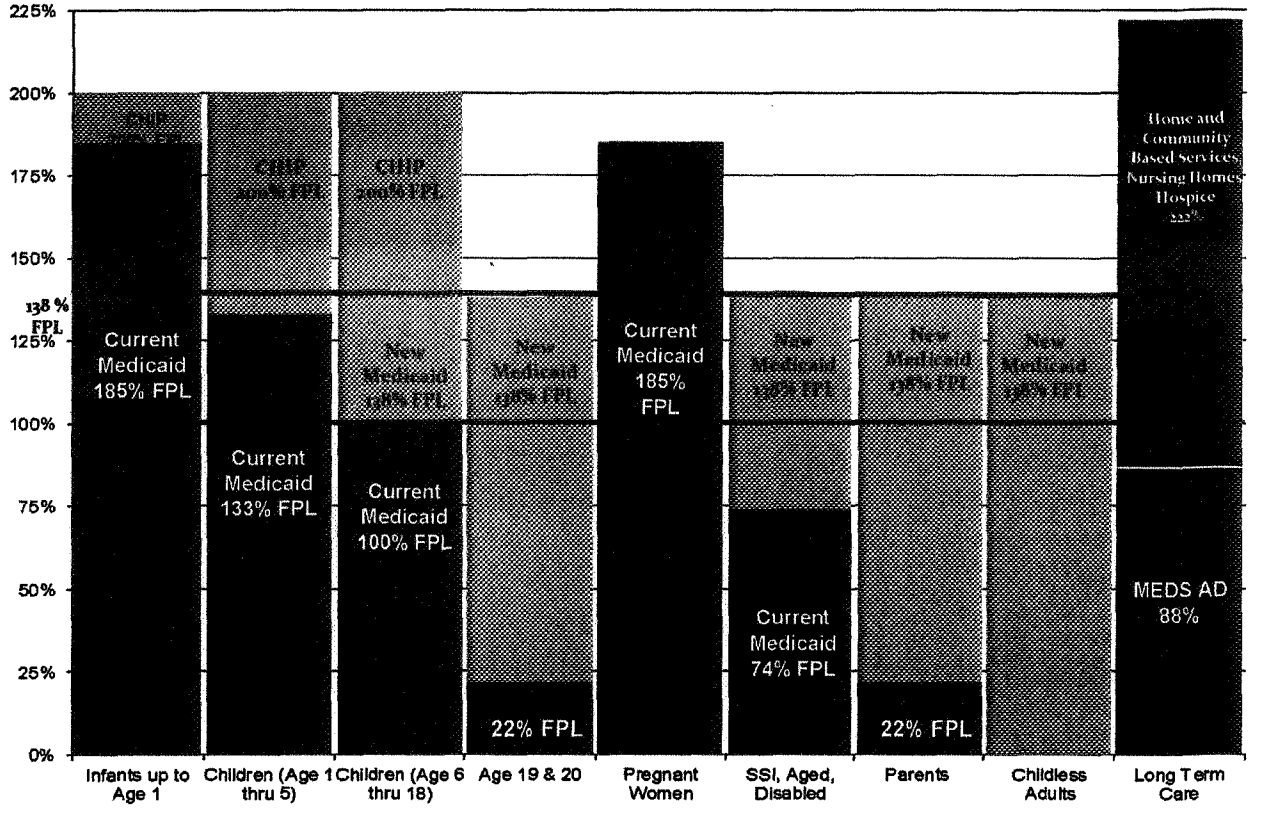
On June 28, 2012, the U.S. Supreme Court, in *National Federation of Independent Business v. Sebelius*,[18] issued a decision affirming the constitutionality of the majority of the provisions of PPACA.[19] In the opinion, the Supreme Court upheld the expansion of the Medicaid program under PPACA, but

[18] 132 S.Ct. 2566 (2012)
[19] Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

limited the ability of the federal government to withhold all federal Medicaid funding if states do not meet all requirements related to Medicaid expansion.[20]

The new Medicaid expansion requirements provide that, beginning on January 1, 2014, all individuals under the age of 65 with income below 138 percent of the federal poverty level (FPL) are newly eligible for Medicaid.[21] The Supreme Court found that compelling the states to participate in the Medicaid expansion or face the loss of all federal funds under the current Medicaid program was coercive and unconstitutional under the Spending Clause of the United States Constitution.[22] The Court concluded that 42 U.S.C. § 1396c, which permits the federal government to withhold all Medicaid funds to a state for failing to comply with a requirement of the Medicaid program, is unconstitutional when used to withdraw existing Medicaid funds from a state that declines to comply with the Medicaid expansion program under PPACA.[23] Based on its ruling, the Court stated, "[a]s a practical matter, that means States may now choose to reject the expansion."[24]

Individuals with household income between 100% and 400% of poverty are eligible to receive an advance premium tax credit to purchase insurance on the PPACA health insurance exchange. Thus everyone in the Medicaid expansion population with incomes between 100% and 138% of poverty would be able to get subsidized coverage in the exchange, in a state that does not expand Medicaid. The chart below illustrates the population between 100% and 138% of poverty (between the red lines) compared to the Medicaid expansion population (light gray).



When the U.S. Supreme Court decision made expansion optional, many states inquired to the United States Department of Health and Human Services (HHS) whether a state may elect to partially expand Medicaid and still receive the enhanced FMAP. On December 10, 2012, HHS issued a memorandum[25]

[20] See supra, FN 17 at 2607-08.
[21] § 2001(a)(1)(C) of PPACA; see also 42 U.S.C. §1396a(a)(10)(i)(VIII).
[22] See supra, FN 19; see also U.S. CONST., Art. I, §8, cl. 1.
[23] Id. at 2607.
[24] Id. at 2608.
[25] Available at: cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf (last viewed 4/11/13)

on "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid." The memorandum states that "the law does not provide for a phased-in or partial expansion." The memorandum concludes that partial expansions are not eligible for the enhanced FMAP.

Fiscal Impact of PPACA on Medicaid

The Social Services Estimating Conference (conference) has reviewed the optional expansion and estimated the fiscal impact.[26, 27] The conference assumed that only 79.7% of the eligible population would actually enroll. This assumption is consistent with the current level of enrollment in the Medicaid program. The conference also assumed that this population would gradually enroll over a four-year period. The conference also assumed that about 150,000 individuals who currently have private insurance would transition into the Medicaid program over a three-year period.

The conference concluded that state costs for the expansion would be $0 for the first three fiscal years, while the FMAP is at 100%. State costs over the next seven fiscal years will be a total of about $3.5 billion. Federal costs for the entire 10-year period are projected to be over $54 billion.

Florida Health Choices Program

In 2008, the Florida Legislature created the Florida Health Choices Program (program).[28] The program includes a single, centralized market for the sale and purchase of health care products including, but not limited to, health insurance plans, health maintenance organization (HMO) plans, prepaid services, service contracts, and flexible spending accounts.[29]

Current law also establishes the Florida Health Choices, Inc., (corporation) as a not-for-profit corporation under chapter 617, F.S.[30] The corporation is responsible for administering the program and may function as a third-party administrator for employers participating in the program.[31] In its capacity as a third-party administrator, the corporation is not subject to the licensing requirements for insurance administrators under part VII of chapter 626, F.S. The corporation is authorized to collect premiums and other payments from employers. In addition, the corporation is not required to maintain any level of bonding. The corporation is responsible for certifying vendors and ensuring the validity of their offerings. Lastly, the corporation is not subject to the provisions of the Unfair Insurance Trade Practices Act.[32] The corporation is governed by a 15-member board of directors appointed by the Governor, Senate President, and Speaker of the House of Representatives.[33]

Current law specifies those entities eligible to purchase products through, and participate in, the program. Employees of the following employers are eligible to purchase coverage through the program, if their employers participate in the program:

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[26] Social Services Estimating Conference Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) & Title XXI (CHIP) Programs , adopted March 7, 2013, available at: http://edr.state.fl.us/Content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf (last viewed 4/11/13).

[27] PPACA imposes other mandatory expenses on states, unrelated to expansion. The mandatory provisions include:

- Transitioning certain children from CHIP to Medicaid
- Primary care providers fee increase for CY 2013 and 2014
- Pass-through of health insurer fees imposed by PPACA
- Enrollment of individuals who are currently eligible but not enrolled, who are likelier to enroll due to the individual mandate.

The conference estimated the costs of the mandatory provisions to be $782 million with the state paying $22.5 million in FY '13-'14 with an increase in enrollment of 17,643. By FY '17-'18, the total cost is estimated to decrease due to the expiration of the primary care provider pay increase. The total cost is estimated to be $491 million in FY '17-'18; however, the state's cost is estimated to increase to $179 million with the additional enrollment at 74,537.

[28] S. 4, ch. 2008-32, L.O.F. (2008); *see also* s. 408.910, F.S.

[29] S. 408.910(5), F.S.

[30] Section 408.910(11), F.S.

[31] S. 408.910(10)(b), F.S.

[32] Part IX, chapter 626, F.S.

[33] The board is composed of five members appointed by the Governor, five members appointed by the President of the Senate, and five members appointed by the Speaker of the House of Representatives; *see* s. 408.910(11)(a), F.S.

- Employers with one to 50 employees;
- Cities with a population less than 50,000 residents;
- Fiscally constrained counties; and
- School districts located in fiscally constrained counties.[34]

The following vendors are eligible to participate in the program:
- Insurers licensed under chapter 624, F.S.;
- HMOs licensed under part I of chapter 641, F.S.;
- Prepaid health clinic providers licensed under part II of chapter 641, F.S.;
- Health care providers;
- Provider organizations; and
- Corporate entities providing specific services via service contracts.[35]

The following individuals are eligible to enroll in the program:
- Individual employees of enrolled employers;
- State employees ineligible for the state group insurance plan;
- State retirees;
- Medicaid reform participants who opt out of the reform program; and
- Statutory rural hospitals.[36]

Employers are required to establish cafeteria plans in order to participate in, and allow their employees to enroll in, the program.

Cafeteria Plans

A cafeteria plan is a plan that offers flexible benefits under the Internal Revenue Code Section 125. Employees choose from a "menu" of benefits. The plan can provide a number of selections, including medical, accident, disability, vision, dental and group term life insurance. It can reimburse actual medical expenses or pay children's day care expenses.

A cafeteria plan reduces both the employer's and employee's tax burden. Contributions by the employer are not subject to the employer social security contribution. Contributions made by the employee are not subject to federal income or social security taxes.

The employer chooses the range of benefits it wishes to offer in a cafeteria plan. The plan can be a simple premium-only plan where only health insurance is offered.[37] Full flex plans, which offer a wide variety of benefits and choices, are more often offered by large employers and allow for more consumer-directed consumption of benefits. In some full flex plans, the employee is offered the choice between receiving additional compensation in lieu of benefits.

High Deductible Health Plan with Health Savings Accounts

High-deductible health plans are paired with health savings accounts[38]. To qualify as a high-deductible plan, the annual deductible must be at least $1,250 for single plans and $2,500 for family coverage. The employer and employee may make annual contributions[39] to a limit of $3,250 for single coverage

[34] S. 408.910(4)(a), F.S.
[35] S. 408.910(4)(d), F.S.
[36] Section 408.910(4)(b), F.S
[37] Sec. 125 I.R.C. requires that a cafeteria plan allow its members to choose between two or more benefits "consisting of cash and qualified benefits." The proposed regulations define "cash" to include a "salary reduction arrangement" whereby salary is deducted pre-tax to pay the employee's share of the insurance premium. If an employer provides for a "salary reduction arrangement", the program qualifies as a cafeteria plan. 26 C.F.R. ss. 1.125-1, et seq.
[38] Internal Revenue Code, 26 U.S.C. sec. 223
[39] The IRS annually sets the contribution limit as adjusted by inflation.

and $6,250 for family coverage. Total out-of pocket spending is capped at $6,250 for individual and $12,500 for family. Both the employer and employee contributions are not subject to federal income tax on the employee's income. Unused funds roll over automatically every year. A health savings account is owned by the employee and is portable.

Flexible Spending Accounts

Flexible spending accounts (FSA)[40] are funded though pre-tax payroll deductions from the employee's salary[41]. The funds can be used to pay for medical expenses that are not covered by the employees' health plan. Prior to 2013 there was no limit on the contribution to a FSA; however, in 2013 the contribution was limited to $2,500 and will be adjusted for inflation. Unlike a HSA, a FSA is a "use it or lose it" arrangement. If the employee does not annually use the contributions to the FSA, the contributions are forfeited.

Medical Expenses

Funds from both health savings accounts and flexible spending accounts must be used for medical expenses. Internal Revenue Service Publication 502[42] provides:

> Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Prepaid Health Clinics (PHCs)

Prepaid Health Clinics (PHCs) are health plans that provide health care services to groups and individual subscribers on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services which subscribers might reasonably require to maintain good health. These plans emphasize effective cost and quality controls. PHCs meet similar quality of care requirements as HMOs and must also be accredited by a nationally recognized accrediting organization.

Florida's PHCs are dually regulated by the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR) under Parts II and III of Ch. 641, F.S. To be a PHC, an organization must receive a health care provider certificate from AHCA and a certificate of authority from the OIR. Quality of care issues, such as timely access to appropriate health care professionals or services, are monitored and enforced by the AHCA. Financial and contractual issues, such as the financial stability of a PHC, are monitored and regulated by OIR.[43]

To obtain a certificate of authority from OIR, an applicant PHC must meet statutory minimum surplus requirements in the amount of $150,000 or 10 percent of total liabilities, whichever is greater.[44] PHCs must file a surety bond, obtain sufficient insurance to satisfy OIR, file an annual report, meet statutory contracting requirements, and are subject to penalties for unfair competition or unfair or deceptive acts or practices. PHCs are subject to inspection by OIR.

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[40] Sec. 125 I.R.C.; see IRS Publication 969 (2011).
[41] Employers are also allowed to contribute to FSAs.
[42] Available at: http://www.irs.gov/file_source/pub/irs-pdf/p502.pdf (last viewed 4/10/13).; Also see Internal Revenue Code Section. 213(d).
[43] Florida Agency for Health Care Administration, Prepaid Health Clinics, available at: http://ahca.myflorida.com/mchq/managed_health_care/PHC/index.shtml (last viewed 4/13/13).
[44] S. 641.407

Currently, PHCs cannot offer inpatient hospital services or hospital inpatient physician services.[45] As of January 2013, there are five PHCs licensed by the OIR.[46]

PPACA Insurance Regulation

The PPACA insurance provisions are phased-in beginning in 2010, but the most dramatic changes become effective January 1, 2014[47]. PPACA applies these requirements to "health insurance issuers"[48] which includes both health insurers and HMOs, and applies to both group and individual health insurance coverage.

Effective in the 2011 plan year:

- No lifetime limits on amount paid out by the plan
- No copayments or deductibles for certain preventive services
- No cancellation of the policy except for fraud
- Coverage for children up to 26 years of age
- No denial of coverage due to a pre-existing condition for children

Effective in the 2014 plan year:

- No denial of coverage to anyone with a pre-existing condition
- No annual limits on amount paid out by the plan
- All individual and small group plans must cover federally defined essential benefits

Also in 2014, PPACA requires that premiums for individual and small group policies may vary only by:

- Age, up to a maximum ratio of 3 to 1. This means that the rates for older adults cannot be more than three times greater than the rates for younger adults.
- Tobacco, up to a maximum ratio of 1.5 to 1
- Geographic rating area
- Whether coverage is for an individual or a family

These regulatory provisions of PPACA do not apply to certain "exempted benefits."[49] Exempted benefits include, but are not limited to, coverage for on-site medical clinics, overage only for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, and short-term duration insurance. Also, the regulatory provisions of PPACA do not apply to products and services that are not considered "health insurance coverage" which means:

> Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.[50]

PPPAC allows catastrophic coverage plans for individuals under the age of 30 or those would be exempt from the individual mandate because of their low income[51]. These plans would offer less coverage but at a lower premium. The catastrophic plans will cover the essential health benefits, but

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[45] S. 641.402(4), F.S.
[46] Florida Office of Insurance Regulation, *Life & Health Financial Oversight*, Presentation to the Health Innovation Subcommittee, page 3 (January 15, 2013), available at www.floir.com/siteDocuments/HouseHealthInnovationTW_1-15-13.pdf (on file with Select Committee staff).
[47] House of Representatives Staff Analysis for HB 7155 (2013) contains a detailed discussion about the insurance regulatory requirements of PPACA available at: http://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=pcb02a.SPPACA.DOCX&DocumentType=Analysis&CommitteeId=2738&Session=2013 (last viewed 4/13/13).
[48] Section 2791. 42 U.S.C. 300gg–91
[49] Id.
[50] Id.
[51] PPACA sec. 1311(d).

with the out-of-pocket limit that same as a high deductible plan ($6,400 individual; $12,800 family). However, prevention benefits and coverage for three primary care visits per year would be exempt from the deductible.

As discussed above, health plans sold on the PPACA exchange must include the essential health benefits and be at least a bronze level plan. Additionally, PPACA provides that:

> A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package.[52]

Health insurance that includes the "essential health benefits package"[53] provides the essential health benefits and meets one of the four "metal levels" of coverage. It is unclear whether the federal government will have the capacity to enforce[54] these requirements outside the PPACA exchange, assuming a state's insurance regulatory agency does not enforce them on the federal government's behalf.

Non-insurance products and exempted benefits may be offered without the essential health benefits package. PPACA contains an expansive definition of "insurance" so it is currently unclear what products will be considered "insurance" under PPACA.

Since the tax penalty for failure to comply with the individual mandate is lower than the average cost of insurance[55], it is possible there will be a market for less expensive products with fewer benefits. An individual may wish to purchase such products and pay the tax penalty. Similarly, populations not subject to the tax penalty, like those with incomes under 138% of poverty in Florida, may also generate such a market.

Temporary Assistance for Needy Families (TANF)

Under the welfare reform legislation of 1996[56], the Temporary Assistance for Needy Families (TANF) program replaced the welfare programs known as Aid to Families with Dependent Children (AFDC), the Job Opportunities and Basic Skills Training (JOBS) program and the Emergency Assistance (EA) program. The law ended federal entitlement to assistance and instead created TANF as a block grant that provides States, territories and tribes federal funds each year. These funds cover benefits, administrative expenses, and services targeted to needy families. TANF became effective July 1, 1997, and was reauthorized in February 2006 under the Deficit Reduction Act of 2005.[57] States receive block grants to operate their individual programs and to accomplish the goals of the TANF program.[58] The Department of Children and Families (DCF) administers the TANF program in conjunction with the Department of Economic Opportunity.[59]

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[52] PPACA s. 2707(a)
[53] PPACA s. 1302(a)
[54] If the U.S. Department of Health and Human Services (HHS) determines that a health insurance issuer has failed to meet an applicable requirement of PPACA (provided the issuer knew of such failure or would have known by exercising reasonable diligence), HHS may impose a maximum civil monetary penalty of $100 for each day for each individual with respect to which such failure occurs. PHSA s. 2722 (42 U.S.C. s. 300gg-22).
[55] The average annual premiums in 2012 are $5,615 for single coverage and $15,745 for family coverage. Employer Health Benefits 2012 Annual Survey, Kaiser Family foundation, available at: http://ehbs.kff.org/?page=charts&id=1&sn=6&p=1 (last viewed 4/13/13).
[56] The Personal Responsibility and Work Opportunity Reconciliation Act (PWRORA), Public Law 104-193.
[57] US Dept. of Health and Human Services, Administration on Children and Families, *accessible at*: http://www.acf.hhs.gov/programs/ofa/tanf/about.html (last visited on 12/21/11).
[58] Temporary Assistance for Needy Families, the Department of Children and Families, *accessible at*: http://www.dcf.state.fl.us/programs/access/docs/TANF%20101%20final.pdf.
[59] *Id.*

Temporary Cash Assistance Program (Cash Assistance)

The purpose of the TANF cash assistance program is to help families become self-supporting while allowing children to remain in their own homes.[60] Cash assistance is available to two categories of families: work-eligible and child-only.[61] Current law provides that families are eligible for temporary cash assistance for a lifetime cumulative total of 48 months (4 years).[62]

Individuals receiving temporary cash assistance are required to work a minimum number of hours required under federal law,[63] not to exceed a maximum of 40 hours per week set in state law.[64] Federal law requires individuals to participate in work activities for at least 30 hours per week[65] and two-parent families to work a minimum combined total of 35 hours weekly.[66] However, if a two-parent family is receiving subsidized child care, the family must work at least a combined total of 55 hours per week.[67] Single parents with a child under the age of six are required to work a minimum of 20 hours per week.[68] Recipients who are married or a single head-of-household and are under the age of 20 must either maintain satisfactory attendance at a secondary school or the equivalent or participate in education directly related to employment for a minimum of 20 hours per week.[69]

A person receiving temporary cash assistance must register for work and engage in work activities, as designated by the regional workforce board.[70] Regional workforce boards are chartered by Workforce Florida, Inc., which is created in s. 445.004, F.S., and is the principal workforce policy agency of the state. The regional workforce boards determine the specific number of hours that an individual must work, between the minimum number of hours required by Federal law and the maximum number set in state law of 40 hours per week.[71] The following activities may be used individually or in combination to satisfy the work requirements for a participant in the temporary cash assistance program:

- **Unsubsidized employment**: Full-or part-time employment in the public or private sector that is not subsidized by TANF or any other public program.
- **Subsidized private sector employment**: Employment in the private sector for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing an individual.
- **Subsidized public sector employment**: Employment in the public sector for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing an individual.
- **On-the-job training**: Training in the public or private sector for a paid employee while engaged in productive work and that provides knowledge and skills essential to the full and adequate performance of the job.
- **Community service programs**: Structured programs and embedded activities in which individuals perform work for the direct benefit of the community under the auspices of public or nonprofit organizations. These programs are limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and child care. These

[60] DCF Food Assistance Program Fact Sheet, www.dcf.state.fl.us/programs/access/docs/fafactsheet.pdf .(last visited 1/4/12).
[61] S. 414.045(1).
[62] Section 414.105, F.S.
[63] 45 CFR 261.
[64] S. 414.024, F.S.
[65] 45 CFR 261.31(a).
[66] 45 CFR 261.32(a).
[67] 45 CFR 261.32(e).
[68] 45 CFR 261.35.
[69] 45 CFR 261.33(b).
[70] S. 414.095, F.S.
[71] Phone conversation with Trina Dickey, the Florida Department of Economic Opportunity, April 12, 2013.

programs are designed to improve the employability of individuals not otherwise able to obtain unsubsidized full-time employment.

- **Work experience**: A work activity that provides an individual with an opportunity to acquire the general skills, knowledge, and work habits necessary to obtain employment. The purpose of work experience is to improve the employability of those who cannot find unsubsidized full-time employment.
- **Job search and job readiness assistance**: The act of seeking or obtaining employment, preparation to seek or obtain employment, including life skills training, and substance abuse treatment, mental health treatment, or rehabilitation activities. Such treatment or therapy must be determined to be necessary and documented by a qualified medical, substance abuse, or mental health professional.
- **Vocational educational training**: Organized educational programs that are directly related to the preparation of individuals for employment in current or emerging occupations.
- **Job skills training directly related to employment**: Training or education for job skills required by an employer to provide an individual with the ability to obtain employment or to advance or adapt to the changing demands of the workplace.
- **Education directly related to employment**: In the case of a recipient who has not received a high school diploma or a certificate of high school equivalency, education directly related to employment means education related to a specific occupation, job, or job offer.
- **Satisfactory attendance at a secondary school or in a course of study leading to a graduate equivalency diploma**: In the case of a recipient who has not completed secondary school or received such a certificate, satisfactory attendance means regular attendance, in accordance with the requirements of the secondary school or course of study, at a secondary school or in a course of study leading to a certificate of general equivalence, in the case of a work-eligible individual who has not completed secondary school or received such a certificate.
- **Providing child care services**: Providing child care to enable another TANF or SSP recipient to participate in a community service program. This is an unpaid activity and must be a structured program designed to improve the employability of individuals who participate in this activity.[72]

State Group Insurance Program

Overview

The State Group Insurance Program (program) is created by s. 110.123, F.S., and is administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS).

The program is an optional benefit for state employees including all state agencies, state universities, the court system, and the Legislature. The program includes health, life, dental, vision, disability, and other supplemental insurance benefits.

The health insurance benefit for active employees has premium rates for single, spouse, or family coverage regardless of plan selection. The state contributes approximately 90% toward the total annual premium for active employees for a total of $1.41 billion out of the total premium of $1.57 billion for FY 2012-13[73].

The program provides several options for employees to choose as their health plans. The preferred provider organization (PPO) plan is the statewide, self-insured health plan administered by Blue Cross Blue Shield of Florida. The administrator is responsible for processing health claims, providing access to a Preferred Provider Care Network, and managing customer service, utilization review, and case management functions. The standard health maintenance organization (HMO) plan is an insurance arrangement in which the state has contracted with multiple statewide and regional HMOs.

[72] S. 445.024, F.S., 46 CFR 261.2
[73] Fiscal information provided by DSGI.

Additionally, the program offers two high-deductible health plans (HDHP) with health savings accounts. The Health Investor PPO Plan is the statewide, high deductible health plan with an integrated health saving account. It is also administered by Blue Cross Blue Shield of Florida. The Health Investor HMO Plan is a high deductible health plan with an integrated health saving account. The state has contracted with multiple state and regional HMOs as providers. The state makes a $500 per year contribution to the health savings account for single coverage and a $1,000 per year contribution for family coverage.

Employer and Employee Contributions

The state program is considered employer-sponsored because the state contracts with providers and contributes a substantial amount on behalf of the employee toward the cost of the insurance premium. The state's employer contribution is part of a state employee's overall compensation. The state program is a defined-benefit program. The employee pays a set monthly premium for either a single or family plan. The state pays the remainder of the cost of the premium. In a defined-contribution program, the employer pays a set amount toward the monthly premium and the employee pays the remainder.

The following chart shows the monthly contributions[74] for the state and the employee to employee health insurance premiums.

Career Service	Single	499.80	50.00	549.80	499.80	15.00	514.80
	Family	1,063.34	180.00	1,243.34	1,063.34	64.30	1,127.64
	Spouse	1,243.32	30.00	1,273.32	1,097.64	30.00	1,127.64
Select Exempt and Senior Mgt. Service	Single	541.46	8.34	549.80	506.46	8.34	514.80
	Family	1,213.34	30.00	1,243.34	1,097.64	30.00	1,127.64

*Includes employer tax-free HSA contribution - $500 per year for single coverage and $1,000 per year for family coverage.

Each year the Legislature specifies in the General Appropriations Act the state program benefit design and the employer and employee premium contributions.

Health Care Workforce

Florida's population is growing and aging. Between 2010 and 2030, the population in Florida is forecasted to grow by about 5.1 million people. Those age 60 or over will account for most of the growth, about 55.2%. The elderly in Florida use more health care services. Approximately one-third of the age 65 or over population in Florida have a Census-defined disability. With the aging and growth of the U.S. population, the need for health care services, especially primary care services, is expected to increase significantly.[75]

[74] State Employees' Group Health Self-Insurance Trust Fund, Report on the Financial Outlook, February 28, 2013, available at: http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf (last viewed 4/13/13).

[75] National Governors Association, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," December 2012, available at http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html (last viewed April 11, 2013); and A. N. Hofer, J. M. Abraham and I. Moscovice, "Expansion of Coverage Under the Patient Protection and Affordable Care Act and Primary Care Utilization," The Milbank Quarterly 89(1) (2011): 69-89, on file with committee staff.

There is an inadequate supply of health care practitioners in the U.S. to meet the existing need for such services. Florida currently has a shortage of primary care physicians and would need 753 doctors just to eliminate the state's 248 primary care crisis areas.[76] As of 2010, Florida has a Registered Nurse shortage of approximately 5,900. An aging workforce will have an impact on supply, as well. The proportion of Advanced Registered Nurse Practitioners (ARNPs) in Florida age 61 or over has increased from 11.8% in 2007 to 18.5% in 2011. In the next 15 years, it is projected that the aging ARNP workforce will cause a large exodus due to retirement.

The workforce disparity will grow as coverage increases due to exchange subsidies and Medicaid expansion, and demand for care grows with that coverage. With implementation of the PPACA, including Medicaid expansion, the U.S. faces a shortage of more than 90,000 physicians by 2020, which will grow to more than 130,000 physicians by 2025.[77] If a health insurance exchange and Medicaid expansion were implemented in Florida, the state would need an additional 50,300 registered nurses to meet the demand for health care services.[78]

To address the health care workforce shortage, states will be competing for existing workforce resources. Some states may change their laws relating to health care practitioners and look for innovative ways to improve and ensure access to care. For example, states may change the scope of practice for certain health care practitioners, make licensure by endorsement or reciprocity available or easier to obtain, provide incentives to practitioners, or change education or licensure requirements.[79]

Effect of Proposed Changes

Florida Health Choices Plus

The bill creates the Florida Health Choices Plus Program (FHC Plus) as a program within Florida Health Choices. The purpose of FHC Plus is to assist uninsured Floridians to gain access to affordable health coverage, products and services.

Eligible enrollees are two groups of low income individuals that earn too much to qualify for Medicaid, but do not earn enough to qualify for an advance premium tax credit for use in the PPACA health insurance exchange. The first group is parents and caretaker relatives[80] of children whose household income is below 100% of poverty. The second group is individuals who are disabled and eligible for Supplemental Security Income program and whose household income is below 100% of poverty. To qualify for FHC Plus these individuals must also be 19 to 64 years of age, inclusive, a United States citizen or a qualified alien[81], and uninsured and ineligible for Medicaid[82].

Floridians with incomes between 100% and 400% of poverty are eligible, under PPACA, for federal advance tax credits to purchase coverage in the exchange. In states which expand Medicaid under

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[76] Florida Department of Health, Presentation by State Surgeon General & Secretary of Health John H. Armstrong, MD, before the House Select Committee on Patient Protection and Affordable Care Act, February 18, 2013.
[77] Association of American Medical Colleges, "Fixing the Doctor Shortage," available at https://www.aamc.org/initiatives/fixdocshortage/ (last viewed April 11, 2013).
[78] Florida Center for Nursing, "RN and LPN Supply and Demand Forecasts, 2010-2025: Florida's Projected Nursing Shortage in View of the Recession and Healthcare Reform," Oct. 2010, available at http://www.flcenterfornursing.org/ForecastsStrategies/Forecasts.aspx (last viewed on April 11, 2013).
[79] National Conference of State Legislatures, "Scope of Practice Legislative Database, 2011-2013," available at http://www.ncsl.org/issues-research/health/scope-of-practice-legislation-tracking-database.aspx (last viewed April 11, 2013).
[80] Caretaker relative means an individual who is a relative that has primary custody or legal guardianship of a dependent child under the age of 19, and who provides the primary care and supervision to that dependent child in the same household, and who is related to the dependent child by blood, marriage, or adoption within the fifth degree of kinship.
[81] Qualified alien" means an alien as defined in s. 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.
[82] Parents whose incomes are below 22% of poverty are eligible for Medicaid and disabled persons who are eligible for SSI and whose incomes are below 75% of poverty are eligible for Medicaid.

PPACA, residents with incomes between 100% and $138% of poverty are no longer eligible for these federal subsidies. The bill preserves eligibility for these subsidies for Floridians at that income level, ensuring they will receive non-Medicaid coverage.

Eligibility determinations will be made by the DCF. DCF will use the same simplified application process and income determination methods used for Medicaid and CHIP. The enrollee will remain eligible for 12 months; however, an enrollee must report changes in income or status that would affect eligibility within 30 days of the change.

PHC Plus will have two 30-day open enrollment periods each fiscal year with the first open enrollment commencing on March 31, 2014. Enrollment in the program may occur through the portal of the Florida Health Choices Program, or by referral from DCF, the Florida Healthy Kids Corporation, or the PPACA health insurance exchange.

Enrollees in FHC Plus will receive $2,000 to fund a contribution amount for responsible expenditures (CARE) account to purchase health coverage, products and services in the FHC Plus marketplace. Each enrollee must make a monthly individual contribution of $25 to the enrollee's CARE account. Enrollees may make additional contributions to their CARE accounts to increase their buying power. The enrollee's employers, local governments, and charitable organizations may also make contributions into enrollees' CARE accounts.

In addition to having to make a monthly contribution of $25, non-disabled enrollees will have to meet the same work requirements as TANF enrollees (described on pp. 13-14 of this analysis).

Enrollees may use their CARE accounts to buy any products available in the FHC Plus marketplace. However, parents and relative caretakers must purchase a product or service, or a combination of products and services, that includes both preventive and catastrophic coverage or hospital care. Disabled individuals[83] may use their CARE accounts account for Medicare-related premiums and cost-sharing. If there are funds remaining the CARE account, an individual may leave the funds in the account for future purchase of additional products in the marketplace. The enrollee may also have the funds transferred into a health savings account and the enrollee may be reimbursed for out-of-pocket medical expenses.

FHC Plus must develop and maintain an education and public outreach campaign. Choice counseling must be provided for enrollees including information about available products and services and participating vendors, and information necessary to enable enrollees to compare products and services.

FHC Plus is not an entitlement program. The funding is subject to an annual appropriation and individuals are enrolled on a first come, first served basis. No cause of action shall arise against FHC Plus, the state, or any political subdivision of the state, for determination of ineligibility, failure to enroll or failure to make a state contribution for any person in the program.

The bill also expands the Florida Health Choices (FHC) Program by allowing all individuals and employers to participate FHC in as long as program criteria are met. The bill clarifies that products sold in the FHC marketplace are not limited to those specifically listed or to risk-bearing products. The bill gives FHC more flexibility in setting open enrollment periods and removes language related to product pricing[84] that is in conflict with the provisions of PPACA.

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[83] A person who is disabled and receives benefits from the Supplemental Security Income program is eligible for Medicare. Consequently these low income individuals can need assistance with Medicare premiums and cost sharing requirements.

[84] S. 408.910(4)(f)4., F.S., provides that for the establishment of product prices based on age, gender, and location. PPACA does not allow pricing based on gender and only allows limited pricing differences based on age. See PPACA Insurance Regulation, supra.

The bill provides that standard forms, website designs, or marketing communications developed by FHC and used by FHC or any vendor participating in the FHC marketplace are not subject to the Florida Insurance Code.

Currently FHC must provide an annual report by February 1 on the activities of the program to the Governor and the Legislature. The bill requires FHC to also include information about the activities of the FHC Plus program in the annual report.

Prepaid Health Clinics

The bill provides that a prepaid health clinic may provide inpatient hospital services and hospital inpatient physician services if the clinic meets the following requirements:

- The PHC obtains a health care provider certificate pursuant to part III of chapter 641, F.S.;
- The PHC meets the requirements of s. 641.225, F.S., regarding surplus sufficiency, by either:
  - Maintaining a minimum surplus of $1.5 million, 10 percent of total liabilities, or 2 percent of total annualized premiums, whichever is greater; or
  - Providing a written guarantee to cover claims and all other liabilities of the PHC if the guarantee is made by a guaranteeing organization that meets the requirements of s. 641.225(6), F.S.; and
- The PHC meets all applicable provisions of part II of chapter 641, F.S.

A PHC that is permitted under the bill to provide inpatient hospital services and inpatient physician services may be offered as product for purchase in the FHC Program.

Task Force

The bill creates the Florida Health Care Market Task Force within the Legislature to study and make recommendations on:

- Strategies for allowing state employees to participate in Florida Health Choices using a defined contribution;
- Methods for increasing the capacity of our current health care workforce to serve more patients by allowing advanced registered nurse practitioners and physician assistants to practice more independently; and
- Options for reducing federal control of the Medicaid program and for building a medical assistance program customized for Florida's needs.

The task force will consist of seven members:

- Three appointed by the President of the Senate
- Three appointed by the Speaker of the House of Representatives
- A chairman appointed jointly by the President of the Senate and the Speaker of the House of Representatives.

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

B. SECTION DIRECTORY:

Section 1: Amends s.408.910, F.S., relating to Florida Health Choices Program.
Section 2: Creates s.408.9105, F.S., relating to Florida Health Choices Plus Program.
Section 3: Amends s. 641.402, F.S., relating to definitions.
Section 4: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Cost Estimates – Four-Year Phase-In

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
FHC+ Uninsured Eligibles				
SSI	$282,935	$371,960	$493,184	$588,186
Parents	$105,176,105	$138,505,848	$183,662,115	$219,131,962
Total Cost - FHC+ Uninsured Eligibles	**$105,459,040**	**$138,877,808**	**$184,155,298**	**$219,720,148**
FHC+ Crowd Out Eligibles				
SSI	0	0	0	0
Parents	$5,080,000	$10,292,000	$13,046,000	$13,231,000
Total Cost - FHC+ Crowd-Out Eligibles	**$110,539,040**	**$149,169,808**	**$197,201,298**	**$232,951,148**
Lapse for Funding Start Date	16.67%	100.00%	100.00%	100.00%
Total Cost – FHC+ Uninsured and Crowd-Out Eligibles	**$18,423,173**	**$149,169,808**	**$197,201,298**	**$232,951,148**
Administrative costs = 2.50%	$460,579	$3,729,245	$4,930,032	$5,823,779
Grand Total	**$18,883,753**	**$152,899,053**	**$202,131,331**	**$238,774,927**

Population Estimates – Four-Year Phase-In

Eligible Groups	Baseline Eligibles - Uninsured (2011)	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
SSI	310	141	186	247	294
Parents	115,367	52,588	69,253	91,831	109,566
Total	**115,677**	**52,730**	**69,439**	**92,078**	**109,860**

Eligible Groups	Baseline Eligibles - Crowd-Out (2011)	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
SSI	0	0	0	0	0
Parents	11,103	2,540	5,146	6,523	6,616
Grand Total	**126,780**	**55,270**	**74,585**	**98,601**	**116,476**

The estimate uses base population numbers from the 2009-2011 3-year American Community Survey (Public Use Microdata Sample) and assumes a rate of growth based on the annual growth rate in total

population of Florida. The estimate applies different sets of assumptions for the uninsured portion of the eligible population and the insured, or "crowd-out", portion.

For the uninsured population, the estimate assumes that 79.7% of the total eligible population will present for services. This is consistent with the current take-up rate for Florida Medicaid and consistent with the assumptions used by the Social Services Estimating Conference (SSEC) for Medicaid expansion. Then the estimate assumes a gradual take-up over four years: 50% of likely new enrollees for the first year; 65% of likely new enrollees for the second year; 85% of likely new enrollees for the third year; 100% of likely new enrollees for the fourth year.

For the crowd-out population, the estimate assumes a 50% take-up rate. Then the estimate assumes a gradual take-up over three years: 40% of likely new enrollees for the first year; 80% of likely new enrollees for the second year; and 100% of likely new enrollees for the third year.

The Florida Health Choices program will require $6,124,421 in nonrecurring general revenue to implement the provisions of the bill. This includes funding for the following:

Corporate Operations	
Personnel	$728,000
General Expense	$435,000
Legal/Accounting	$110,000
Consulting	$200,000
Evaluation	$200,000
Subtotal Corporate Ops.	**$1,673,000**

Third Party Administration	
Development	$312,000
Software License	$4,600,000
Subtotal TPA	**$4,912,000**

Total	$6,585,000
2.5% fee	-$460,579
Total Request	**$6,124,421**

The estimated impact to DCF is indeterminate at this time.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Uninsured, low-income Floridians will receive an economic benefit from having CARE accounts with which to purchase health insurance products and services. Health care providers who establish innovative service packages and insurers and PHCs will also benefit from being able to offer products to more people.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

No applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is needed to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On April 15, 2013, the Select Committee on PPACA adopted two amendments. The first amendment corrected a cross-reference to clarify that the work requirements for enrollees in Florida Health Choices Plus will be consistent with the work requirements for individuals who receive temporary cash assistance through the Temporary Assistance for Needy Families program. The second amendment provided that the Florida Health Care Market Task Force shall expire on February 1, 2014.

The analysis is drafted to the Proposed Committee Bill as amended.

A bill to be entitled

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

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

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

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

408.910 Florida Health Choices Program.—

(3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health Choices Program is created as a single, centralized market for

the sale and purchase of various products that enable individuals and employers to pay for health care. These products include, but are not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. The components of the program include:

(a) Enrollment of employers and individuals.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

4. Distribution of premiums to insurers and payments to other eligible vendors.

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

2. Assistance with assessing the benefits and limits of each product and policy, including information necessary to distinguish between policies offering creditable coverage and other products available through the program.

3. Account information to assist individual participants with managing available resources.

4. Services that promote healthy behaviors.

(d) Recruitment of vendors, including, but not limited to,

insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and any other health care provider ~~providers~~.

(e) Certification of vendors to ensure capability, reliability, and validity of offerings.

(f) Collection of data, monitoring, assessment, and reporting of vendor performance.

(g) Information services for individuals and employers.

(h) Program evaluation.

(4) ELIGIBILITY AND PARTICIPATION.—Participation in the program is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

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

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

~~2. Fiscally constrained counties described in s. 218.67.~~

~~3. Municipalities having populations of fewer than 50,000 residents.~~

~~4. School districts in fiscally constrained counties.~~

~~5. Statutory rural hospitals~~.

(b) Individuals and employees of enrolled employers are eligible to participate in the program ~~include:~~

~~1. Individual employees of enrolled employers.~~

~~2. State employees not eligible for state employee health~~

~~benefits.~~

~~3. State retirees.~~

~~4. Medicaid participants who opt out~~.

(e) ~~Eligible individuals may voluntarily continue participation in the program regardless of subsequent changes in job status or Medicaid eligibility.~~ Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures must include, but are not limited to:

1. Submission of required information.

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

3. Compliance with federal tax requirements.

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

5. Selection of products and services.

(f) Vendors who choose to participate in the program may enroll by complying with the procedures established by the corporation. These procedures ~~may~~ include, but are not limited to:

1. Submission of required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product offered through the program.

2. Execution of an agreement to comply with requirements established by the corporation.

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

4. Communication of product and service prices, established by the vendor ~~Establishment of product prices based on age, gender, and location of the individual participant, which may include medical underwriting~~.

5. Arrangements for receiving payment for enrolled participants.

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

7. Compliance with grievance procedures established by the corporation.

(5) PRODUCTS.—

(a) The products that may be made available for purchase through the program include, but are not limited to:

1. Health insurance policies.

2. Health maintenance contracts.

3. Limited benefit plans.

4. Prepaid clinic services.

5. Service contracts.

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

7. Flexible spending accounts.

(b) Health insurance policies, health maintenance contracts, limited benefit plans, prepaid service contracts, and other contracts for services must ensure the availability of contracted ~~covered~~ services.

(7) THE MARKETPLACE PROCESS.—The program shall provide a single, centralized market for purchase of health insurance, health maintenance contracts, and other health products and

services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive Internet website. A participant needing personal assistance to select products and services shall be referred to a participating agent in his or her area.

(b) Initial selection of products and services must be made during the applicable open ~~by an individual participant within 60 days after the date the individual's employer qualified for participation. An individual who fails to enroll in products and services by the end of this period is limited to participation in flexible spending account services until the next annual~~ enrollment period.

(10) EXEMPTIONS.—

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

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

408.9105 Florida Health Choices Plus Program.—

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

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

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

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

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

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

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

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

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

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

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

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

(3) ELIGIBILITY.-

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

1. Nineteen to 64 years of age, inclusive;

2. A United States citizen or a qualified alien;

3. Uninsured and ineligible for Medicaid; and

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

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

(b) To maintain eligibility, enrollees eligible under subparagraph (a)4. must provide proof to the department of engagement in work activities consistent with the requirements for temporary cash assistance, as defined in s. 414.0252, pursuant to s. 414.045.

(c) The department shall establish and maintain a process for determining eligibility of individuals for coverage under the program. The department shall use the same simplified application process and income determination methods used for

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

(4) ENROLLMENT.-

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

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

(c) Participation in the program is not an entitlement. No cause of action shall arise against the corporation, the state,

or any political subdivision of the state for determination of ineligibility, failure to enroll, or failure to make a state contribution for any person in the program.

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

(5) CARE ACCOUNTS.-

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

(b) As a condition of eligibility, each enrollee shall make a monthly individual contribution of $25, or another amount as otherwise provided in the General Appropriations Act, to the enrollee's CARE account. The corporation shall disenroll an individual who fails to pay the individual contribution. Disenrollment procedures shall include a 1-month grace period. An individual who is disenrolled may reenroll at the next open

enrollment period, if that individual is still eligible, subject to availability of funding.

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

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

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

(f) An enrollee may use contributions for any product available in the marketplace. An enrollee who is eligible under subparagraph (3)(a)4. must purchase a product or service, or a combination of products and services, that includes both preventive and catastrophic coverage or hospital care. The corporation shall provide a secure website to compare and facilitate the selection of products and services and provide public information about the program. Unused funds in the enrollee's CARE account may be used to fund health savings accounts for expenditure on qualified medical expenses as defined in s. 213(d) of the Internal Revenue Code. An enrollee who is eligible for Supplemental Security Income benefits under subparagraph (3)(a)5. may use funds contributed to the health savings account for Medicare-related premiums and cost-sharing. An enrollee may maintain unused funds in the CARE account for additional purchases in the marketplace.

(g) The corporation shall receive the contributions and

manage their use for individual enrollees. The corporation may establish and manage an operating fund for the purposes of addressing the corporation's unique cash-flow needs and facilitating the fiscal management of the corporation. The corporation may accumulate and maintain a cash balance reserve in its operating fund equal to no more than 25 percent of its annualized operating expenses. The corporation must ensure the timely distribution and appropriate expenditure of contributions. The corporation shall establish health savings accounts for unused contributions. The corporation shall establish a refund process for an enrollee who disenrolls from the program to return any unused individual or employer contributions. The enrollee may be refunded only those funds that the enrollee has contributed. The employer may be refunded only those funds that the employer has contributed. Remaining state contribution amounts shall revert to the state. Upon dissolution of the program, any remaining cash balances of state funds shall revert to the General Revenue Fund or such other state funds consistent with the appropriated funding, as provided by law.

(6) PROGRAM EVALUATION; TASK FORCE.—

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

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

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

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

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

(c) The task force shall be composed of seven members. Three members shall be appointed by the President of the Senate, three members shall be appointed by the Speaker of the House of Representatives, and a chair shall be appointed jointly by the President of the Senate and the Speaker of the House of Representatives. The task force shall submit a report to the President of the Senate and the Speaker of the House of Representatives by January 1, 2014.

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

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

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

(4) "Prepaid health clinic" means any organization authorized under this part which provides, either directly or through arrangements with other persons, basic services to

persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services which subscribers might reasonably require to maintain good health. A ~~However, No~~ clinic that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services may not ~~shall~~ be a prepaid health clinic, unless the clinic meets the requirements of this part. Any prepaid health clinic that applies for and obtains a health care provider certificate pursuant to part III of this chapter, meets the surplus requirements of s. 641.225, and meets all other applicable requirements of this part may provide or contract for, either directly or indirectly, inpatient hospital services and hospital inpatient physician services.

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

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Jones, M. offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. The Agency for Health Care Administration is directed to develop and submit a state plan amendment that will extend Title XIX of the Social Security Act, 42 U.S.C. s. 1396, et seq., and regulations adopted thereunder, as provided in part III of chapter 409, Florida Statutes, to individuals, including adults without children, with an income of up to 133 percent of the federal poverty level, as provided for in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148. The agency is further directed to develop the necessary request to draw down all available federal funds under the Patient Protection and Affordable Care Act.

Section 2. This act shall take effect July 1, 2013.

Amendment No. 1

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

An act relating to health care; directing the Agency for Health Care Administration to submit a state plan amendment relating to the Patient Protection and Affordable Care Act and develop a request to drawn down certain federal funds; providing an effective date.

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Cummings offered the following:

Amendment (with directory and title amendments)

Between lines 115 and 116, insert:

(c) Employers who choose to participate in the program may enroll by complying with the procedures established by the corporation. The procedures must include, but are not limited to:

1. Submission of required information.

2. Compliance with federal tax requirements for the establishment of a cafeteria plan, pursuant to s. 125 of the Internal Revenue Code, including designation of the employer's plan as a premium payment plan, a salary reduction plan that has flexible spending arrangements, or a salary reduction plan that has a premium payment and flexible spending arrangements.

3. Determination of the employer's contribution, if any, per employee, provided that such contribution is equal for each eligible employee.

4. Establishment of payroll deduction procedures, subject to the agreement of each individual employee who voluntarily participates in the program.

5. Designation of the corporation as the third-party administrator for the employer's health benefit plan.

6. Identification of eligible employees.

7. Arrangement for periodic payments.

8. Employer notification to employees of the intent to transfer from an existing employee health plan to the program at least 90 days before the transition.

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

D I R E C T O R Y A M E N D M E N T

Remove line 49 and insert:

Section 1. Subsection (3), paragraphs (a), (b), (c), (e), and

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Amendment No. 2

T I T L E A M E N D M E N T

Remove line 8 and insert:

eligible to participate in the program; requiring participating employers to make a defined contribution with certain conditions; providing that

Amendment No. 3

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Cummings offered the following:

Amendment

Remove lines 333-352 and insert:

savings account for Medicare-related premiums and cost-sharing. Unused balances in an enrollee's health savings account may be carried forward to the next year if the enrollee is continuously enrolled. An enrollee may maintain unused funds in the CARE account for additional purchases in the marketplace.

(g) The corporation shall receive the contributions and manage their use for individual enrollees. The corporation may establish and manage an operating fund for the purposes of addressing the corporation's unique cash-flow needs and facilitating the fiscal management of the corporation. The corporation may accumulate and maintain a cash balance reserve in its operating fund equal to no more than 25 percent of its annualized operating expenses. The corporation must ensure the timely distribution and appropriate expenditure of contributions. The corporation shall establish health savings

accounts for unused contributions. The corporation shall establish a process to refund unused CARE and health savings account funds in the event an enrollee disenrolls from the program. The corporation shall first refund individual contributions amounts. Refunds to employers, political subdivisions and charitable organizations shall be based on a pro rata share of the remainder after the individual contribution amounts are refunded. Remaining state contribution amounts shall revert to the state. Upon

Amendment No. 4

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Hudson offered the following:

Amendment (with title amendment)

Between lines 406 and 407, insert:

Section 4. The sum of $18,863,753 in recurring funds is appropriated from the General Revenue Fund to the Agency for Health Care Administration for the 2013-2014 fiscal year for the purpose of implementing the provisions contained in this act.

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

T I T L E A M E N D M E N T

Amendment No. 4

Remove line 45 and insert:

circumstances; providing appropriations; providing an effective date.