The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Monday, June 1, 2015
TIME: 4:00—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Braynon, Flores, Gaetz, Galvano, Garcia, Grimsley, and Joyner

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 2-A** Bean (Compare S 2508-A)	Health Insurance Affordability Exchange; Creating the Florida Health Insurance Affordability Exchange Program or FHIX in the Agency for Health Care Administration; providing patient rights and responsibilities; providing for the development of a long-term reorganization plan and the formation of the FHIX Workgroup; limiting eligible persons in the Medically Needy program to those under the age of 21 and pregnant women, and specifying an effective date; providing an expiration date for the program, etc. HP 06/01/2015 Fav/CS AP	Fav/CS Yeas 7 Nays 0

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 2-A
INTRODUCER:	Health Policy Committee and Senator Bean
SUBJECT:	Health Insurance Affordability Exchange
DATE:	June 1, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP AP	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 2-A creates the "Florida Health Insurance Affordability Exchange Program" (FHIX) under ss. 409.72 - 409.731, F.S., as a multi-phased, consumer-driven approach to providing access to high-quality, affordable health care coverage to low-income, uninsured Floridians.

The bill extends health care coverage to an estimated 800,000 uninsured, low-income Floridians in households earning less than 138 percent of the federal poverty level (FPL) who are not currently eligible under the Medicaid program, s. 409.902, F.S. To be eligible, an individual must be a U.S. citizen and a Florida resident.

The FHIX is implemented in two phases, from July 1, 2015, through September 30, 2016. Florida Health Choices, Inc. (corporation), the Florida Healthy Kids Corporation (FHKC), the Department of Children and Families (DCF), and the Agency for Health Care Administration (AHCA) are given duties to implement the FHIX.

The bill provides the AHCA with authority to seek federal approval to implement the FHIX program. If the waiver varies significantly from the provisions of the act, Legislative approval is required prior to implementation. Triggers for ending the program are also included.

The bill has a fiscal impact of approximately $11.87 million to general revenue for Fiscal Year 2015-2016 and a fiscal impact of approximately $118.5 million to general revenue for Fiscal Year 2016-2017. The bill is also expected to create an indeterminate amount of cost savings in several health-related programs administered by the AHCA and the DCF.

The bill is effective upon becoming a law.

II. Present Situation:

In 2013, the American Community Survey (ACS) of the federal Census Bureau, estimated that four million Floridians were uninsured.[1] Of that number, 594,000 were projected to be children.[2] Approximately 900,000 adults in Florida were estimated to have incomes under 100 percent of the FPL, according to statistics for 2013.[3]

Beginning January 1, 2014, health insurance coverage in Florida became available through the federal exchange[4] to persons with incomes above 100 percent of the FPL. Also, on January 1, 2014, Florida Medicaid coverage to children up to age 18 was extended to 133 percent of the FPL.

The Census Bureau's March 2014 Supplement to the Current Population Survey showed that Florida's overall uninsured number had dropped to 3.6 million and the children's number to 504,900.[5,6] The survey was conducted from January through April 2014.[7]

Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income children and disabled persons. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the AHCA and is financed with federal and state funds. The DCF determines eligibility for the Medicaid program and transmits that information to the AHCA. The AHCA is designated as the single state Medicaid agency and has the lead responsibility for the overall program.[8]

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[1] Office of Economic and Demographic Research, Florida Legislature, *Economic Analysis of PPACA and Medicaid Expansion,* Presentation to Senate Select Committee on Patient Protection and Affordable Care Act (Mar. 4, 2013), http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2071.pdf (last visited May 26, 2015).
[2] Ibid.
[3] Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of the Non-Elderly (0-64) with Income Below 100% Federal Poverty Level (FPL)* http://kff.org/other/state-indicator/nonelderly-up-to-139-fpl/ (May. 26, 2015).
[4] President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. The first open enrollment was held starting on October 1, 2013, and a second one was held from November 15, 2014, through February 15, 2015. Florida does not operate its own exchange, so Floridians purchase coverage through the federal exchange at www.healthcare.gov.
[5] Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of the Total Population (2013),* http://kff.org/other/state-indicator/total-population/ (last visited May 26, 2015).
[6] Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of Children 0-18,* http://kff.org/other/state-indicator/children-0-18/ (last visited Mar. 7, 2015).
[7] More current, reliable estimates of the number of uninsured Floridians is not available at this time.
[8] *See* s. 409.963, F.S.

Over 3.8 million Floridians are currently enrolled in Medicaid[9] and the program's estimated expenditures for the 2014-2015 fiscal year are $23.4 billion.[10] The current traditional federal share is 60.51 percent with the state paying 39.49 percent for Medicaid enrollees.[11] Florida has the fourth largest Medicaid program in the country.[12]

Medicaid currently covers:

- 20 percent of Florida's population;
- 27 percent of Florida's children;
- 62.2 percent of Florida's births; and
- 69 percent of Florida's nursing homes days.[13]

The structure for each state's Medicaid program is different and each state's share of expenditures is largely determined by the federal government. Federal law and regulations set the minimum amount, scope, and duration of services offered in the program, among other requirements. Eligibility for Medicaid is based on a number of factors, including age, household or individual income, and assets. State Medicaid benefits are provided in statute under s. 409.903, F.S. (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.[14] Applicants must also agree to cooperate with Child Support Enforcement during the application process.[15]

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[9]Agency for Health Care Administration, *Report of Medicaid Eligibles - April 30, 2015*, http://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/docs/age_assistance_category_2015-04-30.pdf (last visited May 26, 2015).

[10] Office of Economic and Demographic Research, *Social Services Estimating Conference Medicaid Expenditures* (December 12, 2014) http://edr.state.fl.us/Content/conferences/medicaid/medhistory.pdf (last visited May 26, 2015).

[11] Office of Economic and Demographic Research, *Social Services Estimating Conference - Official FMAP Estimate (February 2015),* http://edr.state.fl.us/Content/conferences/medicaid/fmap.pdf (last viewed May 26, 2015). The SSEC has also created a "real time" FMAP blend" for the Statewide Medicaid Managed Care Program which is 60.43% for SFY 2015-16.

[12]Agency for Health Care Administration, Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - An Overview (Jan. 22, 2015),* Slide 9, http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2759.pdf (last visited: May 26, 2015).

[13] Id at 10.

[14] Florida Department of Children and Families, *Family-Related Medicaid Programs Fact Sheet, (January 2015),* p.3, http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last visited: May 26, 2015).

[15] Id.

Florida's Current Medicaid and CHIP Eligibility Levels in Florida[16] (With Income Disregards and Modified Adjusted Gross Income)						
Children's Medicaid			**CHIP (Kidcare)**	**Pregnant Women**	**Parents**	**Childless Adults**
Age 0-1	Age 1-5	Age 6-18	Ages 0-18	Medicaid		
206% FPL	140% FPL	133% FPL	210% FPL	191% FPL	30% FPL	0% FPL

Federal poverty guidelines are updated every year by the Census Bureau. The guidelines are used to adopt the threshold for eligibility for financial assistance under a number of different social and human service programs, including Medicaid and the Children's Health Insurance Program.

Federal Poverty Guidelines for 2015[17] Annual Income (rounded)				
Family Size	**100%**	**133%**	**150%**	**200%**
1	$11,770	$15,654	$17,655	$23,540
2	$15,930	$21,187	$23,895	$31,860
3	$20,090	$26,720	$30,135	$40,180
4	$24,250	$32,252	$36,375	$48,500
5	$28,410	$37,785	$42,615	$56,820
	Add $4,160 each additional person after 5			

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.[18] States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.[19] For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services, which are those health care and diagnostic services and treatment and measures that may be needed to correct or ameliorate defects or physical and mental illnesses and conditions discovered by screening services, consistent with federal law.[20]

Statewide Medicaid Managed Care

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) Program as part IV of ch. 409, F.S.[21] The SMMC has two components: the Long Term Care Managed Care (LTC) program and the Managed Medical Assistance (MMA) program. The SMMC is an integrated, comprehensive, managed care program for Medicaid enrollees that manages the delivery of primary and acute care in 11 regions.

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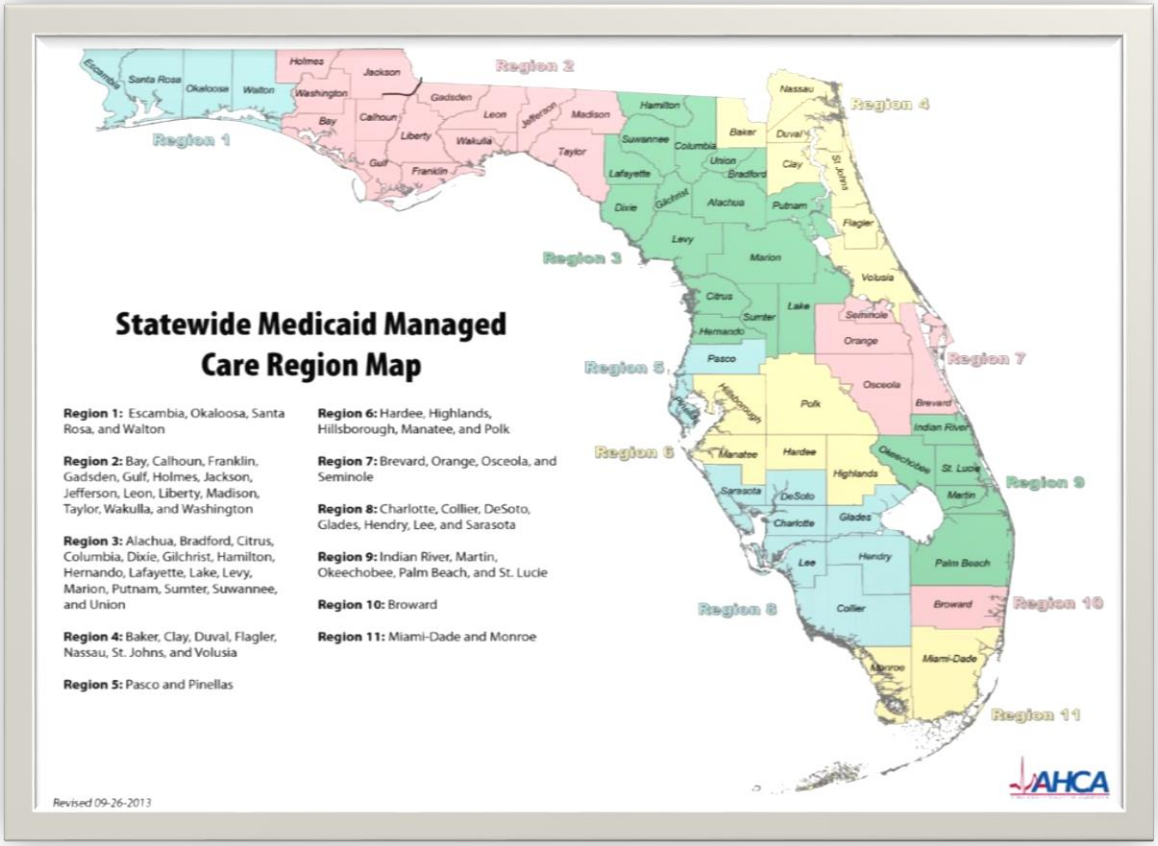
[16] U.S. Centers for Medicare and Medicaid Services, Medicaid.gov, *Florida*, http://www.medicaid.gov/medicaid-chip-program-information/by-state/florida.html (last visited May 26, 2015).
[17] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid and CHIP Program Information - 2015 Federal Poverty Level Charts* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf (last visited May 26, 2015).
[18] Section 409.905, F.S.
[19] Section 409.906, F.S.
[20] *See* Section 1905 9(r) of the Social Security Act.
[21] *See* Chapter Laws, 2011-134 and 2011-135.



To implement the two components and receive federal Medicaid funding, the AHCA received federal authorization through two different Medicaid waivers from the CMS. The first component authorized was the LTC's 1915(b) and (c) waivers on February 1, 2013. The waivers for the LTC program are effective July 1, 2013, through June 30, 2016, and operate concurrently.[22]

Long Term Care Managed Care Program (LTC)

For the LTC program, individuals must meet the following eligibility requirements or participate in one of the following waivers, as applicable, to enroll in the program:

- Age 65 years or older and need nursing facility level of care;
- Age 18 years of age or older and are eligible for Medicaid by reason of a disability and need nursing facility level of care;
- Aged and Disabled Adult (A/DA) waiver;
- Consumer Directed Care Plus for individuals in the A/DA waiver;
- Assisted Living waiver;
- Nursing Home Diversion waiver;

[22] Department of Health and Human Services, Disabled and Elderly Health Programs Group, *Approval Letter to Agency for Health Care Administration* (February 1, 2013), http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (last visited May 26, 2015).

- Frail Elder Option; or
- Channeling Services waiver.[23]

Individuals who are enrolled in the following programs may enroll in the LTC, but are not required to:

- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Injury waiver;
- Project AIDS Care waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver; or
- Model waiver.[24]

The AHCA conducted a competitive procurement to select providers in each of the 11 regions. Contracts were awarded to health maintenance organizations and provider service networks. Seven non-specialty plans are currently contracted, including one provider service network that is available in all 11 regions and one health maintenance organization that is in 10 regions.[25]

Enrollment into the LTC Managed Care program began in August 1, 2013, and finished March 1, 2014. As of May 1, 2015, 86,636 persons were enrolled in the LTC program.[26]

Managed Medical Assistance Program (MMA)

For the MMA component, health care services were also bid competitively using the same 11 regions. Thirteen non-specialty managed care plans contract with AHCA across the different regions. Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans. Most plans supplemented the required benefits and offered enhanced options, such as adult dental, hearing and vision coverage, outpatient hospital coverage and physician services.

Under s. 409.967, F.S., accountability provisions for the managed care plans specify several conditions or requirements, including emergency care and physician reimbursement standards, access and credentialing requirements, encounter data submission guidelines, grievance and resolutions, and medical loss ratio calculations.

Statewide implementation of SMMC started May 1, 2014, and was completed by August 1, 2014.

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[23] Agency for Health Care Administration, *A Snapshot of the Florida Medicaid Long-term Care Program*, *http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf* (last visited May 26, 2015).
[24] Id.
[25] Id.
[26] Agency for Health Care Administration, *SMMC LTC Enrollment by County By Plan Report* (May 1, 2015) *http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml* (last visited May 26, 2015).

Most Medicaid recipients must be enrolled in the MMA program. Those individuals who are not required to enroll, but may choose to do so, are:

- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities under s. 394.455(32), F.S.;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.[27]

Other Medicaid enrollees are exempt from the MMA program and receive Medicaid services on a fee-for-service basis. Exempt enrollees are:

- Women who are eligible for family planning services only;
- Women who are eligible only for breast and cervical cancer services; and
- Persons eligible for emergency Medicaid for aliens.

The MMA program is authorized by a section 1115 demonstration waiver by federal CMS. It was approved in 2005 and is currently operating as an expansion of the managed care pilot program and was renewed on July 31, 2014, for a second 3-year period through June 30, 2017.[28]

Florida Kidcare Program

The Florida Kidcare Program (Kidcare) was created in 1998 by the Legislature in response to the federal enactment of the Children's Health Insurance Program (CHIP) in 1997. The CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who have family incomes under 200 percent of the FPL and meet other eligibility criteria. The state statutory authority for Kidcare is found under part II of ch. 409, F.S., specifically in ss. 409.810 through 409.821, F.S.

The CHIP-funded components of Florida Kidcare serve distinct populations:

- Medicaid for Children: Children from birth until age 1 for family incomes between 185 percent and 200 percent of the FPL.
- Medikids: Children from age 1 until age 5 for family incomes between 133 percent and 200 percent of the FPL. Those enrollees above 200 percent FPL may enroll at a non-subsidized rate established by the AHCA.
- Healthy Kids: Children from age 5 through age 18 for family incomes between 133 and 200 percent of the FPL. Those above 200 percent FPL may enroll at a non-subsidized rate established by the FHKC.
- Children's Medical Services Network: Title XXI and Title XIX funds are available from birth until age 19 for family incomes up to 200 percent of the FPL for children with special

[27] Section 409.972, F.S.

[28] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid 1115 Demonstration Fact Sheet* (July 31, 2014), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf (last visited May 26, 2015).

health care needs. The Department of Health assesses whether children meet the clinical requirements.

Kidcare is funded by Medicaid funds under Title XIX of the Social Security Act, state funds from General Revenue and the Tobacco Settlement Trust Fund, and family contributions.[29] CHIP has an enhanced federal matching rate that is more favorable than Medicaid. For the period of October 2014 through June 2015, the federal match rate is 71.80 percent.[30]

Family contributions are based on family size, household income, and other eligibility factors. Families above the income limits for premium assistance or who are not otherwise eligible for premium assistance are offered the opportunity to participate in Kidcare at a non-subsidized rate (full-pay). The non-subsidized rates are established by the individual program and are based on the actual costs of the program, both premiums and an administrative fee. The income limit for premium assistance is 200 percent of the FPL.

CHIP was re-authorized by Congress in 2009 until federal Fiscal Year 2019, but federal funding was only re-authorized until September 30, 2015. Congress acted in April 2015 to extend funding for an additional 2 years beginning October 1, 2016 through September 30, 2017 under the *Medicare Access and CHIP Reauthorization Act of 2015*.[31] No other substantive changes to the Children's Health Insurance Program were made.

Florida Healthy Kids Corporation

The Florida Healthy Kids Program is authorized under s. 624.91, F.S., which is also known as the "William G. 'Doc' Myers Healthy Kids Corporation Act." The FHKC was created as a private, not-for-profit corporation by the 1990 Legislature in an effort to increase access to health insurance for school-aged children.[32]

Eligibility for the state-funded assistance is prescribed under s. 624.91(3), F.S., and provides cross references to the Florida Kidcare Act. The Healthy Kids program is also identified as a non-entitlement program.[33]

The FHKC is managed by an executive director selected by the board with the number of staff determined by the board. The FHKC is authorized to:

- Collect contributions from families, local sources or employer based premiums;
- Establish administrative and accounting procedures;
- Establish preventive health standards for children that do not limit participation to pediatricians in rural areas with consultation from appropriate experts;

[29] Florida Kidcare Coordinating Council, *2014 Annual Report and Recommendations*, p. 14, http://www.floridakidcare.org/council/wp-content/uploads/2014/08/2014_Annual_Report.pdf (last reviewed May 26, 2015).
[30] Office of Economic and Demographic Research, *Social Services Estimating Conference - Kidcare Program (February 12, 2015 Conference Results)* http://edr.state.fl.us/Content/conferences/kidcare/kidcaredetail.pdf (last viewed May 26, 2015).
[31] Public Law No. 114-10.
[32] Florida Healthy Kids Corporation, *History*, https://www.healthykids.org/healthykids/history/ (last visited May 26, 2015).
[33] A non-entitlement program means that funding may be limited. If more applicants or enrollees apply or enroll for the program than funding allows, an enrollee is not entitled to enrollment, even if eligible.

- Determine eligibility for children seeking enrollment in Title XXI funded and non-Title XXI components;
- Establish grievance processes;
- Establish participation criteria for administrative services for the FHKC;
- Establish enrollment criteria that include penalties or waiting periods for non-payment of premiums of 30 days;
- Contract with authorized insurers and other health care providers meeting standards established by the FHKC for the delivery of services and select health plans through a competitive bid process;
- Purchase goods and services in a cost effective manner with a minimum medical loss ratio of 85 percent for health plan contracts;
- Establish disenrollment criteria for insufficient funding levels;
- Develop a plan to publicize the program;
- Secure staff and the necessary funds to administer the program;
- Provide an annual Kidcare report, in consultation with partner agencies, to the Governor, Chief Financial Officer, Commissioner of Education, President of the Senate, Speaker of the House of Representatives, and minority leaders of the Senate and House of Representatives;
- Provide quarterly enrollment information on the full pay population; and
- Establish benefit packages that conform to the Florida Kidcare benchmark benefit.

Limits on premiums and cost sharing in the Healthy Kids must conform to existing federal law and regulation for Title XIX and XXI. All Title XXI funded enrollees pay monthly premiums of $15 or $20 per family per month based on their family size and income. For those families at or below 150 percent of the FPL, the cost is $15 per family per month. For those between 150 percent of the FPL and 200 percent of the FPL, the cost is $20 per family per month.

Enrollees also have copayments for non-preventive services that range from $5 per prescription to $10 for an inappropriate use of the emergency room visit. There are no copayments for visits related to well-child, preventive health, or dental care.[34]

The FHKC is governed by a 13-member board of directors, chaired by Florida's Chief Financial Officer or his or her designee.[35] The 12 other board members are:

- Secretary of the AHCA;
- One member appointed by the Commissioner of Education from the Office of School Health Programs from the Department of Education;
- One member, appointed by the Chief Financial Officer from among three members nominated by the Florida Pediatric Society;
- One member, appointed by the Governor, who represents the Children's Medical Services Program;
- One member appointed by the Chief Financial Officer from among three members nominated by the Florida Hospital Association;
- One member, appointed by the Governor, who is an expert on child health policy;

[34] *See* Florida Healthy Kids Corporation, *Benefits*, *https://www.healthykids.org/benefits/medical/* (last visited May 26, 2015).
[35] *See* s. 624.91(6), F.S.

- One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Academy of Family Physicians;
- One member, appointed by the Governor, who represents the state Medicaid program;
- One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Association of Counties;
- The state health officer or his or her designee;
- The Secretary of the DCF, or his or her designee; and
- One member, appointed by the Governor, from among three members nominated by the Florida Dental Association.

Board members do not receive compensation for their service but may receive reimbursement for per diem and travel expenses in accordance with s. 112.061, F.S.[36]

The FHKC is not an insurer and is not subject to the licensing requirements of the Department of Financial Services. In addition, the FHKC board is also granted complete fiscal control over the FHKC and responsibility for all fiscal operations. Any liquidation of the FHKC would be supervised by the Department of Financial Services.[37]

Florida Health Choices Corporation, Inc. (Corporation)

In 2008, the Legislature created the Florida Health Choices Program to address the issue of Florida's uninsured.[38] The corporation is a private, non-profit, corporation under s. 408.910, F.S., and operates in compliance with part III of chapter 112 (Public Officers and Employees) and chapter 119 (Public Records), 286 (Public Business), and 617 (Corporations Not for Profit).

The corporation is led by a 15-member board of directors and three ex-officio, non-voting board members for 3-year terms, including:

- Four members appointed by and serving at the pleasure of the Governor;
- Four members appointed by and serving at the pleasure of the President of the Senate;
- Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives; and
- Three non-voting ex-officio members:
  - The Secretary of the AHCA or a designee with expertise in health care services;
  - The Secretary of the Department of Management Services or a designee with expertise in health care services; and
  - The Commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.

Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations (HMOs), prepaid service providers, or any other entity or affiliate or subsidiary of eligible vendors. Board members may not serve for more than 9 years, and members must disclose any conflicts of interest that would prohibit him or her from participating in any decision that would inure to the member's benefit or the member's

[36] *See* s. 624.91(5), F.S.
[37] *See* s. 624.91(7), F.S.
[38] *See* Chapter Law 2008-32.

organization. The board selects a chief executive officer for the corporation who is responsible for the selection of other staff, as authorized by an operating budget.

The corporation is designed as a single, centralized marketplace for the purchase of health products, including, but not limited to, health insurance plans, HMO plans, prepaid services, and flexible spending accounts. Policies sold as part of the program are exempt from regulation under the Insurance Code and laws governing HMOs. The following entities are authorized to be eligible vendors:

- Insurers authorized under ch. 624, of the Insurance Code, such as self-insurers, indemnity plans, life and health insurers, church benefit plans, disability, and multi-employer welfare arrangements, and Florida Healthy Kids Corporation;
- HMOs authorized under part I of ch. 641, F.S., relating to Health Service Programs, including health maintenance organization contracts, limited benefit policies, and other risk bearing coverage, benefits, and products;
- Prepaid limited health service organizations and discount medical plans under ch. 636, F.S.;
- Prepaid health clinics licensed under ch. 641, part II, F.S.;
- Health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers;
- Provider organizations, including service networks, group practices, and professional associations; and
- Corporate entities providing specific health services.

The corporation is authorized to collect premiums and other payments from employers. The law further specifies who may participate as either an employer or an individual. Employers eligible to enroll include employers that meet criteria established by the corporation and their individual employees and other individuals meeting criteria established by the corporation.[39]

The corporation is required to:

- Determine eligibility of employers, vendors, individuals and agents;
- Establish procedures for the operation of the program;
- Arrange for the collection of contributions from employers and participants;
- Establish criteria for disenrollment for failure to pay the individual's share of any contribution required to maintain enrollment in any product;
- Establish criteria for exclusion of vendors;
- Develop and implement a plan for public awareness and program promotion;
- Secure staff and consultant services, as necessary;
- Establish policies and procedures as necessary;
- Operate a toll-free hotline to respond to requests for assistance;
- Provide for initial, open and special enrollment periods; and
- Evaluate options for employer participation which may conform with common insurance practices.

The corporation's Florida Health Insurance Marketplace (marketplace) currently includes individual health plans, discount plans, and limited benefit plans. The marketplace offers options

[39] *See* s. 408.910(4)(a), F.S.

that are compliant with the Patient Protection and Affordable Care Act (PPACA)[40] across the different metal ranges, dental-only plans, vision and hearing plans, telemedicine plans, discount plans, and prescription drug plans.[41] Additional marketplace platforms for group health plans for small employers and associations are planned.

Pricing for products on the marketplace must be transparent to the participants and established by the vendors. The marketplace may assess a surcharge annually of not more than 2.5 percent of the price. The surcharge must be used to support the administrative services provided by corporation and for payments to buyers' representatives.

During its most recent open enrollment – January 5, 2015, through February 15, 2015 – the corporation reported 51 total individual product enrollments covering 56 adults and children with 66 applications started. Of those that purchased coverage, 85 percent purchased individual coverage and 15 percent purchased spouse or family coverage.[42] The marketplace recorded 4,800 visits during its January open enrollment.[43]

The corporation offers a minimum of 20 plans per county from two different companies with a maximum of 46 plans in a county from six different companies as of March 2015.[44]

The Patient Protection and Affordable Care Act of 2010

In March 2010, the Congress passed and the President signed two pieces of legislation: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 that are together called PPACA.[45] Under PPACA, one of the key components required the states to expand Medicaid to a minimum national eligibility threshold of 133 percent of the FPL, or, as it is sometimes expressed, 138 percent of the FPL with application of an automatic 5 percent income disregard, effective January 1, 2014.[46] While the funding for the newly eligible under this expansion would be initially funded at 100 percent federal funds for the first three calendar years (2014, 2015, and 2016), the states would gradually be required to pay a share of the costs, starting at 5 percent in calendar year 2017 before leveling off at 10 percent in

[40] To be compliant with PPACA, plans must eliminate any pre-existing condition exclusions, annual or lifetime dollar limits on the essential benefits, prohibit recisions, provide preventive services without cost sharing, include emergency services without prior authorization, establish an appeals process, provide access to pediatricians and OB/GYNs, extend dependent coverage to age 26 and provide the essential health benefits. For a checklist, see Nat'l Assn. of Insurance Commissioners Compliance Summary: http://www.naic.org/documents/index_health_reform_ppaca_uniform_compliance_summary.pdf (last visited May 26, 2015).
[41] Florida Office of Insurance Regulation, *Cover Florida Health Care Access Program Annual Report* (March 2015), http://www.floir.com/siteDocuments/CoverFlorida2015.pdf (last visited May 26, 2015).
[42] Florida Health Choices Corporation, *Florida Health Choices Reports Zero Glitches with New Online Marketplace Launched in January* (February 20, 2015) http://www.myfloridachoices.org/florida-health-choices-reports-zero-glitches-with-new-online-marketplace-launched-in-january/ (last visited May 26, 2015).
[43] Id.
[44] Conversation with Rose Naff, CEO, Florida Health Choices, Inc.,(Mar. 9, 2015); re-confirmed via email from Rose Naff on May 26, 2015.
[45] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010) and (Pub. Law No. 111-152, 111th Cong. (Mar. 30, 2010).
[46] 42 U.S.C. s. 1396a(1).

2020.[47] As enacted, the PPACA provided that states refusing to expand to the new national eligibility threshold faced the loss of *all* of their federal Medicaid funding.[48]

Enhanced Medicaid Match Rate for Newly Eligible Only: CY 2014 and Beyond[49]							
CY	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020+**
FMAP	100%	100%	100%	95%	94%	93%	90%

Florida, along with 25 other states, challenged the constitutionality of the law. In *NFIB v. Sebelius*, the Supreme Court found the enforcement provisions of the Medicaid expansion unconstitutional.[50] As a result, states can voluntarily expand their Medicaid eligibility thresholds to PPACA standards and receive the enhanced federal match for the expansion population, but states cannot be penalized for not doing so.[51]

Since the decision in *NFIB v. Sebelius*, federal guidance has emphasized state flexibility in how states expand coverage to those defined as the newly eligible population. In a letter to the National Governors Association January 14, 2013, then-Health and Human Services Secretary Kathleen Sebelius reminded states of their ability to design flexible benefit packages without the need for waivers and the alternative benefit plans that are available.[52] This letter was preceded by the Frequently Asked Questions document on Exchange, Market Reforms and Medicaid, issued on December 10, 2012, that discussed promotion of personal responsibility, wellness benefits, and state flexibility to design benefits.[53]

Individual and Employer Mandates

A state Medicaid director letter on November 20, 2012 (ACA #21) further addressed state options for the adult Medicaid expansion group and the alternative benefit plans available under Section 1937 of the Social Security Act.[54] Under Section 1937, state Medicaid programs have the option of providing certain groups with benchmark or benchmark equivalent coverage based on four products: (1) the standard Blue Cross/Blue Shield Preferred Provider option offered to federal employees; (2) state employee coverage that is generally offered to all state employees; (3) the commercial HMO with the largest insured, non-Medicaid enrollment in the state or (4)

[47] 42 U.S.C. s. 1396d(y)(1).
[48] 42 U.S.C. s. 1396c
[49] *Supra* at Note 63.
[50] *National Federal of Independent Business (NFIB) v. Sebelius, Secretary of Health and Human Services*, 648 F. 3d 1235, affirmed in part, reversed in part.
[51] Department of Health and Human Services, *Secretary Sebelius Letter to Governors,* (July 10, 2012), http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf (last visited May 26, 2015).
[52] *Letter to National Governor's Association from Secretary Sebelius*, January 14, 2013 (copy on file with Senate Health Policy Committee).
[53] Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, pp. 15-16, http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf (December 10, 2012), (last visited May 27, 2015).
[54] Centers for Medicare and Medicaid Services, *State Medicaid Director Letter: Essential Health Benefits in the Medicaid Program* (November 20, 2012), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf (last visited May 26, 2015).

Secretary-approved coverage.[55] For children under the age of 21, the coverage must include the Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT). Other aspects of the essential health benefit requirements of the PPACA, as discussed further below, may also be applicable, depending on the benefit package utilized.

In addition to the Medicaid expansion component, the PPACA imposes a mandate on individuals to acquire health insurance or pay a tax penalty when they file their tax returns. Currently, many uninsured individuals are eligible for Medicaid or Kidcare coverage but are not enrolled. The existence of the federal mandate to purchase insurance may result in an unknown number of currently eligible individuals coming forward and enrolling in Medicaid who had not previously chosen to enroll. Their participation – to the extent it occurs – will result in increased costs that the state would not likely have incurred without the catalyst of the federal legislation.

Under the provisions, employers with more than 50 full-time employees that do not offer coverage meeting the essential benefits coverage standard and who does not offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and at least one employee receive a premium tax credit through the PPACA exchange, the employer will be assessed a fee of $2,000 per full time employee, with the first 30 employees, including those who have minimum essential coverage.[56] Or, if an employer does offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and at least one employee receives a premium tax credit through the federal exchange because the employer's coverage was not affordable, did not provide minimum value, or because the employee was not one of the 95 percent of the employees offered coverage, the employer is assessed the lesser of $3,000 per employee receiving the credit.[57] The large employer can only be assessed under one of the scenarios, not both.

Like individuals, certain employers also have a shared responsibility under the PPACA beginning January 1, 2015. This responsibility was slated to start in 2014 under the PPACA; however, the Department of Treasurer and the Internal Revenue Service provided transition relief in 2014 for:

- Information reporting requirements applicable to insurers, self-insuring employers and certain other providers of minimum essential coverage;
- Information reporting requirements applicable to large employers; and
- Employer shared responsibilities.[58]

The notice indicates the delay is intended to give additional time to provide input by employers and other reporting entities and to allow all parties to adapt their reporting systems. The transition relief states that it has no impact on other PPACA provisions.[59]

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[55] Id.
[56] Internal Revenue Service, *Employer Shared Responsibilities Provisions,* http://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions (last visited May 26, 2015).
[57] Id.
[58] Internal Revenue Service, Not-129718-13, *Transition Relief for 2014 Under §§6055 (§6055 Information Reporting), §6056 information Reporting) and 4980H (Employer Responsibility Provisions), http://www.irs.gov/pub/irs-drop/n-13-45.pdf* (last visited May 26, 2015).
[59] Id.

Individuals may be exempt from the requirement to acquire minimum essential coverage if the minimum amount the individual must pay for that coverage is more than 8 percent of his or her household income or he or she qualifies to receive a hardship exemption.[60] Some of the reasons that may qualify an individual for a hardship exemption include, but are not limited to:

- Being ineligible for Medicaid because the individual lives in a state that decided not to expand Medicaid under the PPACA;
- Spending less than three consecutive months without minimum essential health coverage;
- Buying coverage would pose a hardship;
- Having gross income below the applicable tax return filing threshold;
- Finding no affordable coverage on the exchange that meets the minimum value standard; and
- Being eligible for services through Indian Health Care Services.[61]

The Internal Revenue Service releases a rule every year setting the tax penalty for the lack of minimum essential coverage. For 2014, the annual payment amount is the greater of:

- One percent of your household income that is above the tax return filing threshold for your filing status, or
- Your family's flat dollar amount, which is $95 per adult and $47.50 per adult, limited to a family maximum of $285.[62]

The amount is calculated based on the national average for a premium payment for a bronze level health plan in the exchange for 2014. For 2014, the annual national average premium for a bronze level health plan was $2,448 per individual, but $12,240 for a family with five or more members.[63]

Exchanges

A health insurance exchange is intended to create an organized and competitive market for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the health care options available to them.[64] To facilitate coverage, the PPACA authorized the state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges. These exchanges can be administered by governmental agencies or non-profit organizations. The exchanges, at a minimum, must:[65]

- Certify, re-certify and de-certify plans participating on the exchange;
- Operate a toll-free hotline;
- Maintain a website;

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[60] Internal Revenue Service, *Individual Shared Responsibility Provision*, *http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision* (last visited May 26, 2015).
[61] Id.
[62] Internal Revenue Service, *Individual Shared Responsibility Provision - Reporting and Calculating the Payment*, http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment (last visited May 26, 2015).
[63] Id.
[64] Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Exchanges* (April 2010) https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7908-02.pdf (last visited May 26, 2015).
[65] Centers for Medicare and Medicaid Services, *Initial Guidance to States on Exchanges*, (November 18, 2010), http://www.cms.gov/CCIIO/Resources/Files/guidance_to_states_on_exchanges.html (last visited May 26, 2015).

- Provide plan information and plan benefit options;
- Interact with the state's Medicaid and CHIP programs and provide information on eligibility and determination of eligibility for these programs;
- Certify individuals that gain exemptions from the individual responsibility requirement; and,
- Establish a navigator program.

On November 16, 2012, Florida Governor Rick Scott notified then-HHS Secretary Sebelius that Florida had too many unanswered questions to commit to a state-based exchange under the PPACA for the first enrollment period on January 1, 2014.[66] Florida has since opted to use the federal exchange.

Qualifying coverage may be obtained through an employer, the federal exchange, or private individual or group coverage outside of the federal exchange meeting the minimum essential benefits coverage standard.

Exchange Benefits

Each plan sold in the federal exchange must include the "essential health benefits" as defined by the 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 abuse 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

Qualified Health Plans

In order to receive a health care tax credit, an individual must be enrolled in a qualified health plan.[67] Qualified health plans are certified by the federal exchange and meet specific requirements:

- Provide essential health benefits;
- Follow the established limits on cost sharing; and
- Meet all other requirements.[68]

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[66] *Letter from Governor Rick Scott to Health and Human Services Secretary Kathleen Sebelius,* (November 16, 2012) http://www.flgov.com/2012/11/16/letter-from-governor-rick-scott-to-u-s-secretary-of-health-and-human-services-kathleen-sebelius/ (last visited May 26, 2015).
[67] Internal Revenue Service, *Health Care Tax Credits: Qualified Health Plan Requirements*, http://www.irs.gov/Individuals/HCTC:-Qualified-Health-Plan-Requirements (last viewed May 26, 2015).
[68] U.S. Department of Health and Human Services, Healthcare.gov, *Qualified Health Plan*, *https://www.healthcare.gov/glossary/qualified-health-plan/* (last viewed May 26, 2015).

These plans are available on the federal exchange or may also be available directly from an insurance company or one of the state's qualified health plans.[69]

Each plan sold must also be one of the following actuarial values[70] or "metal levels:"
- Bronze: 60 percent actuarial value;
- Silver: 70 percent actuarial value;
- Gold: 80 percent actuarial value; and
- Platinum: 90 percent actuarial value.

Premium Tax Credits and Cost Sharing Subsidies

Premium credits and other cost sharing subsidies are available to United States citizens and legal immigrants within certain income limits for coverage purchased through the exchange. Legal immigrants with incomes at or below 100 percent of the FPL who are not eligible for Medicaid are eligible for premium credits.[71] Premium credits are set on a sliding scale based on the percent of FPL for the household and reduce the out-of-pocket costs incurred by individuals and families.

The amount for premium tax credits, as a percentage of income, are set in section 36B of the Internal Revenue Code follows:[72]

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

In addition to subsidies for the costs of health insurance premiums, individuals may also qualify to offset other out-of-pocket costs through cost sharing credits. Subsidies for cost sharing are available for those individuals between 100 percent of the FPL and 400 percent of the FPL. The cost sharing credits reduce the out-of-pocket amounts incurred by individuals on essential health benefits and will also impact the actuarial value of a health plan. Actuarial value reflects the average share of covered benefits paid by the insurer or health plan. For example, if the actuarial value of a plan is 90 percent, the health plan is paying 90 percent of the costs and the enrollee 10 percent.

[69] Id.
[70] Actuarial value is calculated by computing the ratio of total expected payments by the plan for essential health benefits and costing 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 70 percent would be expected to pay an average of 70 percent of the standard population's expected medical expenses for the essential health benefits. Individuals covered by the plan would then be expected to pay the remaining 30 percent, on average through cost sharing such as deductibles, co-pays and co-insurance.
[71] 26 U.S.C. s. 36B(c).
[72] 26 U.S.C. s. 36B(b).

The maximum amount of cost sharing is 94 percent for those individuals between 100 percent and 150 percent FPL and individuals with incomes up to 400 percent FPL who may qualify for a 70 percent subsidy as the table below illustrates.

Cost Sharing Subsidies[73]	
FPL Level	**Cost Sharing Subsidy**
100% - 150%	94%
150% - 200%	87%
200% - 250%	73%
250% - 400%	70%

Cost sharing limitations are based on the limits placed on Health Savings Accounts under the Internal Revenue Code.[74] The maximum out of pocket costs for any federal exchange plan in 2015 are $6,600 for an individual and $13,200 for a family plan, even with a catastrophic plan.[75]

In addition to enrolling individuals into qualified health plans, an exchange may also determine eligibility for Medicaid and CHIP. The exchange also determines if an individual is eligible for advance premium tax credits and cost sharing reductions.

High Deductible Plans

High deductible plans are paired with health savings accounts.[76] 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 the employee make annual contributions[77] to a limit of $3,250 for single coverage and $6,250 for family coverage. For 2014, total out-of-pocket spending was capped at $6,350 for individual and $12,700 for family.[78] For calendar year 2015, the annual deductible for a high deductible plan is defined as an amount not less than $1,300 for self-only coverage or $2,600 for family coverage. The annual out of pocket expenses do not exceed $6,450 for self-only coverage or $12,900 for family coverage.[79] Amounts are adjusted annually based on inflation by the Internal Revenue Service.

The employer and the 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.

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[73] 42 U.S.C. s. 18071(c)(1)(B)
[74] CFR 45 §126.130; *See also* Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended for self only coverage for 2014; or for other than self-only coverage, the annual dollar amount in section 223(c)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended, for non-self only coverage that is in effect for 2014.
[75] U.S. Department of Health and Human Services, healthcare.gov, *Out of pocket costs,* https://www.healthcare.gov/choose-a-plan/out-of-pocket-costs/ (last visit May 26, 2015).
[76] Internal Revenue Code, 26 U.S.C. sec. 223.
[77] The IRS annually sets the contribution limit as adjusted by inflation.
[78] Internal Revenue Services, *Health Savings Accounts and Other Tax-Favored Health Plans (Pub. 969)(2013)* http://www.irs.gov/publications/p969/index.html (last visited May 26, 2015).
[79] Internal Revenue Services, *2015 Inflation Adjusted Items for Health Savings Accounts,* http://www.irs.gov/pub/irs-drop/rp-14-30.pdf (last viewed May 26, 2015).

Alternative Medicaid Expansion in Other States

Arkansas

Arkansas received approval for a Medicaid Section 1115 demonstration waiver to implement its Medicaid expansion in September 2013. Under its waiver, Arkansas uses Medicaid funds as premium assistance to purchase coverage in the federal exchange for its newly eligible adults up to 138 percent FPL. All newly eligible adults will primarily purchase coverage and enroll in a plan through the federal exchange to receive their coverage. Any services not covered through their plans are provided through the state's fee-for-service Medicaid delivery system.[80]

Individuals excluded from enrolling in the federal exchange include American Indians or Alaskan Natives and the medically frail, who may receive services directly through the state. For all other enrollees affected by the demonstration, enrollment in a QHP is a condition of receiving benefits.[81]

Arkansas' Approved Monthly Premiums - Medicaid Expansion Waiver[82]		
Less than 50%	**50% - 100%**	**100 - 138% FPL**
None	$5 to IA	$10-$25 to IA

All beneficiaries with incomes between 50 percent and 133 percent of the FPL will be assigned an Independence Account (IA). The individual will receive a credit or debit card to access the amounts in that account to cover copayments and coinsurance. Both the state and the participant are required to make contributions to this account.[83]

The state pays the managed care plans selected by the beneficiaries directly and identification cards are sent by the plan directly to a new enrollee. Individuals who do not make a selection are auto-assigned to a silver-level plan and are given 30 days to change plans.

Enrollees under 50 percent of the FPL have no additional cost sharing. Those enrollees above 50 percent of the FPL have cost sharing consistent with Medicaid requirements that does not exceed more than 5 percent of family monthly or quarterly income.[84]

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[80] Centers for Medicare and Medicaid Services, *Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration Fact Sheet*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-fs.pdf (last visited May 26, 2015).
[81] Centers for Medicare and Medicaid Services, Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration, pp.14-15, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (last visited May 26, 2015).
[82] Centers for Medicare and Medicaid Services, Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration, pp.7 & 21, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (last visited May 26, 2015).
[83] Centers for Medicare and Medicaid Services, Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration, p.7, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (last visited May 26, 2015).
[84] Id at 16.

Iowa

In December 2013, Iowa received approval for two Medicaid waivers for implementation of its Medicaid expansion under the PPACA. The waivers cover all newly eligible adults statewide up to 138 percent of the FPL and does so under two delivery systems:

- Expands Medicaid for those at or below 100 percent FPL through Medicaid managed care; and
- Expands Medicaid for those above 100 percent FPL to 138 percent FPL by purchasing silver-level qualified health plan coverage in the exchange.

Premiums were not imposed during the first year of the program but will be in the second year for enrollees above 50 percent of the FPL. Enrollees have the opportunity to have the premiums waived if they complete healthy behaviors, and the premiums can continue to be waived in subsequent years if enrollees meet requirements for the incentives. At the state's option, the non-payment of a premium can result in a collectible debt but not a loss of coverage.[85]

Iowa's Approved Monthly Premiums - Medicaid Expansion Waiver		
Less than 50% FPL	**50% - 100% FPL**	**100 - 133% FPL**
None	$5/household	$10/household
90 day premium grace period		

Individuals in the Wellness Plan (Medicaid Managed Care) receive a Medicaid alternative benefits plan that is at least equivalent to the state employee benefit plan, except for an enhanced dental plan with access to additional dental benefits with prior authorization.[86] Those in the exchange plan receive an essential health benefit plan that is at least equivalent to those provided on the commercial essential health benefits benchmark.[87] Wrap-around services are provided by the Medicaid agency for family planning services at non-network providers and for EPSDT services for 19 and 20 year old enrollees. Iowa is not required to provide non-emergency transportation. The waiver was initially granted in year one of the demonstration and continued through July 31, 2015.[88]

Indiana

An amendment to Indiana's existing Medicaid demonstration, Healthy Indiana Plan 1.0 (HIP) was approved on January 27, 2015, and renamed the Healthy Indiana Plan 2.0. HIP 2.0 extends Medicaid to adults through 133 of the FPL beginning February 1, 2015. Under HIP 2.0, Indiana will offer three different pathways to coverage:

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[85] Centers for Medicare and Medicaid Services, Special Terms and Conditions with Iowa Department of Human Services - Iowa Wellness Plan (11-W-00289/5) http://dhs.iowa.gov/sites/default/files/WellnessSTCsTechnicalCorrections_020215.pdf (last visited May 26, 2015).

[86] Iowa Department of Human Services, Medicaid 1115 Waiver Application, Iowa Wellness Plan, p.5, http://dhs.iowa.gov/sites/default/files/IAWellnessPlan1115_Final.pdf (last visited May 26, 2015).

[87] Iowa Department of Human Services, Medicaid 1115 Waiver, Iowa Marketplace Choice Plan, p.5, http://dhs.iowa.gov/sites/default/files/IAMktplaceChoice1115_Final.pdf (last visited May 26, 2015)

[88] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Iowa Marketplace Choice Plan - Section 1115 Demonstration Fact Sheet, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-fs.pdf* (last visited: May 26, 2015).

- HIP Basic - an ABP for individuals that includes all of the essential health benefits and does not require a premium payment;
- HIP Plus - a comprehensive ABP for individuals who contribute to a POWER account with additional benefits not available in HIP Basic; and
- HIP Link Program - a voluntary premium assistance program for individuals above age 21 with access to cost effective employer sponsored insurance that meets qualification criteria.[89]

Indiana does not offer non-emergency transportation for the first year of the demonstration.

In addition to health benefits coverage, individuals who contribute to a Personal Wellness and Responsibility (POWER) account have access to additional benefits. Contributions to a POWER account are a condition of eligibility for those with incomes above 100 percent of the FPL.[90] Funds in the POWER accounts are used to pay for some of beneficiaries' health care expenses. With the exception of inappropriate use of the emergency room fee, no other cost sharing is charged under the HIP Plus component.

Those enrolled in HIP Basic are subject to copayments. These copayments are consistent with the Medicaid cost sharing rule and must include the automated tracking of the 5 percent monthly or quarterly aggregate cap. Indiana had the following co-payments approved:

Indiana HIP Basic Co-Pay Schedule[91]	
Service	**Per Visit/Service**
Preventive Care Services (including family planning and maternity services)	$0
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-Preferred Drugs	$8
Non-Emergent ER Use (HIP Basic and HIP Plus)	$8 - 1st visit $25 - Recurrent

Enrollees above 100 percent of the FPL who do not make contributions or who cease transition to the HIP Basic program after a 60-day grace period are disqualified from the HIP Plus program for six months.[92] There are exceptions to the lock-out period for the medically frail and other special circumstances.

[89] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Healthy Indiana Plan 2.0 Section 1115 Medicaid Demonstration Fact Sheet (January 27, 2015)*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-fs.pdf (last visited: May 26, 2015).
[90] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Healthy Indiana 2.0" Approval Letter and Special Terms and Conditions (January 27, 2015) http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf (last visited May 26, 2015).
[91] Id at 35 and 36.
[92] Id.

Indiana Maximum Monthly POWER Contributions[93]					
<5% FPL	**<22%**	**22% - 50%**	**51% - 75%**	**76% - 100%**	**101%-138%**
$1	$4.32	$9.82	$14.72	$19.62	$27.39
- Represents approximately 2% of enrollee's income; - When enrollee leaves the program, the member amount is refunded to the member; and - When enrollee remains in the program, the member portion rolls over at the end of the year; can double if member completes required preventive services.					

The POWER accounts function like a health savings account and hold both beneficiary and state contributions. The POWER account funds pay for the first $2,500 in claims; claims beyond that amount are covered through capitation or other payments made by the state.[94] The funds are not for copayments under the HIP Plus accounts. For HIP Link enrollees, the POWER account funds are used to pay premium and cost sharing amounts.[95]

Employers and other third parties are also permitted to contribute to POWER accounts. It is the managed care organization's responsibility to issue the POWER card to each enrollee upon enrollment and to track all of the contributions.[96]

Outside of this demonstration, Indiana will offer a separate work search and job training program to encourage employment called Gateway to Work for those enrollees who choose to participate. Health coverage under Medicaid will not be affected.[97]

III. Effect of Proposed Changes:

Implementation of the FHIX program is contingent upon federal approval. Phase One is planned to start no later than January 1, 2016. To be eligible, an enrollee must be "newly eligible," meet the work or educational requirements, learn and be informed of the FHIX marketplace and federal exchange plan choices, execute a DCF contract, select plans in a timely manner, comply with all program rules and prohibitions, make monthly premium payments and any other cost sharing payments, and meet minimum coverage requirements. A newly eligible enrollee will be provided a premium credit equivalent to the applicable risk-adjusted capitation rate paid to the Medicaid managed care plans with which to purchase health care benefits on the FHIX marketplace.

Phase Two begins no later than July 1, 2016, with the transition of Healthy Kids enrollees to the FHIX marketplace or federal exchange. Healthy Kids enrollees must meet the eligibility requirements and be eligible for the Healthy Kids program under s. 624.91, F.S. A Healthy Kids enrollee who selects a FHIX marketplace or exchange plan will be provided a premium credit equal to the average capitation rate paid in his or her county of residence in the Healthy Kids program as of June 30, 2016. An enrollee will be responsible for any difference in costs. Any

[93] Healthy Indiana Plan 2.0, Presentation to Senate Health Policy Committee (March 4, 2015), slides 16 & 17 (on file with the Senate Committee on Health Policy).
[94] *Supra* Note 108, at 26.
[95] Id.
[96] *Supra* Note 108, at 30.
[97] *Supra* Note 108, at 3.

unexpended funds from the premium credit may be used on the FHIX marketplace for supplemental benefits.

Florida Health Insurance Affordability Exchange Program (Sections 1-14)

The bill directs the Division of Law Revision and Information to rename part II of chapter 409, Florida Statutes, as "Insurance Affordability Programs," instead of "Kidcare," and to incorporate the newly created sections of ss. 409.72-409.731, F.S., under this part. The "Florida Health Insurance Affordability Exchange Program" or "FHIX" is established under ss. 409.72 through 409.731, F.S., as a new program under part II of ch. 409, F.S.

The FHIX program is placed within the Agency for Health Care Administration (AHCA or agency) for the purpose of assisting Floridians in purchasing health benefits coverage and gaining access to health services. The FHIX is based on seven principles:

- Fair Value;
- Consumer Choice;
- Simplicity;
- Portability;
- Employment;
- Consumer Empowerment; and
- Risk Adjustment.

Definitions specific for the FHIX program are:

- "Agency" means the Agency for Health Care Administration;
- "Applicant" means an individual who applies for determination of eligibility for health benefits coverage under this part;
- "Corporation" means Florida Health Choices, Inc.;
- "Enrollee" means an individual who has been determined eligible for and is receiving health benefits coverage under this part;
- "FHIX marketplace" or "marketplace" means the single, centralized market established under ss. 409.72-409.731, F.S.;
- "Florida Health Insurance Affordability Exchange" or "FHIX" means the program created under ss. 409.72-409.731, F.S.;
- "Federal exchange or "exchange" means an insurance platform regulated by the Federal government which offers tiers of health plans from the least comprehensive to the most comprehensive plans;
- "Florida Healthy Kids Corporation" means the entity created under s. 624.91, F.S.;
- "Florida Kidcare Program" or "Kidcare" means the program created under ss. 409.810-409.821, F.S.;
- "Health benefits coverage" means the payment of benefits for covered health care services or the availability, directly or through arrangements with other persons, of covered health care services on prepaid or per capita basis or a prepaid aggregate fixed sum basis;
- "Inactive status" means the enrollment status of a participant previously enrolled in health benefits coverage in the FHIX marketplace, who lost coverage through non-compliance pursuant to s. 409.723, F.S., but who maintains access to his or her balance in a health savings account or health reimbursement account;

- "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and part III and IV of ch. 409, F.S., as administered by the AHCA;
- "Modified adjusted gross income" means the individual's or household's adjusted gross income as defined in s. 36B(d)(2) of the Internal Revenue Code of 1986 and which is used to determine eligibility for FHIX;
- "Patient Protection and Affordable Care Act" or "Affordable Care Act" means Public Law No. 111-148, as further amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and amendments to, and regulations or guidance under, those acts;
- "Premium credit" means the monthly amount paid by the AHCA per enrollee in the FHIX toward health benefits coverage;
- "Qualified alien" means an alien as defined in 8 U.S.C. s. 1641(b) or (c);[98] and
- "Resident" means a United States citizen or qualified alien who is domiciled in this state.

Eligibility

In order to participate in the FHIX, s. 409.723, F.S., requires that an individual must be a resident and must also meet the following requirements, as applicable:

- Qualify as a newly eligible enrollee as described in s. 1902(a)(10)(A)(i)(VIII) of the Social Security Act or s. 2001 of the Affordable Care Act and as may be further defined by federal regulation;
- Meet and maintain the responsibilities under participant responsibilities; and
- Qualify as a participant in the Florida Healthy Kids program under s. 624.91, F.S., subject to the implementation of Phase Two under s. 409.727, F.S.

A "newly eligible enrollee" as described above is an adult between the ages of 19 and 64 whose income is at or below 133 percent of the FPL based on a modified adjusted gross income or MAGI. This includes parents and childless adults who may not have previously qualified for Medicaid.

Enrollment

To enroll in FHIX, applicants will apply using the same process used today for Medicaid eligibility through the DCF. The DCF is responsible for processing applications, determining eligibility and transmitting information to the corporation. An application is only deemed complete when it has met all of the requirements under participant responsibilities.

The DCF is also be responsible for corresponding with the participant on an ongoing basis regarding the participant's status and reviewing the eligibility status at least every 12 months.

Participant Rights

A participant has certain rights under FHIX:

[98] "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.

- Access to the FHIX marketplace or federal exchange to select the scope, amount, and type of health care coverage and services to purchase;
- Continuity and portability of coverage to avoid disruption of coverage and other health care services when the participant's economic circumstances change;
- Retention of unspent credits in the participant's health savings or health reimbursement account following a change in the participant's eligibility status. Credits are maintained for an inactive status participant for up to five years after the participant enters inactive status;
- Ability to select more than one product or plan on the FHIX marketplace or federal exchange; and
- The choice of at least two health benefits products that meet the requirements of the Affordable Care Act.

Participant Responsibilities

A participant under the FHIX program also has certain responsibilities to enroll or remain enrolled or in active status:

- Complete an initial application for health benefits coverage and annual renewal process that includes proof of employment, on-the-job training, or job placement activities that are verified through CareerSource Florida, or pursuit of educational opportunities at certain hourly levels;
- Learn and remain informed about the choices available on the FHIX marketplace or federal exchange and the uses of credits in the individual accounts;
- Execute a contract with the DCF that acknowledges that FHIX is not an entitlement, state and federal funding may end at any time, failure to pay cost sharing may result in a transition to inactive status, and noncompliance with other requirements may also result in a transition to inactive status;
- Select plans and other products in a timely manner;
- Comply with program rules and prohibitions against fraud;
- Make monthly premium payments and other cost sharing payments by their respective deadlines; and
- Meet minimum coverage requirements by selecting a high deductible health plan combined with a health savings or health reimbursement account or a combination of plans or products with an actuarial value that meets or exceeds benefits available under the federal exchange if not selecting a plan with more extensive coverage.

Minimum hourly levels will vary by a participant's individual circumstances in order to maintain an active status in the FHIX. For a parent of a child younger than 18, the minimum hourly requirements for pursuit of these activities or employment is 20 hours weekly. For a childless adult, the minimum weekly hourly requirement is 30. A disabled adult or the caregiver of a disabled child or adult may seek an exemption from these requirements through the corporation on an annual basis.

The bill provides a definition for the term "disabled" for purposes of this section to mean any person who has one or more permanent physical or mental impairments that substantially limit his or her ability to perform one or more major life activities, as defined by the Americans with Disabilities Act, without receiving more than 8 hours of assistance per day.

Cost Sharing

Enrollees are required to make monthly premium payments to maintain their health benefits coverage on the FHIX marketplace. Premiums are assessed based on the enrollee's modified adjusted gross income as a percentage of the FPL and the maximum monthly premiums are as follows:

FPL	**at or <22**	**>22% - 50%**	**>50%-75%**	**>75%-100%**	**>100%**
Amount	$3	$8	$15	$20	$25

Depending on the products and services selected by the enrollee, he or she may incur additional cost sharing, such as copayments, deductibles, or other out-of pocket costs. An enrollee may also be charged an emergency room fee of $8 for the first visit and up to $25 for any subsequent non-emergency visit, based on the plan selected by the enrollee. Cumulative annual cost sharing, however, may not exceed 5 percent of the enrollee's annual modified adjusted gross income.

If after a 30-day grace period, a full premium payment has not been received, the enrollee will be transitioned to an inactive status and may not re-enroll to active status for 6 months, unless a hardship exemption has been granted under the Medicaid Fair Hearing Process.

Available Assistance

Under s. 409.724, F.S., participants under the FHIX receive a standard credit amount equivalent to the applicable risk-adjusted capitation rate paid to Medicaid managed care plans. Subject to federal approval, additional resources could be made available to supplement the standard credit amount and be made available to FHIX enrollees in the future and incorporated into the FHIX.

In addition to the standard health benefits provided, the corporation must also offer each enrollee access to an individual account that qualifies as a health reimbursement or health savings account. Unexpended funds from the monthly premium credit may be placed in the account, as well as potential credits earned from healthy behaviors, adherence to wellness plans, or compliance with disease management plans. Funds in these accounts may be used to pay cost sharing obligations or to purchase other health-related items, as permitted under federal and state law. This account may be retained for up to 5 years after a participant moves into inactive status.

The enrollee or other third parties may also make contributions to the enrollee's account to supplement the premium credit or other earned credits. The enrollee may not withdraw as a refund any funds except those funds the enrollee has deposited into his or her own account.

The choice counseling program for the FHIX will be coordinated by the AHCA, in consultation with the Florida Healthy Kids Corporation and the corporation for the FHIX. The choice counseling program must ensure the enrollees have information about the FHIX marketplace program, the products and services, and whom to call for questions or to make plan selections. The program will also provide culturally sensitive materials that take into consideration the projected participating populations. The corporation is also required to encourage licensed insurance agents to identify and assist eligible enrollees. The bill provides that the act does not prohibit insurance agents from receiving usual and customary commissions from insurers and health maintenance organizations that offer plans in the FHIX marketplace.

The AHCA, the corporation, and the Florida Healthy Kids Corporation must coordinate an ongoing education campaign that includes :

- How the FHIX marketplace operates and the timelines for enrollment;
- Plans that are available and how to research information about available plans;
- Information about other available insurance affordability programs for the individual and his or her family;
- Information about health benefits coverage, provider networks, and cost sharing for available plans in each region;
- Information on how to complete the required annual renewal process, including renewal dates and deadlines; and
- Information on how to update eligibility if the participant's data have changed since his or her last renewal or application date.

Beginning January 1, 2016, the Florida Healthy Kids Corporation will provide customer support for the FHIX marketplace. Customer support will include:

- A toll-free number;
- A web site in multiple languages;
- General program information;
- Financial services information, including enrollee premium collection; and
- Customer service and status reports on enrollee premiums;

The corporation is required to notify enrollees of their premium credit amounts and how to access the FHIX marketplace selection process. Customer service and choice counseling services will also be provided.

The corporation is also required to inform participants who transition to inactive status about other insurance affordability options and to electronically refer such enrollees to the federal exchange or other programs, as appropriate.

Available Products and Services

Section 409.725, F.S., requires the FHIX marketplace to offer the following products and services:

- Authorized products and services that are offered on the Florida Health Choices, Inc., marketplace (409.910, F.S.);
- Products authorized by the federal exchange;
- Authorized products by the Florida Healthy Kids Corporation; and
- Premium credits for Employer-sponsored plans.

Program Accountability

The plans and products that participate in FHIX will be required to meet certain accountability standards under s. 409.726, F.S. All managed care plans must collect and maintain encounter data in the same manner as under Statewide Medicaid Managed Care and will be subject to the

accompanying penalties under s. 409.967(2)(h)2, F.S., for the failure to meet those standards. The AHCA will be responsible for the collection and maintenance of that data.

The corporation, in consultation with the AHCA will work together to develop network and access standards for FHIX contract standards and to develop coverage quality standards for the adult population.

The bill establishes specific performance standards for the DCF for the processing of applications, both initial applications and renewals. The AHCA, the DCF, and the Florida Healthy Kids Corporation must conduct an annual satisfaction survey for the FHIX marketplace which may be incorporated into the annual report. Enrollment reports must be posted online monthly.

Beginning in 2016, an annual report is due no later than July 1 to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The minimum components of the report include enrollment and application data, customer satisfaction, utilization and cost data, enrollee use of funds in reimbursement accounts, types of plans and products purchased, and recommendations for program improvement.

Implementation Schedule

The implementation schedule for the FHIX is based on each phase passing a readiness review before implementation under s. 409.727, F.S. The AHCA is identified as the lead agency for the FHIX, as the state's designated Medicaid agency. The AHCA, the corporation, the DCF, and the Florida Healthy Kids Corporation are directed to begin implementation upon CS/SB 2-A becoming law, with enrollment in the FHIX marketplace for Phase One beginning by January 1, 2016 and availability in all regions by July 1, 2016.

Implementation Activities			
Phase	**Start Date**	**Activities**	**Enrollee Requirements**
Readiness	Effective Date - Ongoing Based on Phase/Region	**Implementation Activities** -The AHCA initiates waiver application and approval process -The Corporation readies for implementation of FHIX marketplace -Healthy Kids prepares for customer service and financial services support in Phases One and Two; continuation of Title XXI eligibility determination services -Agency prepares for choice counseling services -Department prepares for FHIX eligibility determination services	None

Implementation Activities			
Phase	**Start Date**	**Activities**	**Enrollee Requirements**
One	January 1, 2016*	1. Enroll newly eligible, low-income, uninsured into FHIX. 2. Healthy Kids prepares to transition enrollees health plan coverage to FHIX starting July 1, 2016. 3. Agency updates choice counseling materials for Healthy Kids enrollees. 4. Eligibility system adjusts for children participants.	-Complete application -Meet work or educational requirements or seek an exemption -Select plans products, or services from FHIX or federal exchange -Execute enrollee contract -Pay required premium or transition to inactive status -Comply with program rules -Meet minimum coverage requirements -Begin using health savings or health reimbursement account, if applicable
Two	July 1, 2016*	1. Healthy Kids transitions enrollees to health care coverage under FHIX 2. Healthy Kids continues to determine eligibility for Title XXI enrollees	-Complete application -Meet work or educational requirements or seek an exemption -Pay required premium or transition to inactive status -Select plans products, or services from FHIX or federal exchange -Execute enrollee contract -Comply with program rules -Meet minimum coverage requirements -Utilize health savings or health reimbursement account -Healthy Kids enrollees transition health plan coverage to FHIX marketplace or federal exchange plan

**Phases One and Two implementation dates are contingent upon federal approval*

Under s. 409.729, F.S., a FHIX Workgroup is created to facilitate the implementation of the FHIX program and to plan for a reorganization of the state's insurance affordability programs. The Workgroup is chaired by a representative of the AHCA and includes two additional representatives from the AHCA, plus two representatives each from the DCF, the corporation, and the FHKC.

Before implementation of any phase or in any region, the AHCA shall conduct a readiness review in consultation with the FHIX Workgroup. The AHCA must determine that the region has satisfied the following milestones, at a minimum:

- Functional readiness of the service delivery platform for the phase;
- Plan availability and presence of plan choice;
- Provider network capacity and adequacy of the available plans in the region;
- Availability of customer support; and
- Other factors critical to the success of FHIX.

Implementation of FHIX begins on the effective date of this act with enrollment for Phase One starting by January 1, 2016. The AHCA, corporation, department, and the Florida Healthy Kids Corporation are required to coordinate implementation activities.

Activity	**Phase One**	**Phase Two**
Eligibility Determination	DCF	DCF & Healthy Kids
Benefits/Plan Delivery	FHIX & Exchange	FHIX & Exchange
Choice Counseling	AHCA	AHCA
Customer Service	Healthy Kids	Healthy Kids
Financial Service	Healthy Kids	Healthy Kids
Program Oversight	AHCA	AHCA

Program Operation and Management

In order to implement the FHIX program, several agencies and two non-profit corporations created by the state have specific responsibilities under the newly created s. 409.728, F.S.:

Specific Program Operations and Management Duties for FHIX			
Agency for Health Care Admin.	**Dept. of Children and Families**	**Florida Health Choices, Inc.**	**Florida Healthy Kids**
Contract with Fla Health Choices for FHIX for implementation, development and administration and release of funds	Coordinate with other agencies and corporations	Begin implementation of FHIX in Readiness Phase.	Retain duties in Phase One.
	Determine eligibility initially and at annual renewal	Implement FHIX for Phase One and Two	Provide customer service to FHIX
Provide administrative support to FHIX Workgroup	Transmit eligibility determinations to AHCA and corporation	Offer health benefits coverage compliant with PPACA	Collect and transfer family funds to FHIX
		Offer at least 2 plans at each metal level	Conduct financial reporting

Specific Program Operations and Management Duties for FHIX			
Agency for Health Care Admin.	**Dept. of Children and Families**	**Florida Health Choices, Inc.**	**Florida Healthy Kids**
Transmit enrollee information to FHIX		Provide opportunity for enrollees to participate on federal exchange	Coordinate activities with partner agencies
Determine risk adjusted rates annually based on specific statutory criteria		Offer enhanced or customized benefits	Continue to conduct Title XXI eligibility
Transfer funds to FHIX for premium credits		Provide sufficient staff and resources	
		Provide opportunity for Healthy Kids plans to participate at FHIX	
Consult with stakeholders that serve low-income individuals and families, using a public input process		Provide opportunity for enrollees to use premium credits towards employer sponsored plans	
Adopt rules in consultation with other partners to accommodate a seamless transition		Encourage insurance agents to identify and assist enrollees	
Conduct choice counseling			

Long Term Reorganization

The FHIX Workgroup is required to hold its first organizational meeting within 30 days after the effective date of this act and to meet at least bimonthly. The responsibilities of the Workgroup include:

- Develop and present a final implementation plan no later than November 1, 2015 to the Governor and Legislature;
- Review network and access standards for plans and products;
- Assess readiness and recommend actions needed to reorganize the state's insurance affordability programs for each phase or region;
- Recommend any proposed change to Title XIX-funded or Title XXI-funded programs based on the availability of federal funding;

- Identify duplication of services among the corporation, the AHCA, and the FHKC currently and under FHIX's proposed Phase Two program;
- Evaluate fiscal impacts based on proposed Phase Two transition plan;
- Compile a schedule of impacted contracts, leases, and other assets; and
- Determine staff requirements for Phase Two.

Legislative Review

The bill authorizes the AHCA to seek federal approval to implement FHIX. However, the agency is prohibited from implementing FHIX without specific legislative approval unless the terms and conditions of any approved waiver for FHIX are substantially consistent with the statutory requirements of this program.

Program Expiration

The bill establishes triggers for expiration of the FHIX program under certain conditions. FHIX expires at the end of the state fiscal year in which any of these conditions occur:

- Federal match contribution for the newly eligible under the Affordable Care Act falls below 90 percent;
- Federal match contribution falls below the increased Federal Match Assistance Percentage for medical assistance for newly eligible mandatory individuals as specified in the Affordable Care Act; or
- Federal match for the FHIX program and the Medicaid program are blended under federal law or regulation in such a manner that causes the overall federal contribution to diminish when compared to separate, non-blended federal contributions.

Florida Health Choices Program (Section 15)

The bill revises s. 408.910, F.S., to recognize the role the corporation will play in the FHIX marketplace. The bill makes the necessary changes to authorize the corporation to offer the products and services to the newly eligible population under the FHIX.

Definitions are added to include the "Florida Health Insurance Affordability Exchange Program" or "FHIX" and the "Patient Protection and Affordable Care Act" or "Affordable Care Act."

Two new services have been added to the list of services to individual participants that the corporation currently provides:

- Health benefits coverage information about health insurance plans compliant with the Affordable Care Act; and
- Consumer assistance with web-based information services for the FHIX.

The bill includes a modification that recognizes that not all enrollees may have the option of payroll deduction. The bill clarifies that surcharges may not be assessed on products or services sold on the FHIX marketplace. A separate reference to the FHIX marketplace has been created within the statute from the existing Florida Health Choices marketplace to distinguish the process, enrollment periods, and differing limits.

Authority has been granted to the corporation to collect contributions from third parties and governmental entities, to administer the FHIX program, and to coordinate with the AHCA, the DCF and FHKC on the transition plan for FHIX and any subsequent transition activities. Participation in the FHIX marketplace may begin at any time and is not limited to an open enrollment period.

Florida Healthy Kids Corporation (Sections 17 and 18)

The bill revises s. 624.91, F.S., the "William G. 'Doc' Myers Healthy Kids Corporation Act." Obsolete language is deleted throughout the act.

Healthy Kids' authorizations, duties, and powers are amended to include:

- Collect premiums for the Florida Health Insurance Affordability Exchange program;
- Contract with other insurance affordability programs and FHIX to provide customer service other enrollment-focused services;
- Develop performance metrics annually for administrative functions, contracting with vendors, customer service, enrollee education, financial services, and program integrity; and
- Modify the health plan medical loss ratio to include dental and include calculations consistent with federal regulation.

Under the bill, effective July 1, 2016, health and dental services contracts of Healthy Kids must transition to the FHIX marketplace. Qualifying plans may enroll as vendors on FHIX to maintain continuity of care for Healthy Kids' participants.

Quarterly full-pay enrollment and utilization comparison information is required to be provided online. Current law does not specify how the information may be provided.

The board of directors is re-configured with the chair being an appointee designated by the Governor and composed of 12 other members appointed by the Governor and confirmed by the Senate for 3-year terms. The board members serve at the pleasure of the Governor. Those members who are serving as of the effective date of this act may remain on the board until January 1, 2016. Terms for board members appointed under this act are effective January 1, 2016.

Healthy Kids is also directed to confer with the AHCA, the DCF, and the corporation to develop transition plans for FHIX.

The Operating Fund of the Florida Healthy Kids Corporation has never been separately funded. Under the bill, the Operating Fund is repealed effective upon the bill becoming law.

The Medically Needy Program (Section 16)

The bill amends s. 409.904(2), F.S., to require that, effective July 1, 2016, persons eligible under the Medically Needy program will be limited to children under the age of 21 and pregnant women. The bill also provides that the Medically Needy program will expire on October 1, 2019.

Other Provisions (Sections 14, 19, 20)

An obsolete provision relating to managed competition in health care is repealed.

The bill directs the Division of Law Revision and Information to replace the phrase "the effective date of this act" wherever it occurs with the date the act becomes law.

If any law amended by this act was also amended by a law amended at the 2015 Regular Session of the Legislature, such laws shall be construed as if they had been enacted at the same session of the Legislature, and full effect is given to each, if possible.

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 2-A may provide cost saving to Floridians and stimulate economic growth. The following two organizations have published estimates:

- The Florida Chamber of Commerce estimates that Florida's families and business pay $1.4 billion in hidden health care taxes to cover the costs of the uninsured.[99] As an example, the Chamber has estimated that every insured Floridian pays about $2,000 for every hospital stay to cover the cost of the uninsured.[100]
- The Florida Hospital Association (FHA) has also conducted research on the impact of extending health insurance coverage to this population. By covering 1 million or more Floridians, the FHA has projected 121,000 new jobs, savings of more than

[99] Florida Chamber of Commerce, *Smarter Healthcare Coverage in Florida*, p.3, http://www.flchamber.com/wp-content/uploads/FL-Chamber-Plan-for-Smarter-Healthcare-Coverage.pdf (last visited May 27, 2015).
[100] Id.

$2.5 billion in state general revenue, and $541 million a year in local government revenue.[101]

The Affordable Care Act imposes an employer mandate effective in 2015 for businesses that employ 100 or more people. Those employers must provide affordable health insurance coverage or face penalties of $2,000 or $3,000 per person. This may also have an impact on Florida's economy if additional options are not available and more individuals are not covered.[102]

C. Government Sector Impact:

Preliminary Economic Impact Analysis of FHIX Program

The Office of Economic and Demographic Research (EDR) conducted a preliminary analysis of the FHIX program based on SB 2-A and the Amendment for SB 2-A (now CS/SB 2-A). As part of its analysis, EDR reviewed the characteristics of the expansion base population of 829,802 potential enrollees and updated the economic impact of CS/SB 2-A. The analysis was based on population assumptions from the American Community Survey (ACS) 2011-2013, Public Use Microdata PUMS).

Medicaid Expansion Base Population Assumptions Working or School Enrollment Status (2011-2013)[103]	
Population	**Percentage**
Not in School: Not Working	48.3%
Working; Not in School	38.2%
In School	13.4%
Disabled	0.1%

Under the CS/SB 2-A, the Medicaid managed care component was removed from FHIX. All participants will enroll directly into coverage through FHIX. The implementation date of the program moves from July 1, 2015 to January 1, 2016, which also modifies the dates for changes in the Medically Needy program resulting in the loss of savings in the first fiscal year.
The EDR analysis identified the following specific impacts:

- Federal exchange. - Adding this option has a positive, but indeterminate, fiscal impact to insurance premium tax as it is unknown how many participants will select this option;
- Career Source, Inc. - Strengthening the employment requirement for validation of job-seeking efforts through CareerSource, Inc., will have a negative impact on caseload and will likely eliminate additional people from FHIX;
- MMA Plans. - Eliminating MMA plans as an option may make implementation more difficult in some areas of the state, especially with regard to pricing; and

[101] Florida Hospital Association, *A Healthy Florida Works*, http://ahealthyfloridaworks.com/v6/wp-content/uploads/2014/10/AHealthyFloridaIGv10.pdf (last visited May 27, 2015).
[102] Id.
[103] The Florida Legislature, Office of Economic and Demographic Research, *Impact Analysis of SB 2-A, As Filed* (June 1, 2015), p. 25, http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2857&Session=2015A&DocumentType=Meeting Packets&FileName=hhsc 6-1-15.pdf (last visited June 1, 2015).

- Disability definition. - Broadening the disability definition may increase caseload and expenditures.[104]

SB 2-A, Amendment 260258*	Impact on State $$$									
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Uninsured Presenters (new)	-	(32.5)	(75.0)	(92.1)	(125.7)	(154.2)	(160.8)	(167.6)	(174.6)	(181.8)
Crowd-Out (new)	-	(1.9)	(4.3)	(5.2)	(7.0)	(8.5)	(8.8)	(9.0)	(9.3)	(9.6)
Disabled Care Adjustments	-	(9.8)	(22.5)	(27.7)	(37.7)	(46.3)	(48.2)	(50.2)	(52.3)	(54.4)
Medically Needy Shift (net)	69.3	219.0	200.5	193.9	180.8	172.1	172.5	172.8	173.1	173.5
Medically Needy Sunset	0.0	44.2	44.1	44.0	47.1	48.2	48.3	48.4	48.5	48.6
Healthy Kids Title XXI	N/A	0.9	1.0	1.0	5.3	6.8	6.9	7.0	7.1	7.2
Medicaid Subtotal	69.3	219.9	143.8	113.9	62.7	18.2	10.0	1.5	(7.3)	(16.4)
Insurance Premium Revenue Adj.	0.0	(9.3)	(6.3)	(6.6)	(6.9)	(7.2)	(7.5)	(7.8)	(8.2)	(8.5)
Total	69.3	210.7	137.6	107.3	55.8	11.0	2.5	(6.4)	(15.5)	(24.9)
Compared to SB 2-A	**-194.5**	**-12.8**	**-22.5**	**-27.7**	**-37.7**	**-46.3**	**-48.2**	**-50.2**	**-52.3**	**-54.4**

SB 2-A, Amendment 260258*	Impact on Federal $$$ Coming to FL									
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Uninsured Presenters (new)	362.2	1,266.8	1,282.2	1,324.4	1,352.6	1,387.8	1,447.0	1,508.0	1,571.1	1,636.2
Crowd-Out (new)	21.5	74.0	73.9	75.2	75.8	76.7	79.0	81.3	83.7	86.1
Disabled Care Adjustments	109.2	381.5	385.8	398.2	406.3	416.5	433.9	451.8	470.4	489.5
Medically Needy Shift (net)	67.8	213.8	195.3	188.7	175.6	167.0	167.3	167.7	168.0	168.4
Medically Needy Sunset	0.0	(69.6)	(69.9)	(70.3)	(75.9)	(77.8)	(78.0)	(78.2)	(78.3)	(78.5)
Healthy Kids Title XXI	N/A	(21.0)	(23.4)	(23.8)	(19.8)	(18.7)	(19.0)	(19.2)	(19.5)	(19.8)
Medicaid Subtotal	560.7	1,845.6	1,843.9	1,892.5	1,914.6	1,951.5	2,030.2	2,111.4	2,195.3	2,282.0
Insurance Premium Revenue Adj.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total	560.7	1,845.6	1,843.9	1,892.5	1,914.6	1,951.5	2,030.2	2,111.4	2,195.3	2,282.0
Compared to SB 2-A	**-1,600.4**	**+381.5**	**+385.8**	**+398.2**	**+406.3**	**+416.5**	**+433.9**	**+451.8**	**+470.4**	**+489.5**

SB 2-A, Amendment 260258*	Caseload									
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
New Enrollees Related to Disabled Care Adjustments	37,467	38,010	38,551	39,090	39,624	40,147	40,660	41,163	41,658	42,149

*Assuming a start date of January 1, 2016; Phase-in 1/6 of the enrollees each month for all entering FHIX; delayed Medically Needy sunset to July 1, 2016.
Note: Dollars in Millions; Positive Total = Surplus; Negative Total = Shortfall; Numbers may not sum due to rounding.

While the EDR analysis included some assumptions that may not match the CS/SB 2-A analysis, such as changing the participant premium amounts in the Title XXI Healthy Kids program, the chart above, generally provides a summary economic impact of the bill.[105]

The Medically Needy Program and Other Health Care Related Programs

A shift of individuals who receive health care services through the Medically Needy program into comprehensive medical insurance at a higher federal match rate may generate savings in general revenue or Tobacco Settlement funds that could be utilized to offset costs in the program in the long-term.

However, for children, states are required to maintain Medicaid eligibility levels that were in place when the PPACA was enacted through September 30, 2019, which includes children eligible for Medically Needy. Furthermore, the federal Medicaid program requires that if a state

[104] Id at 39.
[105] Id at 12.

provides Medically Needy services for anyone, children and pregnant women must be eligible. Under these requirements, Medically Needy eligibility for both children and pregnant women must be maintained in Florida until October 1, 2019.[106]

Roughly 13.4 percent of persons receiving Medically Needy services in Florida are children or pregnant women, and roughly 83 percent of all Medically Needy enrollees have incomes below 138 percent of the federal poverty level and might be eligible to for coverage under the FHIX.[107]

Further savings could be generated in certain programs that currently provide health-related services to portions of the prospective FHIX population, such as mental health and substance abuse services provided by the DCF and the Aids Drugs Assistance Program within the Department of Health. Such savings would be based on the proportion of these services associated with individuals under 138 of FPL who enroll in the FHIX.

State Government Agencies and Corporations Implementing the FHIX

The Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), and the two state-created, non-profit corporations – Florida Health Choices, Inc., and the Florida Healthy Kids Corporation – affected by the bill have provided fiscal analyses of the recurring and non-recurring costs of development, implementation, and maintenance of the FHIX marketplace based on the three phased implementation. The AHCA and the DCF have not provided updated fiscal information based on the CS/SB 2-A.

For Fiscal Year 2015-2016, the aggregate costs to implement the FHIX are estimated to be approximately $2.82 billion, including federal funds and approximately $12 million of general revenue. In Fiscal Year 2016-2017, the aggregate costs are estimated to be approximately $3.7 billion, including federal funds and approximately $118.5 million of general revenue. These estimates are described below.

Agency for Health Care Administration

In its expenditure estimates, the AHCA assumed that 79.7 percent of the newly eligible population will actually enroll in the FHIX, which is based on historical Medicaid program experience. A phase-in of 50 percent for Fiscal Year 2015-2016 is assumed. The AHCA estimates a total of approximately 968,672 newly eligible individuals, with 386,016 persons enrolling in Fiscal Year 2015-2016. The majority of these individuals are childless adults (679,325), with 270,711 childless adults enrolling in Fiscal Year 2015-2016.

The AHCA also estimates that there will also be a "crowd out" population, i.e. individuals who are currently purchasing insurance directly from an insurance company who will terminate their current coverage and enroll in the FHIX. A phase-in of 40 percent for Fiscal Year 2015-2016 is assumed. A total of 155,757 crowd-out individuals is estimated, with 62,303 enrolling in Fiscal Year 2015-2016.

[106] Email received from the Agency for Health Care Administration by staff of the Senate Appropriations Subcommittee on Health and Human Services, March 13, 2015, on file with subcommittee staff.
[107] Based on enrollment figures provided by the AHCA to staff of the Senate Appropriations Subcommittee on Health and Human Services, March 2015, on file with subcommittee staff.

The AHCA also included costs associated with the Health Insurance Provider Fee (HIPF) at a fee load of 2.5 percent per year. The HIPF is a federal fee imposed under the PPACA on the premiums collected by most insurers and managed care plans providing health coverage. States are required to account for this fee for managed care plans that are contracted to provide health care services to Medicaid enrollees.

The AHCA estimates that total coverage expenditures will be approximately $2.8 billion in Fiscal Year 2015-2016, with approximately $2.4 billion associated with the newly eligible population and approximately $379 million associated with crowd-out. All of these costs will be covered by federal matching funds in Fiscal Year 2015-2016.

For Fiscal Year 2016-2017, total coverage expenditures are estimated to be approximately $3.7 billion, with approximately $3.3 billion associated with the newly eligible and $388 million associated with crowd-out. Under the PPACA, 97.5 percent of these costs will be covered by federal match, leaving a cost of approximately $91.3 million to be covered by the state.

The AHCA advises that the bill creates the need for additional resources at the agency, such as additional contracted actuarial services for the calculation and maintenance of risk adjusted rates and premium assistance in the amount of $500,000 per year, 50 percent of which is covered by federal match.

Additional choice counseling and enrollment broker services will be needed to support the FHIX population. For Fiscal Year 2015-2016, the need is estimated at $6.2 million, 50 percent of which is covered by federal match. Cost estimates for these services are still being calculated for subsequent fiscal years.

The AHCA also advises that the agency's Florida Medicaid Management Information System (FMMIS) will need to be enhanced due to the increase workload created by FHIX enrollees. A rough estimate indicates the cost could be approximately $600,000 for Fiscal Year 2015-2016, 50 percent of which is covered by federal match. The AHCA estimates that $850,000 will be needed in Fiscal Year 2016-2017 and $1.2 million in Fiscal Year 2017-2018 to implement FMMIS enhancements, again with a 50 percent federal match. It is possible that the federal government might provide a 90 percent match rate for these costs since they are associated with the PPACA, but that is uncertain at this time.

Department of Children and Families

The DCF estimates that the bill requires an additional 120 eligibility or case management staff to process and maintain an estimated 487,996 applicants during the first year of the FHIX, based on the DCF's assumption that approximately 60 percent of individuals in the state's current 813,327 food assistance households are projected to qualify as newly eligible for coverage. For nonrecurring expenses, the DCF estimate includes costs for furniture and equipment for the additional FTEs and a one-time mass-mailing to the affected individuals.[108]

[108] Florida Department of Children and Families, *2015 Agency Bill Analysis - SPB 7044* (Mar. 9, 2015) p.5, (on file with the Senate Committee on Health Policy).

The DCF also projects the need for additional budget authority for information technology enhancements; however, the final estimate for this enhancement is not yet known. Information technology costs also include creating an interface with Florida Health Choices and new eligibility rules for a new Medicaid group.

Federal match for costs associated with Medicaid eligibility staff is 75 percent, and the match for the costs of information system development is 90 percent.[109]

The DCF estimates second-year costs based on a workload impact created by the remaining 40 percent of food assistance eligible individuals seeking benefits. The DCF seeks an additional 78 FTEs to handle the increased caseload in year two.

Florida Health Choices

For Florida Health Choices, the corporation expects to incur costs for temporary staff, software licensure, and technical implementation in the first year that will not be incurred in the second year. Costs for both years will include salaries and benefits for new employees, various expenses, enrollment management, and management of health savings accounts. Second year costs reflect the transition of enrollees from Phase One to Phase Two and increased management responsibilities.

Florida Healthy Kids Corporation

The Florida Healthy Kids Corporation will incur third-party administrator (TPA) costs for its responsibilities relating to customer service, financial services, and IT infrastructure for the provision of enrollment support for the FHIX marketplace housed at Florida Health Choices.

The chart below summarizes the estimated costs to the four entities:

	Year One Total	Federal Match	State Share	Year Two Total	Federal Match	State Share
AHCA[110]						
FHIX Coverage	$2,797,672,693	$2,797,672,693		$3,651,074,161	$3,559,797,307	$91,276,854
Actuarial Services	$500,000	$250,000	$250,000	$500,000	$250,000	$250,000
Choice Counseling	$6,200,000	$3,100,000	$3,100,000	$6,200,000	$3,100,000	$3,100,000
FMMIS Upgrade	$600,000	$300,000	$300,000	$850,000	$425,000	$425,000
AHCA Total	**$2,804,972,693**	**$2,801,322,693**	**$3,650,000**	**$3,658,624,161**	**$3,563,572,307**	**$95,051,854**
DCF						
Salaries and Benefits	$4,455,355	$3,341,516	$1,113,839	$2,896,690	$2,172,518	$724,173
Expenses – Recurring	$1,335,499	$1,001,624	$333,875	$878,740	$659,055	$219,685

[109] Id at 6.

[110] An analysis provided by the AHCA to the House Health and Human Services Committee on June 1, 2015, projected a higher fiscal impact primarily related to FHIX coverage. However, the AHCA has not provided a fiscal analysis for CS/SB 2-A to the Senate.

Expenses – non-Recurring	$707,030	$530,273	$176,758	$301,068	$225,801	$75,267
Human Resources Charge	$41,280		$41,280	$26,832		$26,832
Computer expenses	$1,000,000	$900,000	$100,000			
DCF Total	**$7,539,164**	**$5,773,413**	**$1,765,751**	**$4,103,330**	**$3,057,374**	**$1,045,957**

FHC

FHC base annual expenditures	$700,000		$700,000	$700,000		$700,000
Salaries and Benefits	$786,000	$393,000	$393,000	$786,000	$196,500	$589,500
Temporary Staff	$125,000	$62,500	$62,500			
Expenses	$273,300	$136,650	$136,650	$235,800	$117,900	$117,900
Software License	$300,000	$150,000	$150,000			
Technical Implementation	$200,000	$100,000	$100,000			
Enrollment Management	$4,034,871	$2,017,436	$2,017,436	$16,397,140	$8,198,570	$8,198,570
Health Savings Account Management	$2,017,436	$1,008,718	$1,008,718	$8,198,570	$4,099,285	$4,099,285
FHC Total	**$8,436,607**	**$3,868,304**	**$4,568,304**	**$26,317,510**	**$12,612,255**	**$13,705,255**

FHKC

TPA Costs for FHC Enrollment	**$7,526,305**	**$3,868,304**	**$4,568,304**	**$17,372,384**	**$8,686,192**	**$8,686,192**

	Year One	Federal Match	State Share	Year Two	Federal Match	State Share
GRAND TOTALS	**$2,829,634,656**	**$2,815,307,506**	**$14,327,151**	**$3,706,417,385**	**$3,587,928,127**	**$118,489,258**

Note: State share is assumed to be paid from general revenue.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 408.910, 409.904, and 624.91.

This bill creates the following sections of the Florida Statutes: 409.72 through 409.731.

This bill repeals the following sections of the Florida Statutes: 408.70 and 624.915.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Committee on Health Policy on June 1: 2015:
The CS makes the following modifications:

- Removes Phase One enrollment in Medicaid Managed Care and removes participation of Medicaid Managed Care Plans from the FHIX;
- Modifies the enrollment start date for the newly eligible to January 1, 2016, to facilitate participant enrollment directly to the FHIX marketplace;
- Broadens participant choice by allowing the opportunity to select plans on the federal exchange as additional plan options;
- Clarifies that job seeking activities as a qualification for FHIX coverage must involve registration with CareerSource;
- Prohibits the AHCA from implementing any waiver that varies substantially from the provisions of the act. In the event significant changes are made, additional legislative approval is required before implementation;
- Specifies that changes to Florida Healthy Kids Corporation's Board of Directors are effective January 1, 2016; and
- Updates implementation and readiness dates based on modified phases.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
06/01/2015	.	
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The Committee on Health Policy (Bean) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. The Division of Law Revision and Information is directed to rename part II of chapter 409, Florida Statutes, as "Insurance Affordability Programs" and to incorporate ss. 409.72-409.731, Florida Statutes, under this part.

Section 2. Section 409.72, Florida Statutes, is created to read:

409.72 Short title.—Sections 409.72-409.731 may be cited as

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the "Florida Health Insurance Affordability Exchange Program" ("FHIX").

Section 3. Section 409.721, Florida Statutes, is created to read:

409.721 Program authority.—The Florida Health Insurance Affordability Exchange Program (FHIX) is created within the Agency for Health Care Administration to assist Floridians in purchasing health benefits coverage and gaining access to health services. The products and services offered by FHIX are based on the following principles:

(1) FAIR VALUE.—Financial assistance will be rationally allocated regardless of differences in categorical eligibility.

(2) CONSUMER CHOICE.—Participants will be offered meaningful choices in the way the participants can redeem the value of the available assistance.

(3) SIMPLICITY.—Obtaining assistance will be consumer-friendly, and customer support will be available when needed.

(4) PORTABILITY.—Participants can continue to access the FHIX services and products despite changes in their circumstances.

(5) EMPLOYMENT.—Assistance will be offered in a way that incentivizes employment.

(6) CONSUMER EMPOWERMENT.—Assistance will be offered in a manner that maximizes individual control over available resources.

(7) RISK ADJUSTMENT.—The amount of assistance will reflect participants' medical risk.

Section 4. Section 409.722, Florida Statutes, is created to read:

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409.722 Definitions.—As used in ss. 409.72-409.731, the term:

(1) "Agency" means the Agency for Health Care Administration.

(2) "Applicant" means an individual who applies for determination of eligibility for health benefits coverage under this part.

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

(4) "Enrollee" means a participant who has been determined eligible for and is receiving health benefits coverage under this part.

(5) "Federal exchange" or "exchange" means an insurance platform regulated by the Federal Government which offers tiers of health plans from the least comprehensive plan to the most comprehensive plan.

(6) "FHIX marketplace" or "marketplace" means the single, centralized market established under s. 408.910 which facilitates health benefits coverage.

(7) "Florida Health Insurance Affordability Exchange Program" or "FHIX" means the program created under ss. 409.72-409.731.

(8) "Florida Healthy Kids Corporation" means the entity created under s. 624.91.

(9) "Florida Kidcare program" or "Kidcare program" means the health benefits coverage administered through ss. 409.810-409.821.

(10) "Health benefits coverage" means the payment of benefits for covered health care services or the availability,

directly or through arrangements with other persons, of covered health care services on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(11) "Inactive status" means the enrollment status of a participant previously enrolled in health benefits coverage through FHIX who lost coverage for noncompliance pursuant to s. 409.723, but who maintains access to his or her balance in a health savings account or health reimbursement account.

(12) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and parts III and IV of this chapter, as administered in this state by the agency.

(13) "Modified adjusted gross income" means the individual's or household's annual adjusted gross income, as defined in s. 36B(d)(2) of the Internal Revenue Code of 1986, which is used to determine eligibility for FHIX.

(14) "Patient Protection and Affordable Care Act" or "Affordable Care Act" means Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and regulations adopted pursuant to those acts.

(15) "Premium credit" means the monthly amount paid by the agency per enrollee in the Florida Health Insurance Affordability Exchange Program toward health benefits coverage.

(16) "Qualified alien" means an alien as defined in 8 U.S.C. s. 1641(b) or (c).

(17) "Resident" means a United States citizen or qualified alien who is domiciled in this state.

Section 5. Section 409.723, Florida Statutes, is created to read:

409.723 Participation.—

(1) ELIGIBILITY.—To participate in FHIX, an individual must be a resident and meet the following requirements, as applicable:

(a) Qualify as a newly eligible enrollee, and be an individual as described in s. 1902(a)(10)(A)(i)(VIII) of the Social Security Act or s. 2001 of the Affordable Care Act and as may be further defined by federal regulation.

(b) Meet and maintain the responsibilities under subsection (4).

(c) Qualify for participation in the Florida Healthy Kids program under s. 624.91, subject to the implementation of Phase Two under s. 409.727.

(2) ENROLLMENT.—To enroll in FHIX, an applicant must submit an application to the department for an eligibility determination.

(a) Applications may be submitted online, or by mail, facsimile, or any other method permitted by law or regulation.

(b) The department is responsible for any eligibility correspondence and status updates to the participant and other agencies.

(c) The department shall review a participant’s eligibility at least every 12 months.

(d) An application or renewal is deemed complete when the participant has met all the requirements under subsection (4), as applicable.

(3) PARTICIPANT RIGHTS.—A participant has all of the following rights:

(a) Access to the FHIX marketplace or federal exchange to


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select the scope, amount, and type of health care coverage and other services to be purchased.

(b) Continuity and portability of coverage to avoid disruption of coverage and other health care services when the participant's economic circumstances change.

(c) Retention of applicable unspent credits in the participant's health savings or health reimbursement account following a change in the participant's eligibility status. Credits are valid for a participant in an inactive status for up to 5 years after the participant's status first becomes inactive.

(d) Ability to select more than one product or plan on the FHIX marketplace or federal exchange.

(e) Choice of at least two health benefits products that meet the requirements of the Affordable Care Act.

(4) PARTICIPANT RESPONSIBILITIES.—A participant must:

(a) Complete an initial application for health benefits coverage and the annual renewal process.

(b) Provide evidence of participation in one or more of the following activities at the levels required under paragraph (c):

1. Paid employment.

2. On the job training or job placement activities that are validated through registration with CareerSource Florida.

3. Educational pursuits.

A participant who is a disabled adult or the caregiver of a disabled child or adult may submit a request to the department for an exception to the requirements in this paragraph. Such participant shall annually submit to the department a request to


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renew the exception. The term "disabled" means any person who has one or more permanent physical or mental impairments that substantially limit his or her ability to perform one or more major life activities of daily living, as defined by the Americans with Disabilities Act, without receiving more than 8 hours of assistance per day.

(c) Engage in the activities required under paragraph (b) at the following minimum levels:

1. For a parent of a child younger than 18 years of age, a minimum of 20 hours weekly.

2. For a childless adult, a minimum of 30 hours weekly.

(d) Learn and remain informed about the choices available in the FHIX marketplace or the federal exchange and the allowable uses of credits in the individual accounts.

(e) Execute a contract with the department which acknowledges that:

1. FHIX is not an entitlement and state and federal funding may end at any time;

2. Failure to pay required premiums or cost sharing will result in a transition to inactive status; and

3. Noncompliance with the participation requirements as established under s. 409.723 will result in a transition to inactive status.

(f) Select plans and other products in a timely manner.

(g) Comply with program rules and the prohibitions against fraud, as described in s. 414.39.

(h) Timely make monthly premium and any other cost-sharing payments.

(i) Meet minimum coverage requirements by selecting either

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a high-deductible health plan combined with a health savings or a reimbursement account or a combination of plans or products with an actuarial value that meets or exceeds benefits available under the federal exchange.

(5) COST SHARING.—

(a) Enrollees are assessed monthly premiums based on their modified adjusted gross income. The maximum monthly premium payments are set at the following income levels:

1. At or below 22 percent of the federal poverty level: $3.

2. Greater than 22 percent, but at or below 50 percent, of the federal poverty level: $8.

3. Greater than 50 percent, but at or below 75 percent, of the federal poverty level: $15.

4. Greater than 75 percent, but at or below 100 percent, of the federal poverty level: $20.

5. Greater than 100 percent of the federal poverty level: $25.

(b) Depending on the products and services selected by the enrollee, the enrollee may also incur additional cost sharing, such as copayments, deductibles, or other out-of-pocket costs.

(c) An enrollee may be subject to charge for an inappropriate emergency room visit of up to $8 for the first visit and up to $25 for any subsequent visit, based on the enrollee’s benefit plan, to discourage inappropriate use of the emergency room.

(d) Cumulative annual cost sharing per enrollee may not exceed 5 percent of an enrollee’s annual modified adjusted gross income.

(e) If, after a 30-day grace period, a full premium payment

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has not been received, the enrollee shall be transitioned from coverage to inactive status and may not reenroll for a minimum of 6 months, unless a hardship exception has been granted. Enrollees may seek a hardship exception under the Medicaid Fair Hearing Process.

Section 6. Section 409.724, Florida Statutes, is created to read:

409.724 Available assistance.—

(1) PREMIUM CREDITS.—

(a) *Standard amount*.—The standard monthly premium credit is equivalent to the applicable risk-adjusted capitation rate paid to Medicaid managed care plans under part IV of this chapter.

(b) *Supplemental funding*.—Subject to federal approval, additional resources may be made available to enrollees and incorporated into FHIX.

(c) *Savings accounts*.—In addition to the benefits provided under this section, the corporation must offer each enrollee access to an individual account that qualifies as a health reimbursement account or a health savings account.

1. Unexpended Funds.—Eligible unexpended funds from the monthly premium credit must be deposited into each enrollee's individual account in a timely manner. Funds deposited into these individual accounts may be used to pay cost-sharing obligations or to purchase other health-related items to the extent permitted under federal and state law.

2. Healthy Behaviors.—Enrollees may receive credits to their individual accounts for healthy behaviors, adherence to wellness programs, and other activities that demonstrate compliance with prevention or disease management guidelines.

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3. Enrollee contributions.—The enrollee may make deposits to his or her account at any time to supplement the premium credit, to purchase additional FHIX products, or to offset other cost-sharing obligations.

4. Third parties.—Third parties, including, but not limited to, an employer or relative, may also make deposits on behalf of the enrollee into the enrollee's FHIX marketplace account. The enrollee may not withdraw any funds as a refund, except those funds the enrollee has deposited into his or her account.

(2) CHOICE COUNSELING.—The agency, in consultation with the Florida Healthy Kids Corporation and the corporation, shall develop a choice counseling program for FHIX. The choice counseling program must ensure that participants have information about the FHIX marketplace program, the federal exchange, products, and services and that participants know where and whom to call for questions or to make their plan selections. The choice counseling program must provide culturally sensitive materials and must take into consideration the demographics of the projected population.

(3) EDUCATION CAMPAIGN.—The agency, the corporation, and the Florida Healthy Kids Corporation must coordinate in advance of Phase One an ongoing education campaign to inform participants, at a minimum, of the following:

(a) How the FHIX marketplace operates and the timeline for enrollment.

(b) Plans that are available and how to find information about these plans.

(c) Information about other available insurance affordability programs for the participant and his or her

family.

(d) Information about health benefits coverage, provider networks, and cost sharing for available plans in each region.

(e) Information on how to complete the required annual renewal process, including renewal dates and deadlines.

(f) Information on how to update eligibility if the participant's data have changed since his or her last renewal or application date.

(4) CUSTOMER SUPPORT.—The Florida Healthy Kids Corporation shall provide customer support for FHIX, including, but not limited to, general program information, financial information, and enrollee payments. Customer support must also provide a toll-free telephone number and maintain a website that is available in multiple languages and that meets the needs of the enrollee population.

(5) INACTIVE PARTICIPANTS.—The corporation must inform the inactive participant about other insurance affordability programs and electronically refer the participant to the federal exchange or other insurance affordability programs, as appropriate.

Section 7. Section 409.725, Florida Statutes, is created to read:

409.725 Available products and services.—The FHIX marketplace shall offer the following products and services:

(1) Products and services authorized pursuant to s. 408.910.

(2) Products authorized by the federal exchange.

(3) Products authorized by the Florida Healthy Kids Corporation pursuant to s. 624.91.

(4) Premium credits for participation in employer-sponsored plans.

Section 8. Section 409.726, Florida Statutes, is created to read:

409.726 Program accountability.—

(1) All managed care plans that participate in FHIX must collect and maintain encounter level data in accordance with the encounter data requirements under s. 409.967(2)(d) and are subject to the accompanying penalties under s. 409.967(2)(h)2. The agency is responsible for the collection and maintenance of the encounter level data.

(2) The corporation, in consultation with the agency, shall establish access and network standards for contracts on the FHIX marketplace, shall ensure that contracted plans have sufficient providers to meet enrollee needs, and shall develop quality of coverage and provider standards specific to the adult population.

(3) The department shall develop accountability measures and performance standards to be applied to initial and renewal FHIX applications that are submitted online, by mail, by facsimile, or through referrals from a third party. The minimum performance standards are:

(a) *Application processing speed.*—Ninety percent of all applications, regardless of the method of submission, must be processed within 45 days.

(b) *Application processing speed from online sources.*—Ninety-five percent of all applications received from online sources must be processed within 45 days.

(c) *Renewal application processing speed.*—Ninety percent of

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all renewals, regardless of the method of submission, must be processed within 45 days.

(d) *Renewal application processing speed from online sources.*—Ninety-five percent of all applications received from online sources must be processed within 45 days.

(4) The agency, the department, and the Florida Healthy Kids Corporation must meet the following standards for their respective roles in the program:

(a) Eighty-five percent of calls must be answered in 20 seconds or less.

(b) All contacts, including, but not limited to, telephone calls, faxed documents and requests, and e-mails, must be handled within 2 business days.

(c) Any self-service tools available to participants, such as interactive voice response systems, must be operational 7 days a week, 24 hours a day, at least 98 percent of each month.

(5) The agency, the department, and the Florida Healthy Kids Corporation shall conduct an annual satisfaction survey to address all measures that require participant input specific to the FHIX marketplace program. The parties may elect to incorporate these elements into the annual report required under subsection (7).

(6) The agency and the corporation shall post online monthly enrollment reports for FHIX.

(7) Beginning in 2016, an annual report is due no later than July 1 to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The annual report must be coordinated by the agency and the corporation and must include at least the following:

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(a) Enrollment and application trends and issues.

(b) Utilization and cost data.

(c) Customer satisfaction.

(d) Funding sources in health savings accounts or health reimbursement accounts.

(e) Enrollee use of funds in health savings accounts or health reimbursement accounts.

(f) Types of products and plans purchased.

(g) Movement of enrollees across different insurance affordability programs.

(h) Recommendations for program improvement.

Section 9. Section 409.727, Florida Statutes, is created to read:

409.727 Readiness review and implementation schedule.—The agency, the corporation, the department, and the Florida Healthy Kids Corporation shall begin implementation of FHIX on the effective date of this act, with enrollment for Phase One beginning by January 1, 2016.

(1) READINESS REVIEW.—Before implementation of any phase under this part or in any region, the agency shall conduct a readiness review in consultation with the FHIX Workgroup established pursuant to s. 409.729. The agency shall determine, at a minimum, the following readiness milestones:

(a) Functional readiness of the service delivery platform.

(b) Plan availability and presence of plan choice.

(c) Provider network capacity and adequacy of the available plans.

(d) Availability of customer support.

(e) Other factors critical to the success of FHIX.


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(2) PHASE ONE.—The agency, the corporation, and the Florida Healthy Kids Corporation shall coordinate implementation activities to ensure that enrollment begins by January 1, 2016, and is available in all regions by July 1, 2016.

(a) Beginning no later than January 1, 2016, and contingent upon federal approval, participants may enroll in health benefits coverage under the FHIX marketplace or the federal exchange, if eligible.

(b) To be eligible for enrollment during this phase, a participant must meet the requirements under s. 409.723(1)(a) and (b).

(c) An enrollee may select any benefit, service, or product available in the region.

(d) The corporation shall notify an enrollee of his or her premium credit amount and how to access the FHIX marketplace selection process or the federal exchange.

(e) An enrollee must have a choice of at least two managed care plans in each region which meet or exceed the Affordable Care Act's requirements and which qualify for a premium credit on the FHIX marketplace or federal exchange.

(f) Choice counseling and customer service must be provided in accordance with s. 409.724(2) and (4).

(3) PHASE TWO.—

(a) No later than July 1, 2016, the corporation and the Florida Healthy Kids Corporation shall begin the transition of enrollees under s. 624.91 to the FHIX marketplace.

(b) Eligibility during this phase is based on meeting the requirements of s. 409.723(1)(c) and (4).

(c) An enrollee may select any available benefit, service,


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or product available under s. 409.725.

(d) A Florida Healthy Kids enrollee who selects a FHIX marketplace plan or federal exchange plan shall be provided a premium credit equivalent to the average capitation rate paid in his or her county of residence under Florida Healthy Kids as of June 30, 2016. The enrollee is responsible for any difference in costs and may use any unexpended funds deposited in his or her savings account under s. 409.724(1)(c) for supplemental benefits on the FHIX marketplace or federal exchange.

(e) The corporation shall notify an enrollee of his or her premium credit amount and how to access the FHIX marketplace selection process or federal exchange.

(f) Choice counseling and customer service must be provided in accordance with s. 409.724(2) and (4).

(g) Enrollees under s. 624.91 must transition to the FHIX marketplace and coverage under s. 409.725 by September 30, 2016.

Section 10. Section 409.728, Florida Statutes, is created to read:

409.728 Program operation and management.—In order to implement ss. 409.72-409.731:

(1) The agency shall do all of the following:

(a) Contract with the corporation for the development, implementation, and administration of the Florida Health Insurance Affordability Exchange Program and for the release of any federal, state, or other funds appropriated to the corporation.

(b) Provide administrative support to the FHIX Workgroup established pursuant to s. 409.729.

(c) Consult with stakeholders that serve low-income


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individuals and families during implementation, using a public input process.

(d) Timely transmit enrollee information to the corporation.

(e) Annually determine the risk-adjusted rate to be paid per month based on historical utilization and spending data for the medical and behavioral health of enrollee population, projected forward, and adjusted to reflect the eligibility category, medical and dental trends, geographic areas, and the clinical risk profile of the enrollees.

(f) Transfer funds allocated for premium credits by General Appropriations Act to the corporation.

(g) Adopt rules in coordination with the corporation and the Florida Healthy Kids Corporation in order to implement FHIX, including modifying existing rules implementing the Children's Health Insurance Program and adapting adult focused provisions for children to accommodate the seamless transition of Healthy Kids enrollees to FHIX.

(2) The department shall, in coordination with the corporation, the agency, and the Florida Healthy Kids Corporation, determine eligibility of applications and application renewals for FHIX in accordance with s. 409.902 and shall transmit eligibility determination information on a timely basis to the agency and corporation.

(3) The Florida Healthy Kids Corporation shall do all of the following:

(a) Retain its duties and responsibilities under s. 624.91 during Phase One of the program.

(b) In coordination with the agency and the corporation,

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provide customer service for the FHIX marketplace.

(c) Transfer funds and provide financial support to the FHIX marketplace, including the collection of monthly cost-sharing payments.

(d) Conduct financial reporting related to such activities, in coordination with the corporation and the agency.

(e) Coordinate program activities with the agency, the department, and the corporation.

(4) Florida Health Choices, Inc., shall do all of the following:

(a) Develop and maintain the FHIX marketplace.

(b) Implement and administer Phase One and Phase Two of the FHIX marketplace and the ongoing operations of the program.

(c) Offer health benefits coverage packages on the FHIX marketplace, including plans compliant with the Affordable Care Act.

(d) Offer FHIX enrollees a choice of at least two plans per county at each benefit level which meet the requirements under the Affordable Care Act.

(e) Offer the opportunity to participate in the federal exchange.

(f) Offer enhanced or customized benefits to FHIX marketplace enrollees.

(g) Provide sufficient staff and resources to meet the program needs of enrollees.

(h) Provide an opportunity for plans contracted with or previously contracted with the Florida Healthy Kids Corporation under s. 624.91 to participate with FHIX if those plans meet the requirements of the program.

(i) Encourage insurance agents licensed under chapter 626 to identify and assist enrollees. This act does not prohibit these agents from receiving usual and customary commissions from insurers and health maintenance organizations that offer plans in the FHIX marketplace.

Section 11. Section 409.729, Florida Statutes, is created to read:

409.729 Long-term reorganization.—The FHIX Workgroup is created to facilitate the implementation of FHIX and to plan for the reorganization of the state's insurance affordability programs. The FHIX Workgroup consists of two representatives each from the agency, the department, the Florida Healthy Kids Corporation, and the corporation. An additional representative of the agency serves as chair. The FHIX Workgroup must hold its organizational meeting no later than 30 days after the effective date of this act and must meet at least bimonthly. The role of the FHIX Workgroup is to make recommendations to the agency. The responsibilities of the workgroup include, but are not limited to:

(1) Developing and presenting a final implementation plan that meets the requirements of this part in a report submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than November 1, 2015.

(2) Reviewing network and access standards for plans and products.

(3) Assessing readiness and recommending actions needed to reorganize the state's insurance affordability programs for each phase or region. If a phase or region receives a nonreadiness recommendation, the agency shall notify the Legislature of that

recommendation, the reasons for such a recommendation, and proposed plans for achieving readiness.

(4) Recommending any proposed change to the Title XIX-funded or Title XXI-funded programs based on the continued availability and reauthorization of the Title XXI program and its federal funding.

(5) Identifying duplication of services by the corporation, the agency, and the Florida Healthy Kids Corporation currently and under FHIX's proposed Phase Two program.

(6) Evaluating any fiscal impacts based on the proposed transition plan under Phase Two.

(7) Compiling a schedule of impacted contracts, leases, and other assets.

(8) Determining staff requirements for Phase Two.

Section 12. Section 409.73, Florida Statutes, is created to read:

409.73 Legislative Review.—The agency may seek federal approval to implement FHIX as provided in ss. 409.72-409.731. The agency is prohibited from implementing the FHIX waiver without specific legislative approval unless the terms and conditions of the approved waiver are substantially consistent with the statutory requirements for this program.

Section 13. Section 409.731, Florida Statutes, is created to read:

409.731 Program expiration.—The Florida Health Insurance Affordability Exchange Program expires at the end of the state fiscal year in which any of these conditions occurs:

(1) The federal match contribution for the newly eligible under the Affordable Care Act falls below 90 percent.

(2) The federal match contribution falls below the increased Federal Medical Assistance Percentage for medical assistance for newly eligible mandatory individuals as specified in the Affordable Care Act.

(3) The federal match for the FHIX program and the Medicaid program are blended under federal law or regulation in such a manner that causes the overall federal contribution to diminish when compared to separate, nonblended federal contributions.

Section 14. Section 408.70, Florida Statutes, is repealed.

Section 15. Section 408.910, Florida Statutes, is amended to read:

408.910 Florida Health Choices Program.—

(1) LEGISLATIVE INTENT.—The Legislature finds that a significant number of the residents of this state do not have adequate access to affordable, quality health care. The Legislature further finds that increasing access to affordable, quality health care can be best accomplished by establishing a competitive market for purchasing health insurance and health services. It is therefore the intent of the Legislature to create and expand the Florida Health Choices Program to:

(a) Expand opportunities for Floridians to purchase affordable health insurance and health services.

(b) Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits.

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

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


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(e) Disseminate information to consumers on the price and quality of health services.

(f) Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

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

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

(b) "Corporation's marketplace" means the single, centralized market established by the program that facilitates the purchase of products made available in the marketplace.

(c) "Florida Health Insurance Affordability Exchange Program" or "FHIX" is the program created under ss. 409.72-409.731 for low-income, uninsured residents of this state.

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

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

(f) "Patient Protection and Affordable Care Act" or "Affordable Care Act" means Pub. L. No. 111-148, as further amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and regulations adopted pursuant to those acts.

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

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

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

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

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

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

3. Account information to assist individual participants

with managing available resources.

4. Services that promote healthy behaviors.

5. Health benefits coverage information about health insurance plans compliant with the Affordable Care Act.

6. Consumer assistance with web-based information services for the Florida Health Insurance Affordability Exchange Program, or ("FHIX").

(d) Recruitment of vendors, including insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.

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

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

(g) Information services for individuals and employers.

(h) Program evaluation.

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

(a) Employers eligible to enroll in the program include those employers that meet criteria established by the corporation and elect to make their employees eligible through the program.

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

1. Individual employees of enrolled employers.

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

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

1. Submission of required information.

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

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

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

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

6. Identification of eligible employees.

7. Arrangement for periodic payments.

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

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

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing

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coverage, and other products or services.

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

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

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

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

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

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

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

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

(e) Eligible individuals may participate in the program voluntarily. Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures must include, but are not limited to:

1. Submission of required information.

2. Authorization for payroll deduction, if applicable.

3. Compliance with federal tax requirements.

4. Arrangements for payment.

5. Selection of products and services.

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

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

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

3. Execution of an agreement that prohibits refusal to sell any offered product or service to a participant who elects to

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buy it.

4. Establishment of product prices based on applicable criteria.

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.

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

1. Completion of training requirements.

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

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

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

(5) PRODUCTS.—

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

1. Health insurance policies.

2. Health maintenance contracts.

3. Limited benefit plans.

4. Prepaid clinic services.

5. Service contracts.

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

7. Flexible spending accounts.

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

(c) Products may be offered for multiyear periods provided the price of the product is specified for the entire period or for each separately priced segment of the policy or contract.

(d) The corporation shall provide a disclosure form for consumers to acknowledge their understanding of the nature of, and any limitations to, the benefits provided by the products and services being purchased by the consumer.

(e) The corporation must determine that making the plan available through the program is in the interest of eligible individuals and eligible employers in the state.

(6) PRICING.—Prices for the products and services sold through the program must be transparent to participants and

established by the vendors. The corporation may ~~shall~~ annually assess a surcharge for each premium or price set by a participating vendor. Any ~~The~~ surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives; however, a surcharge may not be assessed for products and services sold in the FHIX marketplace.

(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) *Marketplace purchasing.*—A participant needing personal assistance to select products and services shall be referred to a participating agent in his or her area.

1.~~(a)~~ Participation in the program may begin at any time during a year after the employer completes enrollment and meets the requirements specified by the corporation pursuant to paragraph (4)(c).

2.~~(b)~~ Initial selection of products and services must be made by an individual participant within the applicable open enrollment period.

3.~~(c)~~ Initial enrollment periods for each product selected by an individual participant must last at least 12 months, unless the individual participant specifically agrees to a different enrollment period.


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4.~~(d)~~ If an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participant, changes in selected products and services may only be made during the annual enrollment period established by the corporation.

5.~~(e)~~ The limits established in subparagraphs 2., 3., and 4. ~~paragraphs (b)-(d)~~ apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(b) *FHIX marketplace purchasing.*—

1. Participation in the FHIX marketplace may begin at any time during the year.

2. Initial enrollment periods for certain products selected by an individual enrollee which are noncompliant with the Affordable Care Act may be required to last at least 12 months, unless the individual participant specifically agrees to a different enrollment period.

(8) CONSUMER INFORMATION.—The corporation shall:

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

(b) Inform individuals about other public health care

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programs.

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

(10) EXEMPTIONS.—

(a) Products, other than the products set forth in subparagraphs (4)(d)1.-4., sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, as defined in s. 624.01 or the mandated offerings or coverages established in part VI of chapter 627 and chapter 641.

(b) The corporation may act as an administrator as defined in s. 626.88 but is not required to be certified pursuant to part VII of chapter 626. However, a third-party ~~third party~~ administrator used by the corporation must be certified under part VII of chapter 626.

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

(11) CORPORATION.—There is created the Florida Health

Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter 112 and chapters 119, 286, and 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

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

1. Three ex officio, nonvoting members to include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) The corporation may exercise all powers granted to it

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under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this section.

(h) The corporation may establish technical advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

(i) The corporation shall:

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

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

3. Arrange for collection of contributions from participating employers<u>, third parties, governmental entities,</u> and individuals.

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

5. Establish criteria for disenrollment of participating individuals based on failure to pay the individual’s share of any contribution required to maintain enrollment in selected products.

6. Establish criteria for exclusion of vendors pursuant to

paragraph (4)(d).

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

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

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

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

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

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

13. Administer the Florida Health Insurance Affordability Exchange Program in accordance with ss. 409.72-409.731.

14. Coordinate with the Agency for Health Care Administration, the Department of Children and Families, and the Florida Healthy Kids Corporation in developing and implementing the enrollee transition plan.

15. Coordinate with the federal exchange to provide FHIX enrollees with the option of selecting plans from either the FHIX marketplace or the federal exchange.

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

(13) PROGRAM INTEGRITY.—To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

(14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—

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

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

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

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

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

a. Business plans.

b. Internal auditing controls and reports of internal auditors.

c. Reports of external auditors for privately held companies.

d. Client and customer lists.

e. Potentially patentable material.

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

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

(b) *Public record exemptions.*—

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

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

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

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

(d) *Authorized release.*—

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

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

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

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

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

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

(f) *Review and repeal.*—This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2016, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 16. Subsection (2) of section 409.904, Florida Statutes, is amended to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(2) A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from

income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled. Effective July 1, 2016, persons eligible under "medically needy" shall be limited to children under 21 years of age and pregnant women. This subsection expires October 1, 2019.

Section 17. Section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

(1) SHORT TITLE.—This section may be cited as the "William G. 'Doc' Myers Healthy Kids Corporation Act."

(2) LEGISLATIVE INTENT.—

(a) The Legislature finds that increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in this state. Many children do not have comprehensive, affordable health care services available. It is the intent of the Legislature that the Florida Healthy Kids Corporation provide comprehensive health insurance coverage to such children. The corporation is encouraged to cooperate with any existing health service programs funded by the public or the private sector.

(b) It is the intent of the Legislature that the Florida Healthy Kids Corporation serve as one of several providers of services to children eligible for medical assistance under Title XXI of the Social Security Act. Although the corporation may


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serve other children, the Legislature intends the primary recipients of services provided through the corporation be school-age children with a family income below 200 percent of the federal poverty level, who do not qualify for Medicaid. It is also the intent of the Legislature that state and local government Florida Healthy Kids funds be used to continue coverage, subject to specific appropriations in the General Appropriations Act, to children not eligible for federal matching funds under Title XXI.

(3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only residents of this state are eligible ~~the following individuals are eligible~~ for state-funded assistance in paying Florida Healthy Kids premiums pursuant to s. 409.814.~~:~~

~~(a) Residents of this state who are eligible for the Florida Kidcare program pursuant to s. 409.814.~~

~~(b) Notwithstanding s. 409.814, legal aliens who are enrolled in the Florida Healthy Kids program as of January 31, 2004, who do not qualify for Title XXI federal funds because they are not qualified aliens as defined in s. 409.811.~~

(4) NONENTITLEMENT.—Nothing in this section shall be construed as providing an individual with an entitlement to health care services. No cause of action shall arise against the state, the Florida Healthy Kids Corporation, or a unit of local government for failure to make health services available under this section.

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

(a) There is created the Florida Healthy Kids Corporation, a not-for-profit corporation.

(b) The Florida Healthy Kids Corporation shall:

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1. Arrange for the collection of any individual, family, ~~local contributions,~~ or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.

2. Arrange for the collection of any voluntary contributions to provide for payment of Florida Kidcare program or Florida Health Insurance Affordability Exchange Program (FHIX) premiums ~~for children who are not eligible for medical assistance under Title XIX or Title XXI of the Social Security Act~~.

3. ~~Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional Florida Kidcare coverage in contributing counties under Title XXI.~~

~~4.~~ Establish the administrative and accounting procedures for the operation of the corporation.

4.~~5.~~ Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians.

5.~~6.~~ Determine eligibility for children seeking to participate in the Title XXI-funded components of the Florida Kidcare program consistent with the requirements specified in s. 409.814~~, as well as the non-Title-XXI-eligible children as provided in subsection (3)~~.

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6.~~7.~~ Establish procedures under which ~~providers of local match to,~~ applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation.

7.~~8.~~ Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.

8.~~9.~~ Establish enrollment criteria that include penalties or waiting periods of 30 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family or individual premiums.

9.~~10.~~ Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites.

a. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care.

b. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health and dental care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. The calculations must use uniform financial data collected from all plans in a format established by the corporation and shall be computed for each plan on a statewide basis. Funds shall be


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classified in a manner consistent with 45 C.F.R. part 158 ~~For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail~~.

c. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.

d. Effective July 1, 2016, health and dental services contracts of the corporation must transition to the FHIX marketplace under s. 409.722. Qualifying plans may enroll as vendors with the FHIX marketplace to maintain continuity of care for participants.

10.~~11.~~ Establish disenrollment criteria in the event ~~local matching~~ funds are insufficient to cover enrollments.

11.~~12.~~ Develop and implement a plan to publicize the Florida Kidcare program, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.

12.~~13.~~ Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state ~~and local matching funds~~ and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation.

13.~~14.~~ In consultation with the partner agencies, provide a report on the Florida Kidcare program annually to the Governor, the Chief Financial Officer, the Commissioner of Education, the

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President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and the House of Representatives.

14.~~15.~~ Provide information on a quarterly basis online to the Legislature and the Governor which compares the costs and utilization of the full-pay enrolled population and the Title XXI-subsidized enrolled population in the Florida Kidcare program. The information, at a minimum, must include:

a. The monthly enrollment and expenditure for full-pay enrollees in the Medikids and Florida Healthy Kids programs compared to the Title XXI-subsidized enrolled population; and

b. The costs and utilization by service of the full-pay enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population.

15.~~16.~~ Establish benefit packages that conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.821.

16. Contract with other insurance affordability programs to provide such services that are consistent with this act.

17. Annually develop performance metrics for the following focus areas:

a. Administrative functions.

b. Contracting with vendors.

c. Customer service.

d. Enrollee education.

e. Financial services.

f. Program integrity.

(c) Coverage under the corporation's program is secondary to any other available private coverage held by, or applicable

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to, the participant child or family member. Insurers under contract with the corporation are the payors of last resort and must coordinate benefits with any other third-party payor that may be liable for the participant's medical care.

(d) The Florida Healthy Kids Corporation shall be a private corporation not for profit, organized pursuant to chapter 617, and shall have all powers necessary to carry out the purposes of this act, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of this act.

(6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors. The board chair shall be an appointee designated by the Governor, and the board shall be ~~chaired by the Chief Financial Officer or her or his designee, and~~ composed of 12 other members. The Senate shall confirm the designated chair and other board appointees. The board members shall be appointed ~~selected~~ for 3-year terms. ~~of office as follows:~~

~~1. The Secretary of Health Care Administration, or his or her designee.~~

~~2. One member appointed by the Commissioner of Education from the Office of School Health Programs of the Florida Department of Education.~~

~~3. One member appointed by the Chief Financial Officer from among three members nominated by the Florida Pediatric Society.~~

~~4. One member, appointed by the Governor, who represents the Children's Medical Services Program.~~

~~5. One member appointed by the Chief Financial Officer from among three members nominated by the Florida Hospital Association.~~

~~6. One member, appointed by the Governor, who is an expert on child health policy.~~

~~7. One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Academy of Family Physicians.~~

~~8. One member, appointed by the Governor, who represents the state Medicaid program.~~

~~9. One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Association of Counties.~~

~~10. The State Health Officer or her or his designee.~~

~~11. The Secretary of Children and Families, or his or her designee.~~

~~12. One member, appointed by the Governor, from among three members nominated by the Florida Dental Association.~~

(b) A member of the board of directors shall be appointed by and serve at the pleasure of the Governor ~~may be removed by the official who appointed that member~~. The board shall appoint an executive director, who is responsible for other staff authorized by the board.

(c) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061.

(d) There shall be no liability on the part of, and no

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cause of action shall arise against, any member of the board of directors, or its employees or agents, for any action they take in the performance of their powers and duties under this act.

(e) Terms for board members appointed under this act are effective January 1, 2016.

(7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

(a) The corporation shall not be deemed an insurer. The officers, directors, and employees of the corporation shall not be deemed to be agents of an insurer. Neither the corporation nor any officer, director, or employee of the corporation is subject to the licensing requirements of the insurance code or the rules of the Department of Financial Services. However, any marketing representative utilized and compensated by the corporation must be appointed as a representative of the insurers or health services providers with which the corporation contracts.

(b) The board has complete fiscal control over the corporation and is responsible for all corporate operations.

(c) The Department of Financial Services shall supervise any liquidation or dissolution of the corporation and shall have, with respect to such liquidation or dissolution, all power granted to it pursuant to the insurance code.

(8) TRANSITION PLANS.—The corporation shall confer with the Agency for Health Care Administration, the Department of Children and Families, and Florida Health Choices, Inc., to develop transition plans for the Florida Health Insurance Affordability Exchange Program as created under ss. 409.72-409.731.

Section 18. Section 624.915, Florida Statutes, is repealed.

Section 19. The Division of Law Revision and Information is directed to replace the phrase "the effective date of this act" wherever it occurs in this act with the date the act becomes a law.

Section 20. If any law amended by this act was also amended by a law enacted at the 2015 Regular Session of the Legislature, such laws shall be construed as if they had been enacted at the same session of the Legislature, and full effect shall be given to each if possible.

Section 21. This act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to the health insurance affordability exchange; providing a directive to the Division of Law Revision and Information; creating s. 409.72, F.S.; providing a short title; creating s. 409.721, F.S.; creating the Florida Health Insurance Affordability Exchange Program (FHIX) within the Agency for Health Care Administration; providing program authority and principles; creating s. 409.722, F.S.; defining terms; creating s. 409.723, F.S.; providing eligibility and enrollment criteria; providing patient rights and responsibilities; defining the term "disabled" providing premium levels; creating s. 409.724, F.S.; providing for premium credits and choice counseling;

establishing an education campaign; providing for customer support and disenrollment; creating s. 409.725, F.S.; providing for available products and services; creating s. 409.726, F.S.; requiring the department to develop accountability measures and performance standards governing the administration of the program; creating s. 409.727, F.S.; providing for a readiness review and a two-phase implementation schedule; creating s. 409.728, F.S.; providing program operation and management duties; creating s. 409.729, F.S.; providing for the development of a long-term reorganization plan and the formation of the FHIX Workgroup; creating s. 409.73, F.S.; authorizing the agency to seek federal approval; prohibiting the agency from implementing the FHIX waiver under certain circumstances; creating s. 409.731, F.S.; providing for program expiration; repealing s. 408.70, F.S., relating to legislative findings regarding access to affordable health care; amending s. 408.910, F.S.; revising legislative intent; redefining terms; revising the scope of the Florida Health Choices Program and the pricing of services under the program; providing requirements for operation of the marketplace; providing additional duties for the corporation to perform; requiring an annual report to the Governor and the Legislature; amending s. 409.904, F.S.; limiting eligible persons in the Medically Needy program to those under the age of 21 and pregnant women, and specifying an effective date; providing an

expiration date for the program; amending s. 624.91, F.S.; revising eligibility requirements for state-funded assistance; revising the duties and powers of the Florida Healthy Kids Corporation; revising provisions for the appointment of members of the board of the Florida Healthy Kids Corporation; requiring transition plans; repealing s. 624.915, F.S., relating to the operating fund of the Florida Healthy Kids Corporation; providing a directive to the Division of Law Revision and Information; providing for construction of the act in pari materia with laws enacted during the 2015 Regular Session of the Legislature; providing an effective date.

By Senator Bean

4-00009A-15A 20152A__

A bill to be entitled

An act relating to a health insurance affordability exchange; creating s. 409.720, F.S.; providing a short title; creating s. 409.721, F.S.; creating the Florida Health Insurance Affordability Exchange Program or FHIX in the Agency for Health Care Administration; providing program authority and principles; creating s. 409.722, F.S.; defining terms; creating s. 409.723, F.S.; providing eligibility and enrollment criteria; providing patient rights and responsibilities; providing premium levels; creating s. 409.724, F.S.; providing for premium credits and choice counseling; establishing an education campaign; providing for customer support and disenrollment; creating s. 409.725, F.S.; providing for available products and services; creating s. 409.726, F.S.; providing for program accountability; creating s. 409.727, F.S.; providing an implementation schedule; creating s. 409.728, F.S.; providing program operation and management duties; creating s. 409.729, F.S.; providing for the development of a long-term reorganization plan and the formation of the FHIX Workgroup; creating s. 409.730, F.S.; authorizing the agency to seek federal approval; creating s. 409.731, F.S.; providing for program expiration; repealing s. 408.70, F.S., relating to legislative findings regarding access to affordable health care; amending s. 408.910, F.S.; revising legislative intent; redefining terms; revising the scope of the Florida

Health Choices Program and the pricing of services under the program; providing requirements for operation of the marketplace; providing additional duties for the corporation to perform; requiring an annual report to the Governor and the Legislature; amending s. 409.904, F.S.; limiting eligible persons in the Medically Needy program to those under the age of 21 and pregnant women, and specifying an effective date; providing an expiration date for the program; amending s. 624.91, F.S.; revising eligibility requirements for state-funded assistance; revising the duties and powers of the Florida Healthy Kids Corporation; revising provisions for the appointment of members of the board of the Florida Healthy Kids Corporation; requiring transition plans; repealing s. 624.915, F.S., relating to the operating fund of the Florida Healthy Kids Corporation; providing an effective date.

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

Section 1. The Division of Law Revision and Information is directed to rename part II of chapter 409, Florida Statutes, as "Insurance Affordability Programs" and to incorporate ss. 409.720-409.731, Florida Statutes, under this part.

Section 2. Section 409.720, Florida Statutes, is created to read:

409.720 Short title.—Sections 409.720-409.731 may be cited as the "Florida Health Insurance Affordability Exchange Program"

or "FHIX."

Section 3. Section 409.721, Florida Statutes, is created to read:

409.721 Program authority.—The Florida Health Insurance Affordability Exchange Program, or FHIX, is created in the agency to assist Floridians in purchasing health benefits coverage and gaining access to health services. The products and services offered by FHIX are based on the following principles:

(1) FAIR VALUE.—Financial assistance will be rationally allocated regardless of differences in categorical eligibility.

(2) CONSUMER CHOICE.—Participants will be offered meaningful choices in the way they can redeem the value of the available assistance.

(3) SIMPLICITY.—Obtaining assistance will be consumer-friendly, and customer support will be available when needed.

(4) PORTABILITY.—Participants can continue to access the services and products of FHIX despite changes in their circumstances.

(5) PROMOTES EMPLOYMENT.—Assistance will be offered in a way that incentivizes employment.

(6) CONSUMER EMPOWERMENT.—Assistance will be offered in a manner that maximizes individual control over available resources.

(7) RISK ADJUSTMENT.—The amount of assistance will reflect participants' medical risk.

Section 4. Section 409.722, Florida Statutes, is created to read:

409.722 Definitions.—As used in ss. 409.720-409.731, the term:

(1) "Agency" means the Agency for Health Care Administration.

(2) "Applicant" means an individual who applies for determination of eligibility for health benefits coverage under this part.

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

(4) "Enrollee" means an individual who has been determined eligible for and is receiving health benefits coverage under this part.

(5) "FHIX marketplace" or "marketplace" means the single, centralized market established under s. 408.910 which facilitates health benefits coverage.

(6) "Florida Health Insurance Affordability Exchange Program" or "FHIX" means the program created under ss. 409.720-409.731.

(7) "Florida Healthy Kids Corporation" means the entity created under s. 624.91.

(8) "Florida Kidcare program" or "Kidcare program" means the health benefits coverage administered through ss. 409.810-409.821.

(9) "Health benefits coverage" means the payment of benefits for covered health care services or the availability, directly or through arrangements with other persons, of covered health care services on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(10) "Inactive status" means the enrollment status of a participant previously enrolled in health benefits coverage through the FHIX marketplace who lost coverage through the

marketplace for non-payment, but maintains access to his or her balance in a health savings account or health reimbursement account.

(11) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and part III and part IV of this chapter, as administered in this state by the agency.

(12) "Modified adjusted gross income" means the individual's or household's annual adjusted gross income as defined in s. 36B(d)(2) of the Internal Revenue Code of 1986 and which is used to determine eligibility for FHIX.

(13) "Patient Protection and Affordable Care Act" or "Affordable Care Act" means Pub. L. No. 111-148, as further amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and any amendments to, and regulations or guidance under, those acts.

(14) "Premium credit" means the monthly amount paid by the agency per enrollee in the Florida Health Insurance Affordability Exchange Program toward health benefits coverage.

(15) "Qualified alien" means an alien as defined in 8 U.S.C. s. 1641(b) or (c).

(16) "Resident" means a United States citizen or qualified alien who is domiciled in this state.

Section 5. Section 409.723, Florida Statutes, is created to read:

409.723 Participation.—

(1) ELIGIBILITY.—In order to participate in FHIX, an individual must be a resident and must meet the following requirements, as applicable:

(a) Qualify as a newly eligible enrollee, who must be an individual as described in s. 1902(a)(10)(A)(i)(VIII) of the Social Security Act or s. 2001 of the Affordable Care Act and as may be further defined by federal regulation.

(b) Meet and maintain the responsibilities under subsection (4).

(c) Qualify as a participant in the Florida Healthy Kids program under s. 624.91, subject to the implementation of Phase Three under s. 409.727.

(2) ENROLLMENT.—To enroll in FHIX, an applicant must submit an application to the department for an eligibility determination.

(a) Applications may be submitted by mail, fax, online, or any other method permitted by law or regulation.

(b) The department is responsible for any eligibility correspondence and status updates to the participant and other agencies.

(c) The department shall review a participant’s eligibility every 12 months.

(d) An application or renewal is deemed complete when the participant has met all the requirements under subsection (4).

(3) PARTICIPANT RIGHTS.—A participant has all of the following rights:

(a) Access to the FHIX marketplace to select the scope, amount, and type of health care coverage and other services to purchase.

(b) Continuity and portability of coverage to avoid disruption of coverage and other health care services when the participant’s economic circumstances change.

(c) Retention of applicable unspent credits in the participant's health savings or health reimbursement account following a change in the participant's eligibility status. Credits are valid for an inactive status participant for up to 5 years after the participant first enters an inactive status.

(d) Ability to select more than one product or plan on the FHIX marketplace.

(e) Choice of at least two health benefits products that meet the requirements of the Affordable Care Act.

(4) PARTICIPANT RESPONSIBILITIES.—A participant has all of the following responsibilities:

(a) Complete an initial application for health benefits coverage and an annual renewal process;

(b) Annually provide evidence of participation in one of the following activities at the levels required under paragraph (c):

1. Proof of employment.

2. On-the-job training or job placement activities.

3. Pursuit of educational opportunities.

(c) Engage in the activities required under paragraph (b) at the following minimum levels:

1. For a parent of a child younger than 18 years of age, a minimum of 20 hours weekly.

2. For a childless adult, a minimum of 30 hours weekly.

A participant who is a disabled adult or a caregiver of a disabled child or adult may submit a request for an exception to these requirements to the corporation and, thereafter, shall annually submit to the department a request to renew the

exception to the hourly level requirements.

(d) Learn and remain informed about the choices available on the FHIX marketplace and the uses of credits in the individual accounts.

(e) Execute a contract with the department to acknowledge that:

1. FHIX is not an entitlement and state and federal funding may end at any time;

2. Failure to pay required premiums or cost sharing will result in a transition to inactive status; and

3. Noncompliance with work or educational requirements will result in a transition to inactive status.

(f) Select plans and other products in a timely manner.

(g) Comply with program rules and the prohibitions against fraud, as described in s. 414.39.

(h) Timely make monthly premium and any other cost-sharing payments.

(i) Meet minimum coverage requirements by selecting a high-deductible health plan combined with a health savings or health reimbursement account if not selecting a plan offering more extensive coverage.

(5) COST SHARING.—

(a) Enrollees are assessed monthly premiums based on their modified adjusted gross income. The maximum monthly premium payments are set at the following income levels:

1. At or below 22 percent of the federal poverty level: $3.

2. Greater than 22 percent, but at or below 50 percent, of the federal poverty level: $8.

3. Greater than 50 percent, but at or below 75 percent, of

the federal poverty level: $15.

4. Greater than 75 percent, but at or below 100 percent, of the federal poverty level: $20.

5. Greater than 100 percent of the federal poverty level: $25.

(b) Depending on the products and services selected by the enrollee, the enrollee may also incur additional cost-sharing, such as copayments, deductibles, or other out-of-pocket costs.

(c) An enrollee may be subject to an inappropriate emergency room visit charge of up to $8 for the first visit and up to $25 for any subsequent visit, based on the enrollee's benefit plan, to discourage inappropriate use of the emergency room.

(d) Cumulative annual cost sharing per enrollee may not exceed 5 percent of an enrollee's annual modified adjusted gross income.

(e) If, after a 30-day grace period, a full premium payment has not been received, the enrollee shall be transitioned from coverage to inactive status and may not reenroll for a minimum of 6 months, unless a hardship exception has been granted. Enrollees may seek a hardship exception under the Medicaid Fair Hearing Process.

Section 6. Section 409.724, Florida Statutes, is created to read:

409.724 Available assistance.—

(1) PREMIUM CREDITS.—

(a) Standard amount.—The standard monthly premium credit is equivalent to the applicable risk-adjusted capitation rate paid to Medicaid managed care plans under part IV of this chapter.

(b) Supplemental funding.—Subject to federal approval, additional resources may be made available to enrollees and incorporated into FHIX.

(c) Savings accounts.—In addition to the benefits provided under this section, the corporation must offer each enrollee access to an individual account that qualifies as a health reimbursement account or a health savings account. Eligible unexpended funds from the monthly premium credit must be deposited into each enrollee's individual account in a timely manner. Enrollees may also be rewarded for healthy behaviors, adherence to wellness programs, and other activities established by the corporation which demonstrate compliance with prevention or disease management guidelines. Funds deposited into these accounts may be used to pay cost-sharing obligations or to purchase other health-related items to the extent permitted under federal law.

(d) Enrollee contributions.—The enrollee may make deposits to his or her account at any time to supplement the premium credit, to purchase additional FHIX products, or to offset other cost-sharing obligations.

(e) Third parties.—Third parties, including, but not limited to, an employer or relative, may also make deposits on behalf of the enrollee into the enrollee's FHIX marketplace account. The enrollee may not withdraw any funds as a refund, except those funds the enrollee has deposited into his or her account.

(2) CHOICE COUNSELING.—The agency and the corporation shall work together to develop a choice counseling program for FHIX. The choice counseling program must ensure that participants have

information about the FHIX marketplace program, products, and services and that participants know where and whom to call for questions or to make their plan selections. The choice counseling program must provide culturally sensitive materials and must take into consideration the demographics of the projected population.

(3) EDUCATION CAMPAIGN.—The agency, the corporation, and the Florida Healthy Kids Corporation must coordinate an ongoing enrollee education campaign beginning in Phase One, as provided in s. 409.27, informing participants, at a minimum:

(a) How the transition process to the FHIX marketplace will occur and the timeline for the enrollee's specific transition.

(b) What plans are available and how to research information about available plans.

(c) Information about other available insurance affordability programs for the individual and his or her family.

(d) Information about health benefits coverage, provider networks, and cost sharing for available plans in each region.

(e) Information on how to complete the required annual renewal process, including renewal dates and deadlines.

(f) Information on how to update eligibility if the participant's data have changed since his or her last renewal or application date.

(4) CUSTOMER SUPPORT.—Beginning in Phase Two, the Florida Healthy Kids Corporation shall provide customer support for FHIX, shall address general program information, financial information, and customer service issues, and shall provide status updates on bill payments. Customer support must also provide a toll-free number and maintain a website that is

available in multiple languages and that meets the needs of the enrollee population.

(5) INACTIVE PARTICIPANTS.—The corporation must inform the inactive participant about other insurance affordability programs and electronically refer the participant to the federal exchange or other insurance affordability programs, as appropriate.

Section 7. Section 409.725, Florida Statutes, is created to read:

409.725 Available products and services.—The FHIX marketplace shall offer the following products and services:

(1) Authorized products and services pursuant to s. 408.910.

(2) Medicaid managed care plans under part IV of this chapter.

(3) Authorized products under the Florida Healthy Kids Corporation pursuant to s. 624.91.

(4) Employer-sponsored plans.

Section 8. Section 409.726, Florida Statutes, is created to read:

409.726 Program accountability.—

(1) All managed care plans that participate in FHIX must collect and maintain encounter level data in accordance with the encounter data requirements under s. 409.967(2)(d) and are subject to the accompanying penalties under s. 409.967(2)(h)2. The agency is responsible for the collection and maintenance of the encounter level data.

(2) The corporation, in consultation with the agency, shall establish access and network standards for contracts on the FHIX

marketplace and shall ensure that contracted plans have sufficient providers to meet enrollee needs. The corporation, in consultation with the agency, shall develop quality of coverage and provider standards specific to the adult population.

(3) The department shall develop accountability measures and performance standards to be applied to applications and renewal applications for FHIX which are submitted online, by mail, by fax, or through referrals from a third party. The minimum performance standards are:

(a) Application processing speed.—Ninety percent of all applications, from all sources, must be processed within 45 days.

(b) Applications processing speed from online sources.—Ninety-five percent of all applications received from online sources must be processed within 45 days.

(c) Renewal application processing speed.—Ninety percent of all renewals, from all sources, must be processed within 45 days.

(d) Renewal application processing speed from online sources.—Ninety-five percent of all applications received from online sources must be processed within 45 days.

(4) The agency, the department, and the Florida Healthy Kids Corporation must meet the following standards for their respective roles in the program:

(a) Eighty-five percent of calls must be answered in 20 seconds or less.

(b) One hundred percent of all contacts, which include, but are not limited to, telephone calls, faxed documents and requests, and e-mails, must be handled within 2 business days.

(c) Any self-service tools available to participants, such as interactive voice response systems, must be operational 7 days a week, 24 hours a day, at least 98 percent of each month.

(5) The agency, the department, and the Florida Healthy Kids Corporation must conduct an annual satisfaction survey to address all measures that require participant input specific to the FHIX marketplace program. The parties may elect to incorporate these elements into the annual report required under subsection (7).

(6) The agency and the corporation shall post online monthly enrollment reports for FHIX.

(7) An annual report is due no later than July 1 to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The annual report must be coordinated by the agency and the corporation and must include, but is not limited to:

(a) Enrollment and application trends and issues.

(b) Utilization and cost data.

(c) Customer satisfaction.

(d) Funding sources in health savings accounts or health reimbursement accounts.

(e) Enrollee use of funds in health savings accounts or health reimbursement accounts.

(f) Types of products and plans purchased.

(g) Movement of enrollees across different insurance affordability programs.

(h) Recommendations for program improvement.

Section 9. Section 409.727, Florida Statutes, is created to read:

409.727 Implementation schedule.—The agency, the corporation, the department, and the Florida Healthy Kids Corporation shall begin implementation of FHIX by the effective date of this act, with statewide implementation in all regions, as described in s. 409.966(2), by January 1, 2016.

(1) READINESS REVIEW.—Before implementation of any phase under this section, the agency shall conduct a readiness review in consultation with the FHIX Workgroup described in s. 409.729. The agency must determine, at a minimum, the following readiness milestones:

(a) Functional readiness of the service delivery platform for the phase.

(b) Plan availability and presence of plan choice.

(c) Provider network capacity and adequacy of the available plans in the region.

(d) Availability of customer support.

(e) Other factors critical to the success of FHIX.

(2) PHASE ONE.—

(a) Phase One begins on July 1, 2015. The agency, the corporation, the department, and the Florida Healthy Kids Corporation shall coordinate activities to ensure that enrollment begins by July 1, 2015.

(b) To be eligible during this phase, a participant must meet the requirements under s. 409.723(1)(a).

(c) An enrollee is entitled to receive health benefits coverage in the same manner as provided under and through the selected managed care plans in the Medicaid managed care program in part IV of this chapter.

(d) An enrollee shall have a choice of at least two managed

care plans in each region.

(e) Choice counseling and customer service must be provided in accordance with s. 409.724(2).

(3) PHASE TWO.—

(a) Beginning no later than January 1, 2016, and contingent upon federal approval, participants may enroll or transition to health benefits coverage under the FHIX marketplace.

(b) To be eligible during this phase, a participant must meet the requirements under s. 409.723(1)(a) and (b).

(c) An enrollee may select any benefit, service, or product available.

(d) The corporation shall notify an enrollee of his or her premium credit amount and how to access the FHIX marketplace selection process.

(e) A Phase One enrollee must be transitioned to the FHIX marketplace by April 1, 2016. An enrollee who does not select a plan or service on the FHIX marketplace by that deadline shall be moved to inactive status.

(f) An enrollee shall have a choice of at least two managed care plans in each region which meet or exceed the Affordable Care Act's requirements and which qualify for a premium credit on the FHIX marketplace.

(g) Choice counseling and customer service must be provided in accordance with s. 409.724(2) and (4).

(4) PHASE THREE.—

(a) No later than July 1, 2016, the corporation and the Florida Healthy Kids Corporation must begin the transition of enrollees under s. 624.91 to the FHIX marketplace.

(b) Eligibility during this phase is based on meeting the

requirements of Phase Two and s. 409.723(1)(c).

(c) An enrollee may select any benefit, service, or product available under s. 409.725.

(d) A Florida Healthy Kids enrollee who selects a FHIX marketplace plan must be provided a premium credit equivalent to the average capitation rate paid in his or her county of residence under Florida Healthy Kids as of June 30, 2016. The enrollee is responsible for any difference in costs and may use any remaining funds for supplemental benefits on the FHIX marketplace.

(e) The corporation shall notify an enrollee of his or her premium credit amount and how to access the FHIX marketplace selection process.

(f) Choice counseling and customer service must be provided in accordance with s. 409.724(2) and (4).

(g) Enrollees under s. 624.91 must transition to the FHIX marketplace by September 30, 2016.

Section 10. Section 409.728, Florida Statutes, is created to read:

409.728 Program operation and management.—In order to implement ss. 409.720-409.731:

(1) The Agency for Health Care Administration shall do all of the following:

(a) Contract with the corporation for the development, implementation, and administration of the Florida Health Insurance Affordability Exchange Program and for the release of any federal, state, or other funds appropriated to the corporation.

(b) Administer Phase One of FHIX.

(c) Provide administrative support to the FHIX Workgroup under s. 409.729.

(d) Transition the FHIX enrollees to the FHIX marketplace beginning January 1, 2016, in accordance with the transition workplan. Stakeholders that serve low-income individuals and families must be consulted during the implementation and transition process through a public input process. All regions must complete the transition no later than April 1, 2016.

(e) Timely transmit enrollee information to the corporation.

(f) Beginning with Phase Two, determine annually the risk-adjusted rate to be paid per month based on historical utilization and spending data for the medical and behavioral health of this population, projected forward, and adjusted to reflect the eligibility category, medical and dental trends, geographic areas, and the clinical risk profile of the enrollees.

(g) Transfer to the corporation such funds as approved in the General Appropriations Act for the premium credits.

(h) Encourage Medicaid managed care plans to apply as vendors to the marketplace to facilitate continuity of care and family care coordination.

(2) The Department of Children and Families shall, in coordination with the corporation, the agency, and the Florida Healthy Kids Corporation, determine eligibility of applications and application renewals for FHIX in accordance with s. 409.902 and shall transmit eligibility determination information on a timely basis to the agency and corporation.

(3) The Florida Healthy Kids Corporation shall do all of

the following:

(a) Retain its duties and responsibilities under s. 624.91 for Phase One and Phase Two of the program.

(b) Provide customer service for the FHIX marketplace, in coordination with the agency and the corporation.

(c) Transfer funds and provide financial support to the FHIX marketplace, including the collection of monthly cost sharing.

(d) Conduct financial reporting related to such activities, in coordination with the corporation and the agency.

(e) Coordinate activities for the program with the agency, the department, and the corporation.

(4) Florida Health Choices, Inc., shall do all of the following:

(a) Begin the development of FHIX during Phase One.

(b) Implement and administer Phase Two and Phase Three of the FHIX marketplace and the ongoing operations of the program.

(c) Offer health benefits coverage packages on the FHIX marketplace, including plans compliant with the Affordable Care Act.

(d) Offer FHIX enrollees a choice of at least two plans per county at each benefit level which meet the requirements under the Affordable Care Act.

(e) Provide an opportunity for participation in Medicaid managed care plans if those plans meet the requirements of the FHIX marketplace.

(f) Offer enhanced or customized benefits to FHIX marketplace enrollees.

(g) Provide sufficient staff and resources to meet the

program needs of enrollees.

(h) Provide an opportunity for plans contracted with or previously contracted with the Florida Healthy Kids Corporation under s. 624.91 to participate with FHIX if those plans meet the requirements of the program.

(i) Encourage insurance agents licensed under chapter 626 to identify and assist enrollees. This act does not prohibit these agents from receiving usual and customary commissions from insurers and health maintenance organizations that offer plans in the FHIX marketplace.

Section 11. Section 409.729, Florida Statutes, is created to read:

409.729 Long-term reorganization.—The FHIX Workgroup is created to facilitate the implementation of FHIX and to plan for a multiyear reorganization of the state's insurance affordability programs. The FHIX Workgroup consists of two representatives each from the agency, the department, the Florida Healthy Kids Corporation, and the corporation. An additional representative of the agency serves as chair. The FHIX Workgroup must hold its organizational meeting no later than 30 days after the effective date of this act and must meet at least bimonthly. The role of the FHIX Workgroup is to make recommendations to the agency. The responsibilities of the workgroup include, but are not limited to:

(1) Recommend a Phase Two implementation plan no later than October 1, 2015.

(2) Review network and access standards for plans and products.

(3) Assess readiness and recommend actions needed to

reorganize the state's insurance affordability programs for each phase or region. If a phase or region receives a nonreadiness recommendation, the agency must notify the Legislature of that recommendation, the reasons for such a recommendation, and proposed plans for achieving readiness.

(4) Recommend any proposed change to the Title XIX-funded or Title XXI-funded programs based on the continued availability and reauthorization of the Title XXI program and its federal funding.

(5) Identify duplication of services among the corporation, the agency, and the Florida Healthy Kids Corporation currently and under FHIX's proposed Phase Three program.

(6) Evaluate any fiscal impacts based on the proposed transition plan under Phase Three.

(7) Compile a schedule of impacted contracts, leases, and other assets.

(8) Determine staff requirements for Phase Three.

(9) Develop and present a final transition plan that incorporates all elements under this section no later than December 1, 2015, in a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 12. Section 409.730, Florida Statutes, is created to read:

409.730 Federal participation.—The agency may seek federal approval to implement FHIX.

Section 13. Section 409.731, Florida Statutes, is created to read:

409.731 Program expiration.—The Florida Health Insurance Affordability Exchange Program expires at the end of Phase One

if the state does not receive federal approval for Phase Two or at the end of the state fiscal year in which any of these conditions occurs:

(1) The federal match contribution falls below 90 percent.

(2) The federal match contribution falls below the increased Federal Medical Assistance Percentage for medical assistance for newly eligible mandatory individuals as specified in the Affordable Care Act.

(3) The federal match for the FHIX program and the Medicaid program are blended under federal law or regulation in such a manner that causes the overall federal contribution to diminish when compared to separate, nonblended federal contributions.

Section 14. Section 408.70, Florida Statutes, is repealed.

Section 15. Section 408.910, Florida Statutes, is amended to read:

408.910 Florida Health Choices Program.—

(1) LEGISLATIVE INTENT.—The Legislature finds that a significant number of the residents of this state do not have adequate access to affordable, quality health care. The Legislature further finds that increasing access to affordable, quality health care can be best accomplished by establishing a competitive market for purchasing health insurance and health services. It is therefore the intent of the Legislature to create and expand the Florida Health Choices Program to:

(a) Expand opportunities for Floridians to purchase affordable health insurance and health services.

(b) Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits.

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

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

(e) Disseminate information to consumers on the price and quality of health services.

(f) Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

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

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

(b) "Corporation's marketplace" means the single, centralized market established by the program that facilitates the purchase of products made available in the marketplace.

(c) "Florida Health Insurance Affordability Exchange Program" or "FHIX" is the program created under ss. 409.720-409.731 for low-income, uninsured residents of this state.

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

(e) ~~(d)~~ "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, an exclusive provider organization as defined in s. 627.6472, ~~or~~ a health maintenance organization licensed under part I of chapter 641, ~~or~~ a prepaid limited health service organization or discount medical plan organization licensed under chapter 636, or a managed care plan contracted with the Agency for Health Care Administration under

the managed medical assistance program under part IV of chapter 409.

(f) "Patient Protection and Affordable Care Act" or "Affordable Care Act" means Pub. L. No. 111-148, as further amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and any amendments to or regulations or guidance under those acts.

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

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

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

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

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

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

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

4. Services that promote healthy behaviors.

5. Health benefits coverage information about health insurance plans compliant with the Affordable Care Act.

6. Consumer assistance and enrollment services for the Florida Health Insurance Affordability Exchange Program, or FHIX.

(d) Recruitment of vendors, including insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.

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

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

(g) Information services for individuals and employers.

(h) Program evaluation.

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

(a) Employers eligible to enroll in the program include those employers that meet criteria established by the

corporation and elect to make their employees eligible through the program.

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

1. Individual employees of enrolled employers.

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

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

1. Submission of required information.

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

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

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

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

6. Identification of eligible employees.

7. Arrangement for periodic payments.

8. Employer notification to employees of the intent to

transfer from an existing employee health plan to the program at least 90 days before the transition.

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

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

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

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

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

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

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

health services or treatments.

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

A vendor described in subparagraphs 3.-7. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation and is authorized to provide coverage in the relevant geographic area. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

(e) Eligible individuals may participate in the program voluntarily. Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures must include, but are not limited to:

1. Submission of required information.

2. Authorization for payroll deduction, if applicable.

3. Compliance with federal tax requirements.

4. Arrangements for payment.

5. Selection of products and services.

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

1. Submission of required information, including a complete

description of the coverage, services, provider network, payment restrictions, and other requirements of each product offered through the program.

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

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

4. Establishment of product prices based on applicable criteria.

5. Arrangements for receiving payment for enrolled participants.

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

7. Compliance with grievance procedures established by the corporation.

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

a health insurance agent shall comply with the procedures established by the corporation, including:

1. Completion of training requirements.

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

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

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

(5) PRODUCTS.—

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

1. Health insurance policies.

2. Health maintenance contracts.

3. Limited benefit plans.

4. Prepaid clinic services.

5. Service contracts.

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

7. Flexible spending accounts.

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

(c) Products may be offered for multiyear periods provided the price of the product is specified for the entire period or for each separately priced segment of the policy or contract.

(d) The corporation shall provide a disclosure form for consumers to acknowledge their understanding of the nature of,

and any limitations to, the benefits provided by the products and services being purchased by the consumer.

(e) The corporation must determine that making the plan available through the program is in the interest of eligible individuals and eligible employers in the state.

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

(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) Marketplace purchasing.—A participant needing personal assistance to select products and services shall be referred to a participating agent in his or her area.

1.~~(a)~~ Participation in the program may begin at any time during a year after the employer completes enrollment and meets the requirements specified by the corporation pursuant to paragraph (4)(c).

2.~~(b)~~ Initial selection of products and services must be made by an individual participant within the applicable open enrollment period.

3.~~(c)~~ Initial enrollment periods for each product selected by an individual participant must last at least 12 months, unless the individual participant specifically agrees to a different enrollment period.

4.~~(d)~~ If an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participant, changes in selected products and services may only be made during the annual enrollment period established by the corporation.

5.~~(e)~~ The limits established in subparagraphs 2., 3., and 4. ~~paragraphs (b)-(d)~~ apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(b) FHIX marketplace purchasing.—

1. Participation in the FHIX marketplace may begin at any time during the year.

2. Initial enrollment periods for certain products selected by an individual enrollee which are noncompliant with the Affordable Care Act may be required to last at least 12 months, unless the individual participant specifically agrees to a

different enrollment period.

(8) CONSUMER INFORMATION.—The corporation shall:

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

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

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

(10) EXEMPTIONS.—

(a) Products, other than the products set forth in subparagraphs (4)(d)1.-4., sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, as defined in s. 624.01 or the mandated offerings or coverages established in part VI of chapter 627 and chapter 641.

(b) The corporation may act as an administrator as defined in s. 626.88 but is not required to be certified pursuant to part VII of chapter 626. However, a third party administrator used by the corporation must be certified under part VII of

chapter 626.

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

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

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

1. Three ex officio, nonvoting members to include:

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

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

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

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

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

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

5. Board members may not include insurers, health insurance

agents or brokers, health care providers, health maintenance organizations, prepaid service providers, or any other entity, affiliate, or subsidiary of eligible vendors.

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

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

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

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

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

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

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

3. Specify policies and procedures regarding conflicts of

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

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

(h) The corporation may establish technical advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

(i) The corporation shall:

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

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

3. Arrange for collection of contributions from participating employers<u>, third parties, governmental entities,</u> and individuals.

4. Arrange for payment of premiums and other appropriate

disbursements based on the selections of products and services by the individual participants.

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

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

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

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

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

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

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

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

13. Administer the Florida Health Insurance Affordability Exchange Program in accordance with ss. 409.720-409.731.

14. Coordinate with the Agency for Health Care Administration, the Department of Children and Families, and the Florida Healthy Kids Corporation on the transition plan for FHIX and any subsequent transition activities.

(12) REPORT.—The board of the corporation shall ~~Beginning in the 2009-2010 fiscal year,~~ submit by February 1 an annual

report to the Governor, the President of the Senate, and the Speaker of the House of Representatives documenting the corporation's activities in compliance with the duties delineated in this section.

(13) PROGRAM INTEGRITY.—To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

(14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—

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

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

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

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

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

to the public; and that is information concerning:

a. Business plans.

b. Internal auditing controls and reports of internal auditors.

c. Reports of external auditors for privately held companies.

d. Client and customer lists.

e. Potentially patentable material.

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

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

(b) *Public record exemptions.*—

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

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

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

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

(d) *Authorized release.*—

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

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

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

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

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

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

(f) *Review and repeal.*—This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2016, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 16. Subsection (2) of section 409.904, Florida Statutes, is amended to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(2) A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would

be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled. Effective October 1, 2015, persons eligible under "medically needy" shall be limited to children under the age of 21 and pregnant women. This subsection expires October 1, 2019.

Section 17. Section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

(1) SHORT TITLE.—This section may be cited as the "William G. 'Doc' Myers Healthy Kids Corporation Act."

(2) LEGISLATIVE INTENT.—

(a) The Legislature finds that increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in this state. Many children do not have comprehensive, affordable health care services available. It is the intent of the Legislature that the Florida Healthy Kids Corporation provide comprehensive health insurance coverage to such children. The corporation is encouraged to cooperate with any existing health service programs funded by the public or the private sector.

(b) It is the intent of the Legislature that the Florida Healthy Kids Corporation serve as one of several providers of services to children eligible for medical assistance under Title XXI of the Social Security Act. Although the corporation may serve other children, the Legislature intends the primary recipients of services provided through the corporation be school-age children with a family income below 200 percent of the federal poverty level, who do not qualify for Medicaid. It is also the intent of the Legislature that state and local government Florida Healthy Kids funds be used to continue coverage, subject to specific appropriations in the General Appropriations Act, to children not eligible for federal matching funds under Title XXI.

(3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only residents of this state are eligible ~~the following individuals are eligible~~ for state-funded assistance in paying Florida Healthy Kids premiums pursuant to s. 409.814.~~:~~

~~(a) Residents of this state who are eligible for the Florida Kidcare program pursuant to s. 409.814.~~

~~(b) Notwithstanding s. 409.814, legal aliens who are enrolled in the Florida Healthy Kids program as of January 31, 2004, who do not qualify for Title XXI federal funds because they are not qualified aliens as defined in s. 409.811.~~

(4) NONENTITLEMENT.—Nothing in this section shall be construed as providing an individual with an entitlement to health care services. No cause of action shall arise against the state, the Florida Healthy Kids Corporation, or a unit of local government for failure to make health services available under this section.

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

(a) There is created the Florida Healthy Kids Corporation, a not-for-profit corporation.

(b) The Florida Healthy Kids Corporation shall:

1. Arrange for the collection of any individual, family, ~~local contributions,~~ or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.

2. Arrange for the collection of any voluntary contributions to provide for payment of Florida Kidcare program or Florida Health Insurance Affordability Exchange Program premiums ~~for children who are not eligible for medical assistance under Title XIX or Title XXI of the Social Security Act~~.

3. ~~Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional Florida Kidcare coverage in contributing counties under Title XXI.~~

~~4.~~ Establish the administrative and accounting procedures for the operation of the corporation.

4.~~5.~~ Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians.

5.~~6.~~ Determine eligibility for children seeking to

participate in the Title XXI-funded components of the Florida Kidcare program consistent with the requirements specified in s. 409.814~~, as well as the non-Title-XXI-eligible children as provided in subsection (3)~~.

6.~~7.~~ Establish procedures under which ~~providers of local match to,~~ applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation.

7.~~8.~~ Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.

8.~~9.~~ Establish enrollment criteria that include penalties or waiting periods of 30 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family or individual premiums.

9.~~10.~~ Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites.

a. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care.

b. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health and dental care contracts, the minimum medical loss ratio for a

Florida Healthy Kids Corporation contract shall be 85 percent. The calculations must use uniform financial data collected from all plans in a format established by the corporation and shall be computed for each plan on a statewide basis. Funds shall be classified in a manner consistent with 45 C.F.R. part 158 ~~For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail~~.

c. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.

d. Effective July 1, 2016, health and dental services contracts of the corporation must transition to the FHIX marketplace under s. 409.722. Qualifying plans may enroll as vendors with the FHIX marketplace to maintain continuity of care for participants.

10.~~11.~~ Establish disenrollment criteria in the event ~~local matching~~ funds are insufficient to cover enrollments.

11.~~12.~~ Develop and implement a plan to publicize the Florida Kidcare program, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.

12.~~13.~~ Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state ~~and local matching funds~~ and such other private or public funds as become available. The board of directors shall determine the number of

staff members necessary to administer the corporation.

13.~~14.~~ In consultation with the partner agencies, provide a report on the Florida Kidcare program annually to the Governor, the Chief Financial Officer, the Commissioner of Education, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and the House of Representatives.

14.~~15.~~ Provide information on a quarterly basis online to the Legislature and the Governor which compares the costs and utilization of the full-pay enrolled population and the Title XXI-subsidized enrolled population in the Florida Kidcare program. The information, at a minimum, must include:

a. The monthly enrollment and expenditure for full-pay enrollees in the Medikids and Florida Healthy Kids programs compared to the Title XXI-subsidized enrolled population; and

b. The costs and utilization by service of the full-pay enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population.

15.~~16.~~ Establish benefit packages that conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.821.

16. Contract with other insurance affordability programs and FHIX to provide customer service or other enrollment-focused services.

17. Annually develop performance metrics for the following focus areas:

a. Administrative functions.

b. Contracting with vendors.

c. Customer service.

d. Enrollee education.

e. Financial services.

f. Program integrity.

(c) Coverage under the corporation's program is secondary to any other available private coverage held by, or applicable to, the participant child or family member. Insurers under contract with the corporation are the payors of last resort and must coordinate benefits with any other third-party payor that may be liable for the participant's medical care.

(d) The Florida Healthy Kids Corporation shall be a private corporation not for profit, organized pursuant to chapter 617, and shall have all powers necessary to carry out the purposes of this act, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of this act.

(6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors. The board chair shall be an appointee designated by the Governor, and the board shall be ~~chaired by the Chief Financial Officer or her or his designee, and~~ composed of 12 other members. The Senate shall confirm the designated chair and other board appointees. The board members shall be appointed ~~selected~~ for 3-year terms. ~~of office as follows:~~

~~1. The Secretary of Health Care Administration, or his or her designee.~~

~~2. One member appointed by the Commissioner of Education from the Office of School Health Programs of the Florida Department of Education.~~

~~3. One member appointed by the Chief Financial Officer from among three members nominated by the Florida Pediatric Society.~~

~~4. One member, appointed by the Governor, who represents the Children's Medical Services Program.~~

~~5. One member appointed by the Chief Financial Officer from among three members nominated by the Florida Hospital Association.~~

~~6. One member, appointed by the Governor, who is an expert on child health policy.~~

~~7. One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Academy of Family Physicians.~~

~~8. One member, appointed by the Governor, who represents the state Medicaid program.~~

~~9. One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Association of Counties.~~

~~10. The State Health Officer or her or his designee.~~

~~11. The Secretary of Children and Families, or his or her designee.~~

~~12. One member, appointed by the Governor, from among three members nominated by the Florida Dental Association.~~

(b) A member of the board of directors <u>serves at the pleasure of the Governor</u> ~~may be removed by the official who appointed that member~~. The board shall appoint an executive director, who is responsible for other staff authorized by the

board.

(c) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061.

(d) There shall be no liability on the part of, and no cause of action shall arise against, any member of the board of directors, or its employees or agents, for any action they take in the performance of their powers and duties under this act.

(e) Board members who are serving as of the effective date of this act may remain on the board until January 1, 2016.

(7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

(a) The corporation shall not be deemed an insurer. The officers, directors, and employees of the corporation shall not be deemed to be agents of an insurer. Neither the corporation nor any officer, director, or employee of the corporation is subject to the licensing requirements of the insurance code or the rules of the Department of Financial Services. However, any marketing representative utilized and compensated by the corporation must be appointed as a representative of the insurers or health services providers with which the corporation contracts.

(b) The board has complete fiscal control over the corporation and is responsible for all corporate operations.

(c) The Department of Financial Services shall supervise any liquidation or dissolution of the corporation and shall have, with respect to such liquidation or dissolution, all power granted to it pursuant to the insurance code.

(8) TRANSITION PLANS.—The corporation shall confer with the Agency for Health Care Administration, the Department of

Children and Families, and Florida Health Choices, Inc., to develop transition plans for the Florida Health Insurance Affordability Exchange Program as created under ss. 409.720-409.731.

Section 18. Section 624.915, Florida Statutes, is repealed.

Section 19. The Division of Law Revision and Information is directed to replace the phrase "the effective date of this act" wherever it occurs in this act with the date the act becomes a law.

Section 20. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

6/11/15
Meeting Date

2A
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Leslie Dughi

Job Title _____

Address 101 E College Ave
Street
Tall FL 32301
City *State* *Zip*

Phone _____

Email dughi@gtlaw.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

06-01-2015
Meeting Date

2A
Bill Number (if applicable)

Topic Florida Health Information Exchange

Amendment Barcode (if applicable)

Name Michael Daniels

Job Title Executive Director

Address 3333 W Pensacola Street
Street
Tallahassee FL 32304
City *State* *Zip*

Phone

Email

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Alliance for Assistive Services and Technology

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Communications, Energy, and Public Utilities, *Chair*
Agriculture
Appropriations
Appropriations Subcommittee on Health and Human Services
Health Policy
Transportation

JOINT COMMITTEES:
Joint Administrative Procedures Committee
Joint Legislative Budget Commission

SENATOR DENISE GRIMSLEY
Deputy Majority Leader
21st District

May 27, 2015

The Honorable Gardiner
President of the Senate
409, The Capitol
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Mr. President,

I respectfully request to be excused from Senate business Monday June 1st for family business. I will arrive in Tallahassee Monday evening.

Sincerely,

Denise Grimsley

Denise Grimsley
State Senator, District 21

X

REPLY TO:
☐ 205 South Commerce Avenue, Suite A, Sebring, Florida 33870 (863) 386-6016
☐ 212 East Stuart Avenue, Lake Wales, Florida 33853 (863) 679-4847
☐ 306 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5021

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on General Government, *Vice Chair*
Ethics and Elections
Health Policy
Higher Education
Regulated Industries
Transportation

JOINT COMMITTEE:
Joint Legislative Budget Commission

SENATOR OSCAR BRAYNON II
Democratic Leader Pro Tempore
36th District

June 1, 2015

Senator Bean, Chair
Health Policy
302 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1300

Dear Chair Bean:

I respectfully request an excused absence for the Health Policy meeting on, June 1, 2015.

Thank you in advance for your consideration.

Sincerely,

Senator Oscar Braynon II,
District 36

cc. Senator Arthenia Joyner, Minority Leader
Sandra Stovall, Staff Director
Celia Georgiades, Committee Administrative Asst.

REPLY TO:
☐ 606 NW 183rd Street, Miami Gardens, Florida 33169 (305) 654-7150 FAX: (305) 654-7152
☐ 213 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5036

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 6/1/2015 4:06:12 PM
Ends: 6/1/2015 5:02:14 PM Length: 00:56:03

4:06:14 PM Roll Call
4:06:39 PM Chair Bean - Senator Grimsley is excused from today's meeting
4:07:03 PM Chair Bean
4:07:54 PM Senator Sobel, Chair
4:08:32 PM Tab 1: SB 2-A, Health Insurance Affordability Exchange
4:08:41 PM Senator Bean remarks
4:14:30 PM AM 260258 by Senator Bean
4:16:19 PM Chair Sobel
4:16:29 PM Senator Gaetz
4:17:31 PM Senator Bean
4:17:45 PM Carol Gormley, Senior Policy Advisor on Health
4:17:50 PM Senator Gaetz
4:18:18 PM Senator Bean
4:18:42 PM Carol Gormley, Senior Policy Advisor on Health
4:18:58 PM Senator Bean
4:19:32 PM Senator Gaetz
4:20:06 PM Senator Gaetz
4:20:36 PM Senator Bean
4:21:15 PM Senator Gaetz
4:21:19 PM Senator Gaetz
4:21:59 PM Senator Gaetz
4:22:02 PM Carol Gormley, Senior Policy Advisor on Health
4:22:04 PM Senator Gaetz
4:22:42 PM Senator Bean
4:22:45 PM Senator Gaetz
4:23:53 PM Senator Bean
4:24:43 PM Senator Gaetz
4:24:47 PM Chair Sobel
4:24:59 PM Senator Gibson
4:26:13 PM Senator Bean
4:27:02 PM Senator Soto
4:27:13 PM Senator Bean
4:27:55 PM Senator Joyner
4:28:13 PM Senator Bean
4:28:36 PM Chair Sobel
4:28:56 PM Senator Bean
4:28:57 PM Senator Bradley
4:29:28 PM Senator Bean
4:30:34 PM Senator Thompson
4:31:17 PM Carol Gormley, Senior Policy Advisor on Health
4:32:21 PM Senator Gaetz
4:33:15 PM Senator Bean
4:36:21 PM Chair Sobel
4:36:48 PM Senator Bean
4:37:02 PM Jennifer Lloyd, Legislative Analyst
4:37:43 PM Chair Sobel
4:37:49 PM Senator Gaetz
4:37:52 PM Jennifer Lloyd, Legislative Analyst
4:38:13 PM Senator Gaetz
4:39:17 PM Senator Bean
4:39:30 PM Senator Sobel
4:39:34 PM Senator Bean

4:39:45 PM Chair Sobel
4:39:54 PM Senator Bean
4:40:06 PM Senator Gibson
4:41:02 PM Carol Gormley, Senior Policy Advisor on Health
4:42:08 PM Chair Sobel
4:42:13 PM Senator Gibson
4:42:44 PM Chair Sobel
4:43:57 PM Senator Bean
4:44:02 PM Senator Gaetz
4:45:06 PM Senator Gaetz
4:45:06 PM Senator Bean
4:45:19 PM Senator Gaetz
4:45:50 PM Senator Bean
4:46:07 PM Senator Bradley
4:46:34 PM Senator Bean
4:47:29 PM AM 260258 Adopted
4:47:31 PM Chair Sobel
4:47:49 PM Senator Garcia
4:49:08 PM Senator Bean
4:49:11 PM Chair Sobel
4:49:20 PM Senator Bean
4:49:38 PM Chair Sobel
4:49:46 PM Senator Bean
4:49:48 PM Chair Sobel
4:51:13 PM Senator Bean
4:51:20 PM Chair Sobel
4:51:29 PM Senator Garcia
4:52:12 PM Chair Sobel
4:52:16 PM Senator Bean
4:52:34 PM Michael Daniels, Executive Director, Florida Alliance for Assistive Services and Technology, waives in support
4:52:58 PM Leslie Dughi, Associated Industries of Florida, waives in support
4:53:28 PM Senator Galvano
4:54:07 PM Senator Gaetz
4:57:59 PM Senator Garcia
4:59:04 PM Chair Sobel
5:00:48 PM Senator Bean's closing remarks
5:01:38 PM Roll Call SB 2-A
5:02:08 PM Meeting Adjourned