

**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	<b>SB 2-A</b> 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.)

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

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BILL: CS/SB 2-A

INTRODUCER: Health Policy Committee and Senator Bean

SUBJECT: Health Insurance Affordability Exchange

DATE: June 1, 2015

REVISED: \_\_\_\_\_

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

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**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

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**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.<sup>1</sup> Of that number, 594,000 were projected to be children.<sup>2</sup> Approximately 900,000 adults in Florida were estimated to have incomes under 100 percent of the FPL, according to statistics for 2013.<sup>3</sup>

Beginning January 1, 2014, health insurance coverage in Florida became available through the federal exchange<sup>4</sup> 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.<sup>5,6</sup> The survey was conducted from January through April 2014.<sup>7</sup>

### 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.<sup>8</sup>

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<sup>1</sup> 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](http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2071.pdf) (last visited May 26, 2015).

<sup>2</sup> Ibid.

<sup>3</sup> 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).

<sup>4</sup> 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](http://www.healthcare.gov).

<sup>5</sup> 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).

<sup>6</sup> 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).

<sup>7</sup> More current, reliable estimates of the number of uninsured Floridians is not available at this time.

<sup>8</sup> See s. 409.963, F.S.

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

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.<sup>13</sup>

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.<sup>14</sup> Applicants must also agree to cooperate with Child Support Enforcement during the application process.<sup>15</sup>

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<sup>9</sup>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](http://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/docs/age_assistance_category_2015-04-30.pdf) (last visited May 26, 2015).

<sup>10</sup> 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).

<sup>11</sup> 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.

<sup>12</sup>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](http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2759.pdf) (last visited: May 26, 2015).

<sup>13</sup> Id at 10.

<sup>14</sup> 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).

<sup>15</sup> Id.

Florida’s Current Medicaid and CHIP Eligibility Levels in Florida <sup>16</sup> (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 <sup>17</sup> 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.<sup>18</sup> States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.<sup>19</sup> 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.<sup>20</sup>

**Statewide Medicaid Managed Care**

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) Program as part IV of ch. 409, F.S.<sup>21</sup> 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.

<sup>16</sup> 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).

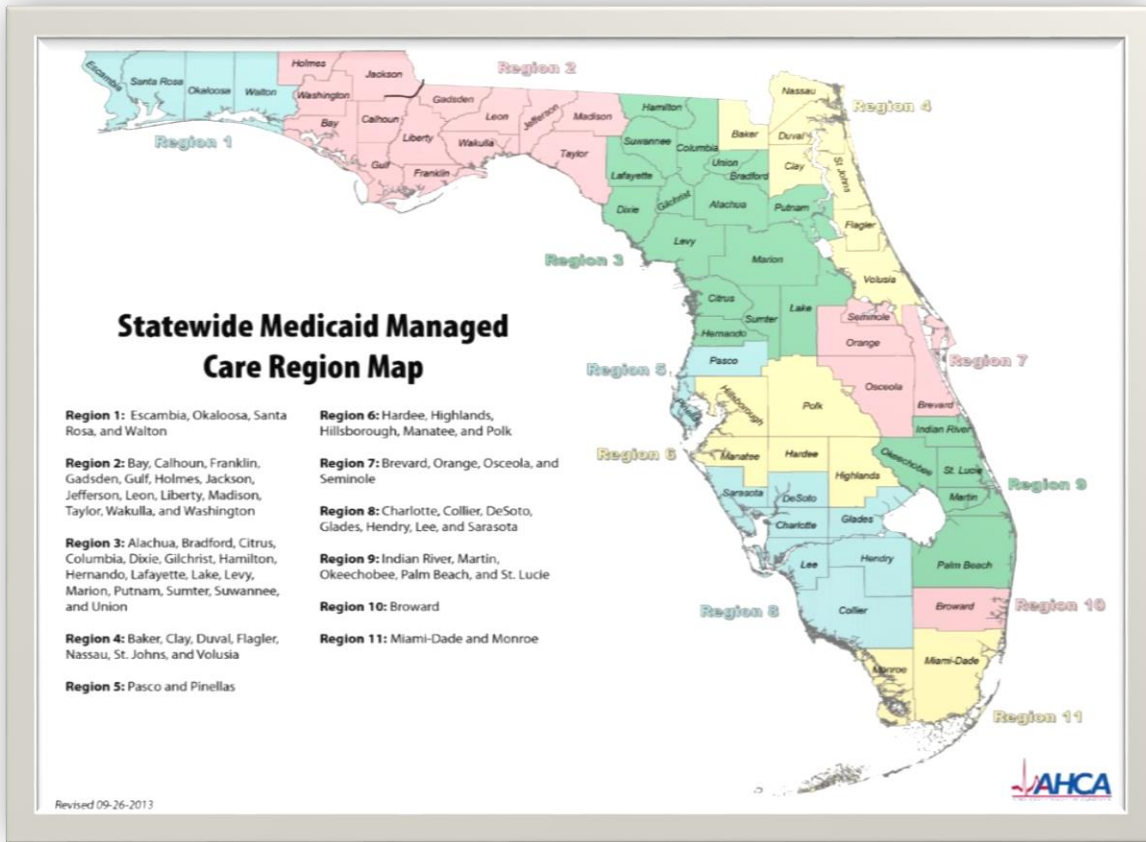
<sup>17</sup> U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid and CHIP Program Information - 2015 Federal Poverty Level Charts* <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf> (last visited May 26, 2015).

<sup>18</sup> Section 409.905, F.S.

<sup>19</sup> Section 409.906, F.S.

<sup>20</sup> See Section 1905 9(r) of the Social Security Act.

<sup>21</sup> 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.<sup>22</sup>

***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;

<sup>22</sup> 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](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.<sup>23</sup>

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.<sup>24</sup>

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.<sup>25</sup>

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.<sup>26</sup>

#### ***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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<sup>23</sup> 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](http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf) (last visited May 26, 2015).

<sup>24</sup> Id.

<sup>25</sup> Id.

<sup>26</sup> 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](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.<sup>27</sup>

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.<sup>28</sup>

### **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

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<sup>27</sup> Section 409.972, F.S.

<sup>28</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid 1115 Demonstration Fact Sheet* (July 31, 2014), <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicare-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.<sup>29</sup> 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.<sup>30</sup>

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*.<sup>31</sup> 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.<sup>32</sup>

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.<sup>33</sup>

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;

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<sup>29</sup> 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](http://www.floridakidcare.org/council/wp-content/uploads/2014/08/2014_Annual_Report.pdf) (last reviewed May 26, 2015).

<sup>30</sup> 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).

<sup>31</sup> Public Law No. 114-10.

<sup>32</sup> Florida Healthy Kids Corporation, *History*, <https://www.healthykids.org/healthykids/history/> (last visited May 26, 2015).

<sup>33</sup> 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.<sup>34</sup>

The FHKC is governed by a 13-member board of directors, chaired by Florida's Chief Financial Officer or his or her designee.<sup>35</sup> 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;

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<sup>34</sup> See Florida Healthy Kids Corporation, *Benefits*, <https://www.healthykids.org/benefits/medical/> (last visited May 26, 2015).

<sup>35</sup> 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.<sup>36</sup>

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.<sup>37</sup>

### **Florida Health Choices Corporation, Inc. (Corporation)**

In 2008, the Legislature created the Florida Health Choices Program to address the issue of Florida's uninsured.<sup>38</sup> 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

<sup>36</sup> See s. 624.91(5), F.S.

<sup>37</sup> See s. 624.91(7), F.S.

<sup>38</sup> 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.<sup>39</sup>

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

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<sup>39</sup> See s. 408.910(4)(a), F.S.

that are compliant with the Patient Protection and Affordable Care Act (PPACA)<sup>40</sup> across the different metal ranges, dental-only plans, vision and hearing plans, telemedicine plans, discount plans, and prescription drug plans.<sup>41</sup> 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.<sup>42</sup> The marketplace recorded 4,800 visits during its January open enrollment.<sup>43</sup>

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.<sup>44</sup>

### **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.<sup>45</sup> 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.<sup>46</sup> 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

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<sup>40</sup> 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](http://www.naic.org/documents/index_health_reform_ppaca_uniform_compliance_summary.pdf) (last visited May 26, 2015).

<sup>41</sup> Florida Office of Insurance Regulation, *Cover Florida Health Care Access Program Annual Report* (March 2015), <http://www.flor.com/siteDocuments/CoverFlorida2015.pdf> (last visited May 26, 2015).

<sup>42</sup> Florida Health Choices Corporation, *Florida Health Choices Reports Zero Glitches with New Online Marketplace Launched in January* (February 20, 2015) <http://www.myfloridachchoices.org/florida-health-choices-reports-zero-glitches-with-new-online-marketplace-launched-in-january/> (last visited May 26, 2015).

<sup>43</sup> Id.

<sup>44</sup> Conversation with Rose Naff, CEO, Florida Health Choices, Inc., (Mar. 9, 2015); re-confirmed via email from Rose Naff on May 26, 2015.

<sup>45</sup> Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010) and (Pub. Law No. 111-152, 111th Cong. (Mar. 30, 2010).

<sup>46</sup> 42 U.S.C. s. 1396a(1).

2020.<sup>47</sup> 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.<sup>48</sup>

<b>Enhanced Medicaid Match Rate for Newly Eligible Only: CY 2014 and Beyond<sup>49</sup></b>							
<b>CY</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020+</b>
<b>FMAP</b>	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.<sup>50</sup> 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.<sup>51</sup>

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.<sup>52</sup> 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.<sup>53</sup>

### **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.<sup>54</sup> 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)

<sup>47</sup> 42 U.S.C. s. 1396d(y)(1).

<sup>48</sup> 42 U.S.C. s. 1396c

<sup>49</sup> *Supra* at Note 63.

<sup>50</sup> *National Federation of Independent Business (NFIB) v. Sebelius, Secretary of Health and Human Services*, 648 F. 3d 1235, affirmed in part, reversed in part.

<sup>51</sup> 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).

<sup>52</sup> *Letter to National Governor's Association from Secretary Sebelius*, January 14, 2013 (copy on file with Senate Health Policy Committee).

<sup>53</sup> 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).

<sup>54</sup> 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.<sup>55</sup> 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.<sup>56</sup> 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.<sup>57</sup> 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.<sup>58</sup>

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.<sup>59</sup>

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<sup>55</sup> Id.

<sup>56</sup> Internal Revenue Service, *Employer Shared Responsibilities Provisions*, <http://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions> (last visited May 26, 2015).

<sup>57</sup> Id.

<sup>58</sup> 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).

<sup>59</sup> 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.<sup>60</sup> 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.<sup>61</sup>

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.<sup>62</sup>

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.<sup>63</sup>

## 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.<sup>64</sup> 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:<sup>65</sup>

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

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<sup>60</sup> 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).

<sup>61</sup>Id.

<sup>62</sup> 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).

<sup>63</sup> Id.

<sup>64</sup> 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).

<sup>65</sup>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](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.<sup>66</sup> 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.<sup>67</sup> 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.<sup>68</sup>

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<sup>66</sup> 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).

<sup>67</sup> 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).

<sup>68</sup> 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.<sup>69</sup>

Each plan sold must also be one of the following actuarial values<sup>70</sup> 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.<sup>71</sup> 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:<sup>72</sup>

<b>Premium Tax Credits</b>	
<b>Income Range</b>	<b>Premium Percentage Range (% of income)</b>
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.

<sup>69</sup> Id.

<sup>70</sup> 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.

<sup>71</sup> 26 U.S.C. s. 36B(c).

<sup>72</sup> 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.

<b>Cost Sharing Subsidies<sup>73</sup></b>	
<b>FPL Level</b>	<b>Cost Sharing Subsidy</b>
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.<sup>74</sup> 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.<sup>75</sup>

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.<sup>76</sup> 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<sup>77</sup> 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.<sup>78</sup> 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.<sup>79</sup> 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.

<sup>73</sup> 42 U.S.C. s. 18071(c)(1)(B)

<sup>74</sup> 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.

<sup>75</sup> 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).

<sup>76</sup> Internal Revenue Code, 26 U.S.C. sec. 223.

<sup>77</sup> The IRS annually sets the contribution limit as adjusted by inflation.

<sup>78</sup> 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).

<sup>79</sup> 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.<sup>80</sup>

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.<sup>81</sup>

<b>Arkansas’ Approved Monthly Premiums - Medicaid Expansion Waiver<sup>82</sup></b>		
<b>Less than 50%</b>	<b>50% - 100%</b>	<b>100 - 138% FPL</b>
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.<sup>83</sup>

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.<sup>84</sup>

<sup>80</sup> 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).

<sup>81</sup> 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).

<sup>82</sup> 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).

<sup>83</sup> 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).

<sup>84</sup> 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.<sup>85</sup>

<b>Iowa’s Approved Monthly Premiums - Medicaid Expansion Waiver</b>		
<b>Less than 50% FPL</b>	<b>50% - 100% FPL</b>	<b>100 - 133% FPL</b>
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.<sup>86</sup> 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.<sup>87</sup> 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.<sup>88</sup>

***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:

<sup>85</sup> 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](http://dhs.iowa.gov/sites/default/files/WellnessSTCsTechnicalCorrections_020215.pdf) (last visited May 26, 2015).

<sup>86</sup> Iowa Department of Human Services, Medicaid 1115 Waiver Application, Iowa Wellness Plan, p.5, [http://dhs.iowa.gov/sites/default/files/IAWellnessPlan1115\\_Final.pdf](http://dhs.iowa.gov/sites/default/files/IAWellnessPlan1115_Final.pdf) (last visited May 26, 2015).

<sup>87</sup> Iowa Department of Human Services, Medicaid 1115 Waiver, Iowa Marketplace Choice Plan, p.5, [http://dhs.iowa.gov/sites/default/files/IAMktplaceChoice1115\\_Final.pdf](http://dhs.iowa.gov/sites/default/files/IAMktplaceChoice1115_Final.pdf) (last visited May 26, 2015)

<sup>88</sup> 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.medicare.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.<sup>89</sup>

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.<sup>90</sup> 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:

<b>Indiana HIP Basic Co-Pay Schedule<sup>91</sup></b>	
<b>Service</b>	<b>Per Visit/Service</b>
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.<sup>92</sup> There are exceptions to the lock-out period for the medically frail and other special circumstances.

<sup>89</sup> 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).

<sup>90</sup> 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).

<sup>91</sup> Id at 35 and 36.

<sup>92</sup> Id.



<b>Indiana Maximum Monthly POWER Contributions<sup>93</sup></b>					
<b>&lt;5% FPL</b>	<b>&lt;22%</b>	<b>22% - 50%</b>	<b>51% - 75%</b>	<b>76% - 100%</b>	<b>101%-138%</b>
\$1	\$4.32	\$9.82	\$14.72	\$19.62	\$27.39
<ul style="list-style-type: none"> <li>- Represents approximately 2% of enrollee’s income;</li> <li>- When enrollee leaves the program, the member amount is refunded to the member; and</li> <li>- 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.</li> </ul>					

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.<sup>94</sup> 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.<sup>95</sup>

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.<sup>96</sup>

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.<sup>97</sup>

**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

<sup>93</sup> 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).

<sup>94</sup> *Supra* Note 108, at 26.

<sup>95</sup> *Id.*

<sup>96</sup> *Supra* Note 108, at 30.

<sup>97</sup> *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);<sup>98</sup> 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:

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<sup>98</sup> “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:

<b>FPL</b>	<b>at or &lt;22</b>	<b>&gt;22% - 50%</b>	<b>&gt;50%-75%</b>	<b>&gt;75%-100%</b>	<b>&gt;100%</b>
<b>Amount</b>	\$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.

<b>Implementation Activities</b>			
<b>Phase</b>	<b>Start Date</b>	<b>Activities</b>	<b>Enrollee Requirements</b>
Readiness	Effective Date - Ongoing Based on Phase/Region	<p><b>Implementation Activities</b></p> <ul style="list-style-type: none"> <li>-The AHCA initiates waiver application and approval process</li> <li>-The Corporation readies for implementation of FHIX marketplace</li> <li>-Healthy Kids prepares for customer service and financial services support in Phases One and Two; continuation of Title XXI eligibility determination services</li> <li>-Agency prepares for choice counseling services</li> <li>-Department prepares for FHIX eligibility determination services</li> </ul>	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.

<b>Activity</b>	<b>Phase One</b>	<b>Phase Two</b>
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.:

<b>Specific Program Operations and Management Duties for FHIX</b>			
<b>Agency for Health Care Admin.</b>	<b>Dept. of Children and Families</b>	<b>Florida Health Choices, Inc.</b>	<b>Florida Healthy Kids</b>
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

<b>Specific Program Operations and Management Duties for FHIX</b>			
<b>Agency for Health Care Admin.</b>	<b>Dept. of Children and Families</b>	<b>Florida Health Choices, Inc.</b>	<b>Florida Healthy Kids</b>
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.<sup>99</sup> 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.<sup>100</sup>
- 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

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<sup>99</sup> 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).

<sup>100</sup> Id.

\$2.5 billion in state general revenue, and \$541 million a year in local government revenue.<sup>101</sup>

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.<sup>102</sup>

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).

<b>Medicaid Expansion Base Population Assumptions Working or School Enrollment Status (2011-2013)<sup>103</sup></b>	
<b>Population</b>	<b>Percentage</b>
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

<sup>101</sup> Florida Hospital Association, *A Healthy Florida Works*, <http://ahealthyfloridaworks.com/v6/wp-content/uploads/2014/10/AHealthyFloridaIGv10.pdf> (last visited May 27, 2015).

<sup>102</sup> Id.

<sup>103</sup> 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](http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2857&Session=2015A&DocumentType=Meeting%20Packets&FileName=hhsc%206-1-15.pdf) (last visited June 1, 2015).

- Disability definition. - Broadening the disability definition may increase caseload and expenditures.<sup>104</sup>

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
<i>Uninsured Presenters (new)</i>	-	(32.5)	(75.0)	(92.1)	(125.7)	(154.2)	(160.8)	(167.6)	(174.6)	(181.8)
<i>Crowd-Out (new)</i>	-	(1.9)	(4.3)	(5.2)	(7.0)	(8.5)	(8.8)	(9.0)	(9.3)	(9.6)
<i>Disabled Care Adjustments</i>	-	(9.8)	(22.5)	(27.7)	(37.7)	(46.3)	(48.2)	(50.2)	(52.3)	(54.4)
<i>Medically Needy Shift (net)</i>	69.3	219.0	200.5	193.9	180.8	172.1	172.5	172.8	173.1	173.5
<i>Medically Needy Sunset</i>	0.0	44.2	44.1	44.0	47.1	48.2	48.3	48.4	48.5	48.6
<i>Healthy Kids Title XXI</i>	N/A	0.9	1.0	1.0	5.3	6.8	6.9	7.0	7.1	7.2
<i>Medicaid Subtotal</i>	69.3	219.9	143.8	113.9	62.7	18.2	10.0	1.5	(7.3)	(16.4)
<i>Insurance Premium Revenue Adj.</i>	0.0	(9.3)	(6.3)	(6.6)	(6.9)	(7.2)	(7.5)	(7.8)	(8.2)	(8.5)
<b>Total</b>	69.3	210.7	137.6	107.3	55.8	11.0	2.5	(6.4)	(15.5)	(24.9)
<b>Compared to SB 2-A</b>	-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
<i>Uninsured Presenters (new)</i>	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
<i>Crowd-Out (new)</i>	21.5	74.0	73.9	75.2	75.8	76.7	79.0	81.3	83.7	86.1
<i>Disabled Care Adjustments</i>	109.2	381.5	385.8	398.2	406.3	416.5	433.9	451.8	470.4	489.5
<i>Medically Needy Shift (net)</i>	67.8	213.8	195.3	188.7	175.6	167.0	167.3	167.7	168.0	168.4
<i>Medically Needy Sunset</i>	0.0	(69.6)	(69.9)	(70.3)	(75.9)	(77.8)	(78.0)	(78.2)	(78.3)	(78.5)
<i>Healthy Kids Title XXI</i>	N/A	(21.0)	(23.4)	(23.8)	(19.8)	(18.7)	(19.0)	(19.2)	(19.5)	(19.8)
<i>Medicaid Subtotal</i>	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
<i>Insurance Premium Revenue Adj.</i>	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
<b>Total</b>	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
<b>Compared to SB 2-A</b>	-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
<i>New Enrollees Related to Disabled Care Adjustments</i>	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.<sup>105</sup>

### 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

<sup>104</sup> Id at 39.

<sup>105</sup> 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.<sup>106</sup>

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.<sup>107</sup>

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.

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<sup>106</sup> 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.

<sup>107</sup> 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.<sup>108</sup>

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<sup>108</sup> 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.<sup>109</sup>

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 FHIIX marketplace housed at Florida Health Choices.

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

	<b>Year One Total</b>	<b>Federal Match</b>	<b>State Share</b>	<b>Year Two Total</b>	<b>Federal Match</b>	<b>State Share</b>
<b>AHCA</b> <sup>110</sup>						
FHIIX 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
<b>AHCA Total</b>	<b>\$2,804,972,693</b>	<b>\$2,801,322,693</b>	<b>\$3,650,000</b>	<b>\$3,658,624,161</b>	<b>\$3,563,572,307</b>	<b>\$95,051,854</b>
<b>DCF</b>						
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

<sup>109</sup> Id at 6.

<sup>110</sup> 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 FHIIX 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			
<b>DCF Total</b>	<b>\$7,539,164</b>	<b>\$5,773,413</b>	<b>\$1,765,751</b>	<b>\$4,103,330</b>	<b>\$3,057,374</b>	<b>\$1,045,957</b>

**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
<b>FHC Total</b>	<b>\$8,436,607</b>	<b>\$3,868,304</b>	<b>\$4,568,304</b>	<b>\$26,317,510</b>	<b>\$12,612,255</b>	<b>\$13,705,255</b>

**FHKC**

TPA Costs for FHC Enrollment	\$7,526,305	\$3,868,304	\$4,568,304	\$17,372,384	\$8,686,192	\$8,686,192
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	Year One	Federal Match	State Share	Year Two	Federal Match	State Share
<b>GRAND TOTALS</b>	<b>\$2,829,634,656</b>	<b>\$2,815,307,506</b>	<b>\$14,327,151</b>	<b>\$3,706,417,385</b>	<b>\$3,587,928,127</b>	<b>\$118,489,258</b>

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

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

16 409.721 Program authority.—The Florida Health Insurance  
17 Affordability Exchange Program (FHIX) is created within the  
18 Agency for Health Care Administration to assist Floridians in  
19 purchasing health benefits coverage and gaining access to health  
20 services. The products and services offered by FHIX are based on  
21 the following principles:

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

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

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

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

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

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

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

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



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41 409.722 Definitions.—As used in ss. 409.72-409.731, the  
42 term:

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

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

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

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

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

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

60 (7) "Florida Health Insurance Affordability Exchange  
61 Program" or "FHIX" means the program created under ss. 409.72-  
62 409.731.

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

65 (9) "Florida Kidcare program" or "Kidcare program" means  
66 the health benefits coverage administered through ss. 409.810-  
67 409.821.

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





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

73 (11) "Inactive status" means the enrollment status of a  
74 participant previously enrolled in health benefits coverage  
75 through FHIx who lost coverage for noncompliance pursuant to s.  
76 409.723, but who maintains access to his or her balance in a  
77 health savings account or health reimbursement account.

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

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

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

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

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

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

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



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99           409.723 Participation.-

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

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

107           (b) Meet and maintain the responsibilities under subsection  
108 (4).

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

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

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

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

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

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

125           (3) PARTICIPANT RIGHTS.-A participant has all of the  
126 following rights:

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



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

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

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

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

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

143 (4) PARTICIPANT RESPONSIBILITIES.—A participant must:

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

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

148 1. Paid employment.

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

151 3. Educational pursuits.

152  
153 A participant who is a disabled adult or the caregiver of a  
154 disabled child or adult may submit a request to the department  
155 for an exception to the requirements in this paragraph. Such  
156 participant shall annually submit to the department a request to



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

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

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

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

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

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

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

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

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

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

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

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

185 (i) Meet minimum coverage requirements by selecting either



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

190 (5) COST SHARING.—

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

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

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

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

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

201 5. Greater than 100 percent of the federal poverty level:  
202 \$25.

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

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

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

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



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215 has not been received, the enrollee shall be transitioned from  
216 coverage to inactive status and may not reenroll for a minimum  
217 of 6 months, unless a hardship exception has been granted.

218 Enrollees may seek a hardship exception under the Medicaid Fair  
219 Hearing Process.

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

222 409.724 Available assistance.—

223 (1) PREMIUM CREDITS.—

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

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

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

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

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



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

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

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

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

267 (a) How the FHIIX marketplace operates and the timeline for  
268 enrollment.

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

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



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273 family.

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

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

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

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

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

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

295 409.725 Available products and services.—The FHIX  
296 marketplace shall offer the following products and services:

297 (1) Products and services authorized pursuant to s.  
298 408.910.

299 (2) Products authorized by the federal exchange.

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





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

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

306 409.726 Program accountability.-

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

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

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

324 (a) Application processing speed.-Ninety percent of all  
325 applications, regardless of the method of submission, must be  
326 processed within 45 days.

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

330 (c) Renewal application processing speed.-Ninety percent of



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

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

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

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

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

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

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

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

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



- 360        (a) Enrollment and application trends and issues.
- 361        (b) Utilization and cost data.
- 362        (c) Customer satisfaction.
- 363        (d) Funding sources in health savings accounts or health
- 364 reimbursement accounts.
- 365        (e) Enrollee use of funds in health savings accounts or
- 366 health reimbursement accounts.
- 367        (f) Types of products and plans purchased.
- 368        (g) Movement of enrollees across different insurance
- 369 affordability programs.
- 370        (h) Recommendations for program improvement.
- 371        Section 9. Section 409.727, Florida Statutes, is created to
- 372 read:
- 373        409.727 Readiness review and implementation schedule.—The
- 374 agency, the corporation, the department, and the Florida Healthy
- 375 Kids Corporation shall begin implementation of FHIX on the
- 376 effective date of this act, with enrollment for Phase One
- 377 beginning by January 1, 2016.
- 378        (1) READINESS REVIEW.—Before implementation of any phase
- 379 under this part or in any region, the agency shall conduct a
- 380 readiness review in consultation with the FHIX Workgroup
- 381 established pursuant to s. 409.729. The agency shall determine,
- 382 at a minimum, the following readiness milestones:
- 383        (a) Functional readiness of the service delivery platform.
- 384        (b) Plan availability and presence of plan choice.
- 385        (c) Provider network capacity and adequacy of the available
- 386 plans.
- 387        (d) Availability of customer support.
- 388        (e) Other factors critical to the success of FHIX.



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

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

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

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

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

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

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

411       (3) PHASE TWO.—

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

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

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



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418 or product available under s. 409.725.

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

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

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

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

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

436 409.728 Program operation and management.—In order to  
437 implement ss. 409.72-409.731:

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

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

444 (b) Provide administrative support to the FHI Workgroup  
445 established pursuant to s. 409.729.

446 (c) Consult with stakeholders that serve low-income



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

449 (d) Timely transmit enrollee information to the  
450 corporation.

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

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

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

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

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

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

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



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476 provide customer service for the FHIIX marketplace.  
477 (c) Transfer funds and provide financial support to the  
478 FHIIX marketplace, including the collection of monthly cost-  
479 sharing payments.  
480 (d) Conduct financial reporting related to such activities,  
481 in coordination with the corporation and the agency.  
482 (e) Coordinate program activities with the agency, the  
483 department, and the corporation.  
484 (4) Florida Health Choices, Inc., shall do all of the  
485 following:  
486 (a) Develop and maintain the FHIIX marketplace.  
487 (b) Implement and administer Phase One and Phase Two of the  
488 FHIIX marketplace and the ongoing operations of the program.  
489 (c) Offer health benefits coverage packages on the FHIIX  
490 marketplace, including plans compliant with the Affordable Care  
491 Act.  
492 (d) Offer FHIIX enrollees a choice of at least two plans per  
493 county at each benefit level which meet the requirements under  
494 the Affordable Care Act.  
495 (e) Offer the opportunity to participate in the federal  
496 exchange.  
497 (f) Offer enhanced or customized benefits to FHIIX  
498 marketplace enrollees.  
499 (g) Provide sufficient staff and resources to meet the  
500 program needs of enrollees.  
501 (h) Provide an opportunity for plans contracted with or  
502 previously contracted with the Florida Healthy Kids Corporation  
503 under s. 624.91 to participate with FHIIX if those plans meet the  
504 requirements of the program.



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

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

512 409.729 Long-term reorganization.—The FHIIX Workgroup is  
513 created to facilitate the implementation of FHIIX and to plan for  
514 the reorganization of the state's insurance affordability  
515 programs. The FHIIX Workgroup consists of two representatives  
516 each from the agency, the department, the Florida Healthy Kids  
517 Corporation, and the corporation. An additional representative  
518 of the agency serves as chair. The FHIIX Workgroup must hold its  
519 organizational meeting no later than 30 days after the effective  
520 date of this act and must meet at least bimonthly. The role of  
521 the FHIIX Workgroup is to make recommendations to the agency. The  
522 responsibilities of the workgroup include, but are not limited  
523 to:

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

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

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





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

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

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

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

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

547 (8) Determining staff requirements for Phase Two.

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

550 409.73 Legislative Review.—The agency may seek federal  
551 approval to implement FHIX as provided in ss. 409.72-409.731.  
552 The agency is prohibited from implementing the FHIX waiver  
553 without specific legislative approval unless the terms and  
554 conditions of the approved waiver are substantially consistent  
555 with the statutory requirements for this program.

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

558 409.731 Program expiration.—The Florida Health Insurance  
559 Affordability Exchange Program expires at the end of the state  
560 fiscal year in which any of these conditions occurs:

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



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

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

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

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

574           408.910 Florida Health Choices Program.—

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

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

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

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

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



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

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

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

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

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

603 (c) "Florida Health Insurance Affordability Exchange  
604 Program" or "FHIX" is the program created under ss. 409.72-  
605 409.731 for low-income, uninsured residents of this state.

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

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

616 (f) "Patient Protection and Affordable Care Act" or  
617 "Affordable Care Act" means Pub. L. No. 111-148, as further  
618 amended by the Health Care and Education Reconciliation Act of  
619 2010, Pub. L. No. 111-152, and regulations adopted pursuant to  
620 those acts.



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

623            (3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health  
624 Choices Program is created as a single, centralized market for  
625 the sale and purchase of various products that enable  
626 individuals to pay for health care. These products include, but  
627 are not limited to, health insurance plans, health maintenance  
628 organization plans, prepaid services, service contracts, and  
629 flexible spending accounts. The components of the program  
630 include:

631            (a) Enrollment of employers.

632            (b) Administrative services for participating employers,  
633 including:

634            1. Assistance in seeking federal approval of cafeteria  
635 plans.

636            2. Collection of premiums and other payments.

637            3. Management of individual benefit accounts.

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

640            5. Assistance for participants in complying with reporting  
641 requirements.

642            (c) Services to individual participants, including:

643            1. Information about available products and participating  
644 vendors.

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

649            3. Account information to assist individual participants



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650 with managing available resources.

651 4. Services that promote healthy behaviors.

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

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

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

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

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

664 (g) Information services for individuals and employers.

665 (h) Program evaluation.

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

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

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

676 1. Individual employees of enrolled employers.

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



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

- 683 1. Submission of required information.
- 684 2. Compliance with federal tax requirements for the  
685 establishment of a cafeteria plan, pursuant to s. 125 of the  
686 Internal Revenue Code, including designation of the employer's  
687 plan as a premium payment plan, a salary reduction plan that has  
688 flexible spending arrangements, or a salary reduction plan that  
689 has a premium payment and flexible spending arrangements.
- 690 3. Determination of the employer's contribution, if any,  
691 per employee, provided that such contribution is equal for each  
692 eligible employee.
- 693 4. Establishment of payroll deduction procedures, subject  
694 to the agreement of each individual employee who voluntarily  
695 participates in the program.

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

698 6. Identification of eligible employees.

699 7. Arrangement for periodic payments.

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

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

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



708 coverage, and other products or services.  
709       2. Health maintenance organizations licensed under part I  
710 of chapter 641 may sell health maintenance contracts, limited  
711 benefit policies, other risk-bearing products, and other  
712 products or services.  
713       3. Prepaid limited health service organizations may sell  
714 products and services as authorized under part I of chapter 636,  
715 and discount medical plan organizations may sell products and  
716 services as authorized under part II of chapter 636.  
717       4. Prepaid health clinic service providers licensed under  
718 part II of chapter 641 may sell prepaid service contracts and  
719 other arrangements for a specified amount and type of health  
720 services or treatments.  
721       5. Health care providers, including hospitals and other  
722 licensed health facilities, health care clinics, licensed health  
723 professionals, pharmacies, and other licensed health care  
724 providers, may sell service contracts and arrangements for a  
725 specified amount and type of health services or treatments.  
726       6. Provider organizations, including service networks,  
727 group practices, professional associations, and other  
728 incorporated organizations of providers, may sell service  
729 contracts and arrangements for a specified amount and type of  
730 health services or treatments.  
731       7. Corporate entities providing specific health services in  
732 accordance with applicable state law may sell service contracts  
733 and arrangements for a specified amount and type of health  
734 services or treatments.  
735  
736 A vendor described in subparagraphs 3.-7. may not sell products



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

745 (e) Eligible individuals may participate in the program  
746 voluntarily. Individuals who join the program may participate by  
747 complying with the procedures established by the corporation.

748 These procedures must include, but are not limited to:

- 749 1. Submission of required information.
- 750 2. Authorization for payroll deduction, if applicable.
- 751 3. Compliance with federal tax requirements.
- 752 4. Arrangements for payment.
- 753 5. Selection of products and services.

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

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

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

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





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766 buy it.

767 4. Establishment of product prices based on applicable  
768 criteria.

769 5. Arrangements for receiving payment for enrolled  
770 participants.

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

773 7. Compliance with grievance procedures established by the  
774 corporation.

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

790 1. Completion of training requirements.

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

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



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

797 (5) PRODUCTS.—

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

800 1. Health insurance policies.

801 2. Health maintenance contracts.

802 3. Limited benefit plans.

803 4. Prepaid clinic services.

804 5. Service contracts.

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

807 7. Flexible spending accounts.

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

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

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

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

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



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

831 (7) THE MARKETPLACE PROCESS.—The program shall provide a  
832 single, centralized market for purchase of health insurance,  
833 health maintenance contracts, and other health products and  
834 services. Purchases may be made by participating individuals  
835 over the Internet or through the services of a participating  
836 health insurance agent. Information about each product and  
837 service available through the program shall be made available  
838 through printed material and an interactive Internet website.

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

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

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

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



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

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

868           (b) FHIR marketplace purchasing.-

869           1. Participation in the FHIR marketplace may begin at any  
870 time during the year.

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

876           (8) CONSUMER INFORMATION.—The corporation shall:

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

881           (b) Inform individuals about other public health care



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882 programs.

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

894 (10) EXEMPTIONS.—

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

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

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

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



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911 Choices, Inc., which shall be registered, incorporated,  
912 organized, and operated in compliance with part III of chapter  
913 112 and chapters 119, 286, and 617. The purpose of the  
914 corporation is to administer the program created in this section  
915 and to conduct such other business as may further the  
916 administration of the program.

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

980 (i) The corporation shall:

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

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

987 3. Arrange for collection of contributions from  
988 participating employers, third parties, governmental entities,  
989 and individuals.

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

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

997 6. Establish criteria for exclusion of vendors pursuant to





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998 paragraph (4) (d).

999 7. Develop and implement a plan for promoting public  
1000 awareness of and participation in the program.

1001 8. Secure staff and consultant services necessary to the  
1002 operation of the program.

1003 9. Establish policies and procedures regarding  
1004 participation in the program for individuals, vendors, health  
1005 insurance agents, and employers.

1006 10. Provide for the operation of a toll-free hotline to  
1007 respond to requests for assistance.

1008 11. Provide for initial, open, and special enrollment  
1009 periods.

1010 12. Evaluate options for employer participation which may  
1011 conform to with common insurance practices.

1012 13. Administer the Florida Health Insurance Affordability  
1013 Exchange Program in accordance with ss. 409.72-409.731.

1014 14. Coordinate with the Agency for Health Care  
1015 Administration, the Department of Children and Families, and the  
1016 Florida Healthy Kids Corporation in developing and implementing  
1017 the enrollee transition plan.

1018 15. Coordinate with the federal exchange to provide FHIX  
1019 enrollees with the option of selecting plans from either the  
1020 FHIX marketplace or the federal exchange.

1021 (12) REPORT.—The board of the corporation shall ~~Beginning~~  
1022 ~~in the 2009-2010 fiscal year,~~ submit by February 1 an annual  
1023 report to the Governor, the President of the Senate, and the  
1024 Speaker of the House of Representatives documenting the  
1025 corporation's activities in compliance with the duties  
1026 delineated in this section.



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1027           (13) PROGRAM INTEGRITY.—To ensure program integrity and to  
1028 safeguard the financial transactions made under the auspices of  
1029 the program, the corporation is authorized to establish  
1030 qualifying criteria and certification procedures for vendors,  
1031 require performance bonds or other guarantees of ability to  
1032 complete contractual obligations, monitor the performance of  
1033 vendors, and enforce the agreements of the program through  
1034 financial penalty or disqualification from the program.

1035           (14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—

1036           (a) *Definitions*.—For purposes of this subsection, the term:

1037           1. "Buyer's representative" means a participating insurance  
1038 agent as described in paragraph (4) (g).

1039           2. "Enrollee" means an employer who is eligible to enroll  
1040 in the program pursuant to paragraph (4) (a).

1041           3. "Participant" means an individual who is eligible to  
1042 participate in the program pursuant to paragraph (4) (b).

1043           4. "Proprietary confidential business information" means  
1044 information, regardless of form or characteristics, that is  
1045 owned or controlled by a vendor requesting confidentiality under  
1046 this section; that is intended to be and is treated by the  
1047 vendor as private in that the disclosure of the information  
1048 would cause harm to the business operations of the vendor; that  
1049 has not been disclosed unless disclosed pursuant to a statutory  
1050 provision, an order of a court or administrative body, or a  
1051 private agreement providing that the information may be released  
1052 to the public; and that is information concerning:

1053           a. Business plans.

1054           b. Internal auditing controls and reports of internal  
1055 auditors.



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1056           c. Reports of external auditors for privately held  
1057 companies.  
1058           d. Client and customer lists.  
1059           e. Potentially patentable material.  
1060           f. A trade secret as defined in s. 688.002.  
1061           5. "Vendor" means a participating insurer or other provider  
1062 of services as described in paragraph (4) (d).  
1063           (b) *Public record exemptions.*—  
1064           1. Personal identifying information of an enrollee or  
1065 participant who has applied for or participates in the Florida  
1066 Health Choices Program is confidential and exempt from s.  
1067 119.07(1) and s. 24(a), Art. I of the State Constitution.  
1068           2. Client and customer lists of a buyer's representative  
1069 held by the corporation are confidential and exempt from s.  
1070 119.07(1) and s. 24(a), Art. I of the State Constitution.  
1071           3. Proprietary confidential business information held by  
1072 the corporation is confidential and exempt from s. 119.07(1) and  
1073 s. 24(a), Art. I of the State Constitution.  
1074           (c) *Retroactive application.*—The public record exemptions  
1075 provided for in paragraph (b) apply to information held by the  
1076 corporation before, on, or after the effective date of this  
1077 exemption.  
1078           (d) *Authorized release.*—  
1079           1. Upon request, information made confidential and exempt  
1080 pursuant to this subsection shall be disclosed to:  
1081           a. Another governmental entity in the performance of its  
1082 official duties and responsibilities.  
1083           b. Any person who has the written consent of the program  
1084 applicant.



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1085 c. The Florida Kidcare program for the purpose of  
1086 administering the program authorized in ss. 409.810-409.821.

1087 2. Paragraph (b) does not prohibit a participant's legal  
1088 guardian from obtaining confirmation of coverage, dates of  
1089 coverage, the name of the participant's health plan, and the  
1090 amount of premium being paid.

1091 (e) *Penalty.*—A person who knowingly and willfully violates  
1092 this subsection commits a misdemeanor of the second degree,  
1093 punishable as provided in s. 775.082 or s. 775.083.

1094 (f) *Review and repeal.*—This subsection is subject to the  
1095 Open Government Sunset Review Act in accordance with s. 119.15,  
1096 and shall stand repealed on October 2, 2016, unless reviewed and  
1097 saved from repeal through reenactment by the Legislature.

1098 Section 16. Subsection (2) of section 409.904, Florida  
1099 Statutes, is amended to read:

1100 409.904 Optional payments for eligible persons.—The agency  
1101 may make payments for medical assistance and related services on  
1102 behalf of the following persons who are determined to be  
1103 eligible subject to the income, assets, and categorical  
1104 eligibility tests set forth in federal and state law. Payment on  
1105 behalf of these Medicaid eligible persons is subject to the  
1106 availability of moneys and any limitations established by the  
1107 General Appropriations Act or chapter 216.

1108 (2) A family, a pregnant woman, a child under age 21, a  
1109 person age 65 or over, or a blind or disabled person, who would  
1110 be eligible under any group listed in s. 409.903(1), (2), or  
1111 (3), except that the income or assets of such family or person  
1112 exceed established limitations. For a family or person in one of  
1113 these coverage groups, medical expenses are deductible from



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1114 income in accordance with federal requirements in order to make  
1115 a determination of eligibility. A family or person eligible  
1116 under the coverage known as the "medically needy," is eligible  
1117 to receive the same services as other Medicaid recipients, with  
1118 the exception of services in skilled nursing facilities and  
1119 intermediate care facilities for the developmentally disabled.  
1120 Effective July 1, 2016, persons eligible under "medically needy"  
1121 shall be limited to children under 21 years of age and pregnant  
1122 women. This subsection expires October 1, 2019.

1123 Section 17. Section 624.91, Florida Statutes, is amended to  
1124 read:

1125 624.91 The Florida Healthy Kids Corporation Act.—

1126 (1) SHORT TITLE.—This section may be cited as the "William  
1127 G. 'Doc' Myers Healthy Kids Corporation Act."

1128 (2) LEGISLATIVE INTENT.—

1129 (a) The Legislature finds that increased access to health  
1130 care services could improve children's health and reduce the  
1131 incidence and costs of childhood illness and disabilities among  
1132 children in this state. Many children do not have comprehensive,  
1133 affordable health care services available. It is the intent of  
1134 the Legislature that the Florida Healthy Kids Corporation  
1135 provide comprehensive health insurance coverage to such  
1136 children. The corporation is encouraged to cooperate with any  
1137 existing health service programs funded by the public or the  
1138 private sector.

1139 (b) It is the intent of the Legislature that the Florida  
1140 Healthy Kids Corporation serve as one of several providers of  
1141 services to children eligible for medical assistance under Title  
1142 XXI of the Social Security Act. Although the corporation may



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1143 serve other children, the Legislature intends the primary  
1144 recipients of services provided through the corporation be  
1145 school-age children with a family income below 200 percent of  
1146 the federal poverty level, who do not qualify for Medicaid. It  
1147 is also the intent of the Legislature that state and local  
1148 government Florida Healthy Kids funds be used to continue  
1149 coverage, subject to specific appropriations in the General  
1150 Appropriations Act, to children not eligible for federal  
1151 matching funds under Title XXI.

1152 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only residents  
1153 of this state are eligible ~~the following individuals are~~  
1154 ~~eligible~~ for state-funded assistance in paying Florida Healthy  
1155 Kids premiums pursuant to s. 409.814.‡

1156 ~~(a) Residents of this state who are eligible for the~~  
1157 ~~Florida Kidcare program pursuant to s. 409.814.~~

1158 ~~(b) Notwithstanding s. 409.814, legal aliens who are~~  
1159 ~~enrolled in the Florida Healthy Kids program as of January 31,~~  
1160 ~~2004, who do not qualify for Title XXI federal funds because~~  
1161 ~~they are not qualified aliens as defined in s. 409.811.~~

1162 (4) NONENTITLEMENT.—Nothing in this section shall be  
1163 construed as providing an individual with an entitlement to  
1164 health care services. No cause of action shall arise against the  
1165 state, the Florida Healthy Kids Corporation, or a unit of local  
1166 government for failure to make health services available under  
1167 this section.

1168 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

1169 (a) There is created the Florida Healthy Kids Corporation,  
1170 a not-for-profit corporation.

1171 (b) The Florida Healthy Kids Corporation shall:



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1172           1. Arrange for the collection of any individual, family,  
1173 ~~local contributions~~, or employer payment or premium, in an  
1174 amount to be determined by the board of directors, to provide  
1175 for payment of premiums for comprehensive insurance coverage and  
1176 for the actual or estimated administrative expenses.

1177           2. Arrange for the collection of any voluntary  
1178 contributions to provide for payment of Florida Kidcare program  
1179 or Florida Health Insurance Affordability Exchange Program  
1180 (FHIX) premiums for children who are not eligible for medical  
1181 assistance under Title XIX or Title XXI of the Social Security  
1182 Act.

1183           3. ~~Subject to the provisions of s. 409.8134, accept~~  
1184 ~~voluntary supplemental local match contributions that comply~~  
1185 ~~with the requirements of Title XXI of the Social Security Act~~  
1186 ~~for the purpose of providing additional Florida Kidcare coverage~~  
1187 ~~in contributing counties under Title XXI.~~

1188           4. Establish the administrative and accounting procedures  
1189 for the operation of the corporation.

1190           ~~4.5.~~ Establish, with consultation from appropriate  
1191 professional organizations, standards for preventive health  
1192 services and providers and comprehensive insurance benefits  
1193 appropriate to children, provided that such standards for rural  
1194 areas shall not limit primary care providers to board-certified  
1195 pediatricians.

1196           ~~5.6.~~ Determine eligibility for children seeking to  
1197 participate in the Title XXI-funded components of the Florida  
1198 Kidcare program consistent with the requirements specified in s.  
1199 ~~409.814, as well as the non-Title XXI-eligible children as~~  
1200 ~~provided in subsection (3).~~



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1201           ~~6.7.~~ Establish procedures under which ~~providers of local~~  
1202 ~~match to,~~ applicants to and participants in the program may have  
1203 grievances reviewed by an impartial body and reported to the  
1204 board of directors of the corporation.

1205           ~~7.8.~~ Establish participation criteria and, if appropriate,  
1206 contract with an authorized insurer, health maintenance  
1207 organization, or third-party administrator to provide  
1208 administrative services to the corporation.

1209           ~~8.9.~~ Establish enrollment criteria that include penalties  
1210 or waiting periods of 30 days for reinstatement of coverage upon  
1211 voluntary cancellation for nonpayment of family or individual  
1212 premiums.

1213           ~~9.10.~~ Contract with authorized insurers or any provider of  
1214 health care services, meeting standards established by the  
1215 corporation, for the provision of comprehensive insurance  
1216 coverage to participants. Such standards shall include criteria  
1217 under which the corporation may contract with more than one  
1218 provider of health care services in program sites.

1219           a. Health plans shall be selected through a competitive bid  
1220 process. The Florida Healthy Kids Corporation shall purchase  
1221 goods and services in the most cost-effective manner consistent  
1222 with the delivery of quality medical care.

1223           b. The maximum administrative cost for a Florida Healthy  
1224 Kids Corporation contract shall be 15 percent. For health and  
1225 dental care contracts, the minimum medical loss ratio for a  
1226 Florida Healthy Kids Corporation contract shall be 85 percent.  
1227 The calculations must use uniform financial data collected from  
1228 all plans in a format established by the corporation and shall  
1229 be computed for each plan on a statewide basis. Funds shall be





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1230 classified in a manner consistent with 45 C.F.R. part 158 ~~For~~  
1231 ~~dental contracts, the remaining compensation to be paid to the~~  
1232 ~~authorized insurer or provider under a Florida Healthy Kids~~  
1233 ~~Corporation contract shall be no less than an amount which is 85~~  
1234 ~~percent of premium; to the extent any contract provision does~~  
1235 ~~not provide for this minimum compensation, this section shall~~  
1236 ~~prevail.~~

1237 c. The health plan selection criteria and scoring system,  
1238 and the scoring results, shall be available upon request for  
1239 inspection after the bids have been awarded.

1240 d. Effective July 1, 2016, health and dental services  
1241 contracts of the corporation must transition to the FHI  
1242 marketplace under s. 409.722. Qualifying plans may enroll as  
1243 vendors with the FHI marketplace to maintain continuity of care  
1244 for participants.

1245 ~~10.11.~~ Establish disenrollment criteria in the event ~~local~~  
1246 ~~matching~~ funds are insufficient to cover enrollments.

1247 ~~11.12.~~ Develop and implement a plan to publicize the  
1248 Florida Kidcare program, the eligibility requirements of the  
1249 program, and the procedures for enrollment in the program and to  
1250 maintain public awareness of the corporation and the program.

1251 ~~12.13.~~ Secure staff necessary to properly administer the  
1252 corporation. Staff costs shall be funded from state ~~and local~~  
1253 ~~matching funds~~ and such other private or public funds as become  
1254 available. The board of directors shall determine the number of  
1255 staff members necessary to administer the corporation.

1256 ~~13.14.~~ In consultation with the partner agencies, provide a  
1257 report on the Florida Kidcare program annually to the Governor,  
1258 the Chief Financial Officer, the Commissioner of Education, the



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1259 President of the Senate, the Speaker of the House of  
1260 Representatives, and the Minority Leaders of the Senate and the  
1261 House of Representatives.

1262 ~~14.15.~~ Provide information on a quarterly basis online to  
1263 the Legislature and the Governor which compares the costs and  
1264 utilization of the full-pay enrolled population and the Title  
1265 XXI-subsidized enrolled population in the Florida Kidcare  
1266 program. The information, at a minimum, must include:

1267 a. The monthly enrollment and expenditure for full-pay  
1268 enrollees in the Medikids and Florida Healthy Kids programs  
1269 compared to the Title XXI-subsidized enrolled population; and

1270 b. The costs and utilization by service of the full-pay  
1271 enrollees in the Medikids and Florida Healthy Kids programs and  
1272 the Title XXI-subsidized enrolled population.

1273 ~~15.16.~~ Establish benefit packages that conform to the  
1274 provisions of the Florida Kidcare program, as created in ss.  
1275 409.810-409.821.

1276 16. Contract with other insurance affordability programs to  
1277 provide such services that are consistent with this act.

1278 17. Annually develop performance metrics for the following  
1279 focus areas:

1280 a. Administrative functions.

1281 b. Contracting with vendors.

1282 c. Customer service.

1283 d. Enrollee education.

1284 e. Financial services.

1285 f. Program integrity.

1286 (c) Coverage under the corporation's program is secondary  
1287 to any other available private coverage held by, or applicable



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1288 to, the participant child or family member. Insurers under  
1289 contract with the corporation are the payors of last resort and  
1290 must coordinate benefits with any other third-party payor that  
1291 may be liable for the participant's medical care.

1292 (d) The Florida Healthy Kids Corporation shall be a private  
1293 corporation not for profit, organized pursuant to chapter 617,  
1294 and shall have all powers necessary to carry out the purposes of  
1295 this act, including, but not limited to, the power to receive  
1296 and accept grants, loans, or advances of funds from any public  
1297 or private agency and to receive and accept from any source  
1298 contributions of money, property, labor, or any other thing of  
1299 value, to be held, used, and applied for the purposes of this  
1300 act.

1301 (6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

1302 (a) The Florida Healthy Kids Corporation shall operate  
1303 subject to the supervision and approval of a board of directors.  
1304 The board chair shall be an appointee designated by the  
1305 Governor, and the board shall be chaired by the Chief Financial  
1306 Officer or her or his designee, and composed of 12 other  
1307 members. The Senate shall confirm the designated chair and other  
1308 board appointees. The board members shall be appointed ~~selected~~  
1309 ~~for 3-year terms. of office as follows:~~

1310 ~~1. The Secretary of Health Care Administration, or his or~~  
1311 ~~her designee.~~

1312 ~~2. One member appointed by the Commissioner of Education~~  
1313 ~~from the Office of School Health Programs of the Florida~~  
1314 ~~Department of Education.~~

1315 ~~3. One member appointed by the Chief Financial Officer from~~  
1316 ~~among three members nominated by the Florida Pediatric Society.~~



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- 1317           ~~4. One member, appointed by the Governor, who represents~~  
1318 ~~the Children's Medical Services Program.~~
- 1319           ~~5. One member appointed by the Chief Financial Officer from~~  
1320 ~~among three members nominated by the Florida Hospital~~  
1321 ~~Association.~~
- 1322           ~~6. One member, appointed by the Governor, who is an expert~~  
1323 ~~on child health policy.~~
- 1324           ~~7. One member, appointed by the Chief Financial Officer,~~  
1325 ~~from among three members nominated by the Florida Academy of~~  
1326 ~~Family Physicians.~~
- 1327           ~~8. One member, appointed by the Governor, who represents~~  
1328 ~~the state Medicaid program.~~
- 1329           ~~9. One member, appointed by the Chief Financial Officer,~~  
1330 ~~from among three members nominated by the Florida Association of~~  
1331 ~~Counties.~~
- 1332           ~~10. The State Health Officer or her or his designee.~~
- 1333           ~~11. The Secretary of Children and Families, or his or her~~  
1334 ~~designee.~~
- 1335           ~~12. One member, appointed by the Governor, from among three~~  
1336 ~~members nominated by the Florida Dental Association.~~
- 1337           (b) A member of the board of directors shall be appointed  
1338 by and serve at the pleasure of the Governor ~~may be removed by~~  
1339 ~~the official who appointed that member.~~ The board shall appoint  
1340 an executive director, who is responsible for other staff  
1341 authorized by the board.
- 1342           (c) Board members are entitled to receive, from funds of  
1343 the corporation, reimbursement for per diem and travel expenses  
1344 as provided by s. 112.061.
- 1345           (d) There shall be no liability on the part of, and no



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1346 cause of action shall arise against, any member of the board of  
1347 directors, or its employees or agents, for any action they take  
1348 in the performance of their powers and duties under this act.

1349 (e) Terms for board members appointed under this act are  
1350 effective January 1, 2016.

1351 (7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

1352 (a) The corporation shall not be deemed an insurer. The  
1353 officers, directors, and employees of the corporation shall not  
1354 be deemed to be agents of an insurer. Neither the corporation  
1355 nor any officer, director, or employee of the corporation is  
1356 subject to the licensing requirements of the insurance code or  
1357 the rules of the Department of Financial Services. However, any  
1358 marketing representative utilized and compensated by the  
1359 corporation must be appointed as a representative of the  
1360 insurers or health services providers with which the corporation  
1361 contracts.

1362 (b) The board has complete fiscal control over the  
1363 corporation and is responsible for all corporate operations.

1364 (c) The Department of Financial Services shall supervise  
1365 any liquidation or dissolution of the corporation and shall  
1366 have, with respect to such liquidation or dissolution, all power  
1367 granted to it pursuant to the insurance code.

1368 (8) TRANSITION PLANS.—The corporation shall confer with the  
1369 Agency for Health Care Administration, the Department of  
1370 Children and Families, and Florida Health Choices, Inc., to  
1371 develop transition plans for the Florida Health Insurance  
1372 Affordability Exchange Program as created under ss. 409.72-  
1373 409.731.

1374 Section 18. Section 624.915, Florida Statutes, is repealed.



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1375           Section 19. The Division of Law Revision and Information is  
1376 directed to replace the phrase "the effective date of this act"  
1377 wherever it occurs in this act with the date the act becomes a  
1378 law.

1379           Section 20. If any law amended by this act was also amended  
1380 by a law enacted at the 2015 Regular Session of the Legislature,  
1381 such laws shall be construed as if they had been enacted at the  
1382 same session of the Legislature, and full effect shall be given  
1383 to each if possible.

1384           Section 21. This act shall take effect upon becoming a law.

1385

1386 ===== T I T L E   A M E N D M E N T =====

1387 And the title is amended as follows:

1388           Delete everything before the enacting clause  
1389 and insert:

1390                                   A bill to be entitled  
1391           An act relating to the health insurance affordability  
1392           exchange; providing a directive to the Division of Law  
1393           Revision and Information; creating s. 409.72, F.S.;  
1394           providing a short title; creating s. 409.721, F.S.;  
1395           creating the Florida Health Insurance Affordability  
1396           Exchange Program (FHIX) within the Agency for Health  
1397           Care Administration; providing program authority and  
1398           principles; creating s. 409.722, F.S.; defining terms;  
1399           creating s. 409.723, F.S.; providing eligibility and  
1400           enrollment criteria; providing patient rights and  
1401           responsibilities; defining the term "disabled"  
1402           providing premium levels; creating s. 409.724, F.S.;  
1403           providing for premium credits and choice counseling;



1404 establishing an education campaign; providing for  
1405 customer support and disenrollment; creating s.  
1406 409.725, F.S.; providing for available products and  
1407 services; creating s. 409.726, F.S.; requiring the  
1408 department to develop accountability measures and  
1409 performance standards governing the administration of  
1410 the program; creating s. 409.727, F.S.; providing for  
1411 a readiness review and a two-phase implementation  
1412 schedule; creating s. 409.728, F.S.; providing program  
1413 operation and management duties; creating s. 409.729,  
1414 F.S.; providing for the development of a long-term  
1415 reorganization plan and the formation of the FHIX  
1416 Workgroup; creating s. 409.73, F.S.; authorizing the  
1417 agency to seek federal approval; prohibiting the  
1418 agency from implementing the FHIX waiver under certain  
1419 circumstances; creating s. 409.731, F.S.; providing  
1420 for program expiration; repealing s. 408.70, F.S.,  
1421 relating to legislative findings regarding access to  
1422 affordable health care; amending s. 408.910, F.S.;  
1423 revising legislative intent; redefining terms;  
1424 revising the scope of the Florida Health Choices  
1425 Program and the pricing of services under the program;  
1426 providing requirements for operation of the  
1427 marketplace; providing additional duties for the  
1428 corporation to perform; requiring an annual report to  
1429 the Governor and the Legislature; amending s. 409.904,  
1430 F.S.; limiting eligible persons in the Medically Needy  
1431 program to those under the age of 21 and pregnant  
1432 women, and specifying an effective date; providing an



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1433 expiration date for the program; amending s. 624.91,  
1434 F.S.; revising eligibility requirements for state-  
1435 funded assistance; revising the duties and powers of  
1436 the Florida Healthy Kids Corporation; revising  
1437 provisions for the appointment of members of the board  
1438 of the Florida Healthy Kids Corporation; requiring  
1439 transition plans; repealing s. 624.915, F.S., relating  
1440 to the operating fund of the Florida Healthy Kids  
1441 Corporation; providing a directive to the Division of  
1442 Law Revision and Information; providing for  
1443 construction of the act in pari materia with laws  
1444 enacted during the 2015 Regular Session of the  
1445 Legislature; providing an effective date.



By Senator Bean

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1                                   A bill to be entitled  
2           An act relating to a health insurance affordability  
3           exchange; creating s. 409.720, F.S.; providing a short  
4           title; creating s. 409.721, F.S.; creating the Florida  
5           Health Insurance Affordability Exchange Program or  
6           FHIX in the Agency for Health Care Administration;  
7           providing program authority and principles; creating  
8           s. 409.722, F.S.; defining terms; creating s. 409.723,  
9           F.S.; providing eligibility and enrollment criteria;  
10          providing patient rights and responsibilities;  
11          providing premium levels; creating s. 409.724, F.S.;  
12          providing for premium credits and choice counseling;  
13          establishing an education campaign; providing for  
14          customer support and disenrollment; creating s.  
15          409.725, F.S.; providing for available products and  
16          services; creating s. 409.726, F.S.; providing for  
17          program accountability; creating s. 409.727, F.S.;  
18          providing an implementation schedule; creating s.  
19          409.728, F.S.; providing program operation and  
20          management duties; creating s. 409.729, F.S.;  
21          providing for the development of a long-term  
22          reorganization plan and the formation of the FHIX  
23          Workgroup; creating s. 409.730, F.S.; authorizing the  
24          agency to seek federal approval; creating s. 409.731,  
25          F.S.; providing for program expiration; repealing s.  
26          408.70, F.S., relating to legislative findings  
27          regarding access to affordable health care; amending  
28          s. 408.910, F.S.; revising legislative intent;  
29          redefining terms; revising the scope of the Florida

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30 Health Choices Program and the pricing of services  
31 under the program; providing requirements for  
32 operation of the marketplace; providing additional  
33 duties for the corporation to perform; requiring an  
34 annual report to the Governor and the Legislature;  
35 amending s. 409.904, F.S.; limiting eligible persons  
36 in the Medically Needy program to those under the age  
37 of 21 and pregnant women, and specifying an effective  
38 date; providing an expiration date for the program;  
39 amending s. 624.91, F.S.; revising eligibility  
40 requirements for state-funded assistance; revising the  
41 duties and powers of the Florida Healthy Kids  
42 Corporation; revising provisions for the appointment  
43 of members of the board of the Florida Healthy Kids  
44 Corporation; requiring transition plans; repealing s.  
45 624.915, F.S., relating to the operating fund of the  
46 Florida Healthy Kids Corporation; providing an  
47 effective date.

48  
49 Be It Enacted by the Legislature of the State of Florida:

50  
51 Section 1. The Division of Law Revision and Information is  
52 directed to rename part II of chapter 409, Florida Statutes, as  
53 "Insurance Affordability Programs" and to incorporate ss.  
54 409.720-409.731, Florida Statutes, under this part.

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

57 409.720 Short title.—Sections 409.720-409.731 may be cited  
58 as the "Florida Health Insurance Affordability Exchange Program"

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59 or "FHIX."

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

62 409.721 Program authority.—The Florida Health Insurance  
63 Affordability Exchange Program, or FHIX, is created in the  
64 agency to assist Floridians in purchasing health benefits  
65 coverage and gaining access to health services. The products and  
66 services offered by FHIX are based on the following principles:

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

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

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

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

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

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

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

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

86 409.722 Definitions.—As used in ss. 409.720-409.731, the  
87 term:

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

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

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

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

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

101           (6) "Florida Health Insurance Affordability Exchange  
102 Program" or "FHIX" means the program created under ss. 409.720-  
103 409.731.

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

106           (8) "Florida Kidcare program" or "Kidcare program" means  
107 the health benefits coverage administered through ss. 409.810-  
108 409.821.

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

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

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

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

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

128 (13) "Patient Protection and Affordable Care Act" or  
 129 "Affordable Care Act" means Pub. L. No. 111-148, as further  
 130 amended by the Health Care and Education Reconciliation Act of  
 131 2010, Pub. L. No. 111-152, and any amendments to, and  
 132 regulations or guidance under, those acts.

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

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

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

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

142 409.723 Participation.-

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

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

150 (b) Meet and maintain the responsibilities under subsection  
151 (4).

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

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

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

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

163 (c) The department shall review a participant's eligibility  
164 every 12 months.

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

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

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

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

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

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

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

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

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

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

190 (c):

191 1. Proof of employment.

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

193 3. Pursuit of educational opportunities.

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

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

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

199

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

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204 exception to the hourly level requirements.

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

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

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

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

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

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

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

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

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

225 (5) COST SHARING.-

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

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

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

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



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233 the federal poverty level: \$15.

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

236 5. Greater than 100 percent of the federal poverty level:  
237 \$25.

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

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

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

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

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

257 409.724 Available assistance.—

258 (1) PREMIUM CREDITS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

329 409.725 Available products and services.—The FHI  
330 marketplace shall offer the following products and services:

331 (1) Authorized products and services pursuant to s.  
332 408.910.

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

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

337 (4) Employer-sponsored plans.

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

340 409.726 Program accountability.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

394 (a) Enrollment and application trends and issues.

395 (b) Utilization and cost data.

396 (c) Customer satisfaction.

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

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

401 (f) Types of products and plans purchased.

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

404 (h) Recommendations for program improvement.

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

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407       409.727 Implementation schedule.—The agency, the  
408 corporation, the department, and the Florida Healthy Kids  
409 Corporation shall begin implementation of FHIX by the effective  
410 date of this act, with statewide implementation in all regions,  
411 as described in s. 409.966(2), by January 1, 2016.

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

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

419       (b) Plan availability and presence of plan choice.

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

422       (d) Availability of customer support.

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

424       (2) PHASE ONE.—

425       (a) Phase One begins on July 1, 2015. The agency, the  
426 corporation, the department, and the Florida Healthy Kids  
427 Corporation shall coordinate activities to ensure that  
428 enrollment begins by July 1, 2015.

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

431       (c) An enrollee is entitled to receive health benefits  
432 coverage in the same manner as provided under and through the  
433 selected managed care plans in the Medicaid managed care program  
434 in part IV of this chapter.

435       (d) An enrollee shall have a choice of at least two managed

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436 care plans in each region.

437 (e) Choice counseling and customer service must be provided  
438 in accordance with s. 409.724(2).

439 (3) PHASE TWO.—

440 (a) Beginning no later than January 1, 2016, and contingent  
441 upon federal approval, participants may enroll or transition to  
442 health benefits coverage under the FHIIX marketplace.

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

445 (c) An enrollee may select any benefit, service, or product  
446 available.

447 (d) The corporation shall notify an enrollee of his or her  
448 premium credit amount and how to access the FHIIX marketplace  
449 selection process.

450 (e) A Phase One enrollee must be transitioned to the FHIIX  
451 marketplace by April 1, 2016. An enrollee who does not select a  
452 plan or service on the FHIIX marketplace by that deadline shall  
453 be moved to inactive status.

454 (f) An enrollee shall have a choice of at least two managed  
455 care plans in each region which meet or exceed the Affordable  
456 Care Act's requirements and which qualify for a premium credit  
457 on the FHIIX marketplace.

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

460 (4) PHASE THREE.—

461 (a) No later than July 1, 2016, the corporation and the  
462 Florida Healthy Kids Corporation must begin the transition of  
463 enrollees under s. 624.91 to the FHIIX marketplace.

464 (b) Eligibility during this phase is based on meeting the



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465 requirements of Phase Two and s. 409.723(1)(c).

466 (c) An enrollee may select any benefit, service, or product  
467 available under s. 409.725.

468 (d) A Florida Healthy Kids enrollee who selects a FHI  
469 marketplace plan must be provided a premium credit equivalent to  
470 the average capitation rate paid in his or her county of  
471 residence under Florida Healthy Kids as of June 30, 2016. The  
472 enrollee is responsible for any difference in costs and may use  
473 any remaining funds for supplemental benefits on the FHI  
474 marketplace.

475 (e) The corporation shall notify an enrollee of his or her  
476 premium credit amount and how to access the FHI marketplace  
477 selection process.

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

480 (g) Enrollees under s. 624.91 must transition to the FHI  
481 marketplace by September 30, 2016.

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

484 409.728 Program operation and management.—In order to  
485 implement ss. 409.720-409.731:

486 (1) The Agency for Health Care Administration shall do all  
487 of the following:

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

493 (b) Administer Phase One of FHI.

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494 (c) Provide administrative support to the FHIIX Workgroup  
495 under s. 409.729.

496 (d) Transition the FHIIX enrollees to the FHIIX marketplace  
497 beginning January 1, 2016, in accordance with the transition  
498 workplan. Stakeholders that serve low-income individuals and  
499 families must be consulted during the implementation and  
500 transition process through a public input process. All regions  
501 must complete the transition no later than April 1, 2016.

502 (e) Timely transmit enrollee information to the  
503 corporation.

504 (f) Beginning with Phase Two, determine annually the risk-  
505 adjusted rate to be paid per month based on historical  
506 utilization and spending data for the medical and behavioral  
507 health of this population, projected forward, and adjusted to  
508 reflect the eligibility category, medical and dental trends,  
509 geographic areas, and the clinical risk profile of the  
510 enrollees.

511 (g) Transfer to the corporation such funds as approved in  
512 the General Appropriations Act for the premium credits.

513 (h) Encourage Medicaid managed care plans to apply as  
514 vendors to the marketplace to facilitate continuity of care and  
515 family care coordination.

516 (2) The Department of Children and Families shall, in  
517 coordination with the corporation, the agency, and the Florida  
518 Healthy Kids Corporation, determine eligibility of applications  
519 and application renewals for FHIIX in accordance with s. 409.902  
520 and shall transmit eligibility determination information on a  
521 timely basis to the agency and corporation.

522 (3) The Florida Healthy Kids Corporation shall do all of

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523 the following:

524 (a) Retain its duties and responsibilities under s. 624.91  
525 for Phase One and Phase Two of the program.

526 (b) Provide customer service for the FHIIX marketplace, in  
527 coordination with the agency and the corporation.

528 (c) Transfer funds and provide financial support to the  
529 FHIIX marketplace, including the collection of monthly cost  
530 sharing.

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

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

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

537 (a) Begin the development of FHIIX during Phase One.

538 (b) Implement and administer Phase Two and Phase Three of  
539 the FHIIX marketplace and the ongoing operations of the program.

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

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

546 (e) Provide an opportunity for participation in Medicaid  
547 managed care plans if those plans meet the requirements of the  
548 FHIIX marketplace.

549 (f) Offer enhanced or customized benefits to FHIIX  
550 marketplace enrollees.

551 (g) Provide sufficient staff and resources to meet the

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552 program needs of enrollees.

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

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

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

564 409.729 Long-term reorganization.—The FHIIX Workgroup is  
565 created to facilitate the implementation of FHIIX and to plan for  
566 a multiyear reorganization of the state's insurance  
567 affordability programs. The FHIIX Workgroup consists of two  
568 representatives each from the agency, the department, the  
569 Florida Healthy Kids Corporation, and the corporation. An  
570 additional representative of the agency serves as chair. The  
571 FHIIX Workgroup must hold its organizational meeting no later  
572 than 30 days after the effective date of this act and must meet  
573 at least bimonthly. The role of the FHIIX Workgroup is to make  
574 recommendations to the agency. The responsibilities of the  
575 workgroup include, but are not limited to:

576 (1) Recommend a Phase Two implementation plan no later than  
577 October 1, 2015.

578 (2) Review network and access standards for plans and  
579 products.

580 (3) Assess readiness and recommend actions needed to

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581 reorganize the state's insurance affordability programs for each  
582 phase or region. If a phase or region receives a nonreadiness  
583 recommendation, the agency must notify the Legislature of that  
584 recommendation, the reasons for such a recommendation, and  
585 proposed plans for achieving readiness.

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

590 (5) Identify duplication of services among the corporation,  
591 the agency, and the Florida Healthy Kids Corporation currently  
592 and under FHIX's proposed Phase Three program.

593 (6) Evaluate any fiscal impacts based on the proposed  
594 transition plan under Phase Three.

595 (7) Compile a schedule of impacted contracts, leases, and  
596 other assets.

597 (8) Determine staff requirements for Phase Three.

598 (9) Develop and present a final transition plan that  
599 incorporates all elements under this section no later than  
600 December 1, 2015, in a report to the Governor, the President of  
601 the Senate, and the Speaker of the House of Representatives.

602 Section 12. Section 409.730, Florida Statutes, is created  
603 to read:

604 409.730 Federal participation.—The agency may seek federal  
605 approval to implement FHIX.

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

608 409.731 Program expiration.—The Florida Health Insurance  
609 Affordability Exchange Program expires at the end of Phase One

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610 if the state does not receive federal approval for Phase Two or  
611 at the end of the state fiscal year in which any of these  
612 conditions occurs:

613 (1) The federal match contribution falls below 90 percent.

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

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

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

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

625 408.910 Florida Health Choices Program.—

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

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

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

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

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

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

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

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

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

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

654 (c) "Florida Health Insurance Affordability Exchange  
655 Program" or "FHIX" is the program created under ss. 409.720-  
656 409.731 for low-income, uninsured residents of this state.

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

659 (e)~~(d)~~ "Insurer" means an entity licensed under chapter 624  
660 which offers an individual health insurance policy or a group  
661 health insurance policy, a preferred provider organization as  
662 defined in s. 627.6471, an exclusive provider organization as  
663 defined in s. 627.6472, ~~or~~ a health maintenance organization  
664 licensed under part I of chapter 641, ~~or~~ a prepaid limited  
665 health service organization or discount medical plan  
666 organization licensed under chapter 636, or a managed care plan  
667 contracted with the Agency for Health Care Administration under

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668 the managed medical assistance program under part IV of chapter  
669 409.

670 (f) "Patient Protection and Affordable Care Act" or  
671 "Affordable Care Act" means Pub. L. No. 111-148, as further  
672 amended by the Health Care and Education Reconciliation Act of  
673 2010, Pub. L. No. 111-152, and any amendments to or regulations  
674 or guidance under those acts.

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

677 (3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health  
678 Choices Program is created as a single, centralized market for  
679 the sale and purchase of various products that enable  
680 individuals to pay for health care. These products include, but  
681 are not limited to, health insurance plans, health maintenance  
682 organization plans, prepaid services, service contracts, and  
683 flexible spending accounts. The components of the program  
684 include:

685 (a) Enrollment of employers.

686 (b) Administrative services for participating employers,  
687 including:

688 1. Assistance in seeking federal approval of cafeteria  
689 plans.

690 2. Collection of premiums and other payments.

691 3. Management of individual benefit accounts.

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

694 5. Assistance for participants in complying with reporting  
695 requirements.

696 (c) Services to individual participants, including:



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- 697 1. Information about available products and participating  
698 vendors.
- 699 2. Assistance with assessing the benefits and limits of  
700 each product, including information necessary to distinguish  
701 between policies offering creditable coverage and other products  
702 available through the program.
- 703 3. Account information to assist individual participants  
704 with managing available resources.
- 705 4. Services that promote healthy behaviors.
- 706 5. Health benefits coverage information about health  
707 insurance plans compliant with the Affordable Care Act.
- 708 6. Consumer assistance and enrollment services for the  
709 Florida Health Insurance Affordability Exchange Program, or  
710 FHIX.
- 711 (d) Recruitment of vendors, including insurers, health  
712 maintenance organizations, prepaid clinic service providers,  
713 provider service networks, and other providers.
- 714 (e) Certification of vendors to ensure capability,  
715 reliability, and validity of offerings.
- 716 (f) Collection of data, monitoring, assessment, and  
717 reporting of vendor performance.
- 718 (g) Information services for individuals and employers.
- 719 (h) Program evaluation.
- 720 (4) ELIGIBILITY AND PARTICIPATION.—Participation in the  
721 program is voluntary and shall be available to employers,  
722 individuals, vendors, and health insurance agents as specified  
723 in this subsection.
- 724 (a) Employers eligible to enroll in the program include  
725 those employers that meet criteria established by the

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726 corporation and elect to make their employees eligible through  
727 the program.

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

730 1. Individual employees of enrolled employers.

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

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

737 1. Submission of required information.

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

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

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

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

752 6. Identification of eligible employees.

753 7. Arrangement for periodic payments.

754 8. Employer notification to employees of the intent to

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755 transfer from an existing employee health plan to the program at  
756 least 90 days before the transition.

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

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

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

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

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

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

780 6. Provider organizations, including service networks,  
781 group practices, professional associations, and other  
782 incorporated organizations of providers, may sell service  
783 contracts and arrangements for a specified amount and type of

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784 health services or treatments.

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

789  
790 A vendor described in subparagraphs 3.-7. may not sell products  
791 that provide risk-bearing coverage unless that vendor is  
792 authorized under a certificate of authority issued by the Office  
793 of Insurance Regulation and is authorized to provide coverage in  
794 the relevant geographic area. Otherwise eligible vendors may be  
795 excluded from participating in the program for deceptive or  
796 predatory practices, financial insolvency, or failure to comply  
797 with the terms of the participation agreement or other standards  
798 set by the corporation.

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

- 803             1. Submission of required information.
- 804             2. Authorization for payroll deduction, if applicable.
- 805             3. Compliance with federal tax requirements.
- 806             4. Arrangements for payment.
- 807             5. Selection of products and services.

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

- 812             1. Submission of required information, including a complete

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813 description of the coverage, services, provider network, payment  
814 restrictions, and other requirements of each product offered  
815 through the program.

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

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

821 4. Establishment of product prices based on applicable  
822 criteria.

823 5. Arrangements for receiving payment for enrolled  
824 participants.

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

827 7. Compliance with grievance procedures established by the  
828 corporation.

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

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842 a health insurance agent shall comply with the procedures  
843 established by the corporation, including:

- 844 1. Completion of training requirements.
- 845 2. Execution of a participation agreement specifying the  
846 terms and conditions of participation.
- 847 3. Disclosure of any appointments to solicit insurance or  
848 procure applications for vendors participating in the program.
- 849 4. Arrangements to receive payment from the corporation for  
850 services as a buyer's representative.

851 (5) PRODUCTS.—

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

- 854 1. Health insurance policies.
- 855 2. Health maintenance contracts.
- 856 3. Limited benefit plans.
- 857 4. Prepaid clinic services.
- 858 5. Service contracts.
- 859 6. Arrangements for purchase of specific amounts and types  
860 of health services and treatments.
- 861 7. Flexible spending accounts.

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

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

869 (d) The corporation shall provide a disclosure form for  
870 consumers to acknowledge their understanding of the nature of,

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871 and any limitations to, the benefits provided by the products  
872 and services being purchased by the consumer.

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

876 (6) PRICING.—Prices for the products and services sold  
877 through the program must be transparent to participants and  
878 established by the vendors. The corporation may ~~shall~~ annually  
879 assess a surcharge for each premium or price set by a  
880 participating vendor. Any ~~The~~ surcharge may not be more than 2.5  
881 percent of the price and shall be used to generate funding for  
882 administrative services provided by the corporation and payments  
883 to buyers' representatives; however, a surcharge may not be  
884 assessed for products and services sold in the FHI marketplace.

885 (7) THE MARKETPLACE PROCESS.—The program shall provide a  
886 single, centralized market for purchase of health insurance,  
887 health maintenance contracts, and other health products and  
888 services. Purchases may be made by participating individuals  
889 over the Internet or through the services of a participating  
890 health insurance agent. Information about each product and  
891 service available through the program shall be made available  
892 through printed material and an interactive Internet website.

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

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

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

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

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

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

922       (b) FHIR marketplace purchasing.-

923       1. Participation in the FHIR marketplace may begin at any  
924 time during the year.

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



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929 different enrollment period.

930 (8) CONSUMER INFORMATION.—The corporation shall:

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

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

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

948 (10) EXEMPTIONS.—

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

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

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958 chapter 626.

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

964 (11) CORPORATION.—There is created the Florida Health  
965 Choices, Inc., which shall be registered, incorporated,  
966 organized, and operated in compliance with part III of chapter  
967 112 and chapters 119, 286, and 617. The purpose of the  
968 corporation is to administer the program created in this section  
969 and to conduct such other business as may further the  
970 administration of the program.

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

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

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

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

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

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

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

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

986 5. Board members may not include insurers, health insurance

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987 agents or brokers, health care providers, health maintenance  
988 organizations, prepaid service providers, or any other entity,  
989 affiliate, or subsidiary of eligible vendors.

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

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

998 (d) Board members are entitled to receive, from funds of  
999 the corporation, reimbursement for per diem and travel expenses  
1000 as provided by s. 112.061. No other compensation is authorized.

1001 (e) There is no liability on the part of, and no cause of  
1002 action shall arise against, any member of the board or its  
1003 employees or agents for any action taken by them in the  
1004 performance of their powers and duties under this section.

1005 (f) The board shall develop and adopt bylaws and other  
1006 corporate procedures as necessary for the operation of the  
1007 corporation and carrying out the purposes of this section. The  
1008 bylaws shall:

1009 1. Specify procedures for selection of officers and  
1010 qualifications for reappointment, provided that no board member  
1011 shall serve more than 9 consecutive years.

1012 2. Require an annual membership meeting that provides an  
1013 opportunity for input and interaction with individual  
1014 participants in the program.

1015 3. Specify policies and procedures regarding conflicts of

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1016 interest, including the provisions of part III of chapter 112,  
1017 which prohibit a member from participating in any decision that  
1018 would inure to the benefit of the member or the organization  
1019 that employs the member. The policies and procedures shall also  
1020 require public disclosure of the interest that prevents the  
1021 member from participating in a decision on a particular matter.

1022 (g) The corporation may exercise all powers granted to it  
1023 under chapter 617 necessary to carry out the purposes of this  
1024 section, including, but not limited to, the power to receive and  
1025 accept grants, loans, or advances of funds from any public or  
1026 private agency and to receive and accept from any source  
1027 contributions of money, property, labor, or any other thing of  
1028 value to be held, used, and applied for the purposes of this  
1029 section.

1030 (h) The corporation may establish technical advisory panels  
1031 consisting of interested parties, including consumers, health  
1032 care providers, individuals with expertise in insurance  
1033 regulation, and insurers.

1034 (i) The corporation shall:

- 1035 1. Determine eligibility of employers, vendors,  
1036 individuals, and agents in accordance with subsection (4).
- 1037 2. Establish procedures necessary for the operation of the  
1038 program, including, but not limited to, procedures for  
1039 application, enrollment, risk assessment, risk adjustment, plan  
1040 administration, performance monitoring, and consumer education.
- 1041 3. Arrange for collection of contributions from  
1042 participating employers, third parties, governmental entities,  
1043 and individuals.
- 1044 4. Arrange for payment of premiums and other appropriate

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1045 disbursements based on the selections of products and services  
 1046 by the individual participants.

1047 5. Establish criteria for disenrollment of participating  
 1048 individuals based on failure to pay the individual's share of  
 1049 any contribution required to maintain enrollment in selected  
 1050 products.

1051 6. Establish criteria for exclusion of vendors pursuant to  
 1052 paragraph (4) (d).

1053 7. Develop and implement a plan for promoting public  
 1054 awareness of and participation in the program.

1055 8. Secure staff and consultant services necessary to the  
 1056 operation of the program.

1057 9. Establish policies and procedures regarding  
 1058 participation in the program for individuals, vendors, health  
 1059 insurance agents, and employers.

1060 10. Provide for the operation of a toll-free hotline to  
 1061 respond to requests for assistance.

1062 11. Provide for initial, open, and special enrollment  
 1063 periods.

1064 12. Evaluate options for employer participation which may  
 1065 conform to ~~with~~ common insurance practices.

1066 13. Administer the Florida Health Insurance Affordability  
 1067 Exchange Program in accordance with ss. 409.720-409.731.

1068 14. Coordinate with the Agency for Health Care  
 1069 Administration, the Department of Children and Families, and the  
 1070 Florida Healthy Kids Corporation on the transition plan for FHIX  
 1071 and any subsequent transition activities.

1072 (12) REPORT.—The board of the corporation shall Beginning  
 1073 ~~in the 2009-2010 fiscal year,~~ submit by February 1 an annual

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1074 report to the Governor, the President of the Senate, and the  
1075 Speaker of the House of Representatives documenting the  
1076 corporation's activities in compliance with the duties  
1077 delineated in this section.

1078 (13) PROGRAM INTEGRITY.—To ensure program integrity and to  
1079 safeguard the financial transactions made under the auspices of  
1080 the program, the corporation is authorized to establish  
1081 qualifying criteria and certification procedures for vendors,  
1082 require performance bonds or other guarantees of ability to  
1083 complete contractual obligations, monitor the performance of  
1084 vendors, and enforce the agreements of the program through  
1085 financial penalty or disqualification from the program.

1086 (14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—

1087 (a) *Definitions*.—For purposes of this subsection, the term:

1088 1. "Buyer's representative" means a participating insurance  
1089 agent as described in paragraph (4) (g).

1090 2. "Enrollee" means an employer who is eligible to enroll  
1091 in the program pursuant to paragraph (4) (a).

1092 3. "Participant" means an individual who is eligible to  
1093 participate in the program pursuant to paragraph (4) (b).

1094 4. "Proprietary confidential business information" means  
1095 information, regardless of form or characteristics, that is  
1096 owned or controlled by a vendor requesting confidentiality under  
1097 this section; that is intended to be and is treated by the  
1098 vendor as private in that the disclosure of the information  
1099 would cause harm to the business operations of the vendor; that  
1100 has not been disclosed unless disclosed pursuant to a statutory  
1101 provision, an order of a court or administrative body, or a  
1102 private agreement providing that the information may be released

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- 1103 to the public; and that is information concerning:
- 1104       a. Business plans.
- 1105       b. Internal auditing controls and reports of internal
- 1106 auditors.
- 1107       c. Reports of external auditors for privately held
- 1108 companies.
- 1109       d. Client and customer lists.
- 1110       e. Potentially patentable material.
- 1111       f. A trade secret as defined in s. 688.002.
- 1112       5. "Vendor" means a participating insurer or other provider
- 1113 of services as described in paragraph (4) (d).
- 1114       (b) *Public record exemptions.*—
- 1115       1. Personal identifying information of an enrollee or
- 1116 participant who has applied for or participates in the Florida
- 1117 Health Choices Program is confidential and exempt from s.
- 1118 119.07(1) and s. 24(a), Art. I of the State Constitution.
- 1119       2. Client and customer lists of a buyer's representative
- 1120 held by the corporation are confidential and exempt from s.
- 1121 119.07(1) and s. 24(a), Art. I of the State Constitution.
- 1122       3. Proprietary confidential business information held by
- 1123 the corporation is confidential and exempt from s. 119.07(1) and
- 1124 s. 24(a), Art. I of the State Constitution.
- 1125       (c) *Retroactive application.*—The public record exemptions
- 1126 provided for in paragraph (b) apply to information held by the
- 1127 corporation before, on, or after the effective date of this
- 1128 exemption.
- 1129       (d) *Authorized release.*—
- 1130       1. Upon request, information made confidential and exempt
- 1131 pursuant to this subsection shall be disclosed to:

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1132 a. Another governmental entity in the performance of its  
1133 official duties and responsibilities.

1134 b. Any person who has the written consent of the program  
1135 applicant.

1136 c. The Florida Kidcare program for the purpose of  
1137 administering the program authorized in ss. 409.810-409.821.

1138 2. Paragraph (b) does not prohibit a participant's legal  
1139 guardian from obtaining confirmation of coverage, dates of  
1140 coverage, the name of the participant's health plan, and the  
1141 amount of premium being paid.

1142 (e) *Penalty.*—A person who knowingly and willfully violates  
1143 this subsection commits a misdemeanor of the second degree,  
1144 punishable as provided in s. 775.082 or s. 775.083.

1145 (f) *Review and repeal.*—This subsection is subject to the  
1146 Open Government Sunset Review Act in accordance with s. 119.15,  
1147 and shall stand repealed on October 2, 2016, unless reviewed and  
1148 saved from repeal through reenactment by the Legislature.

1149 Section 16. Subsection (2) of section 409.904, Florida  
1150 Statutes, is amended to read:

1151 409.904 Optional payments for eligible persons.—The agency  
1152 may make payments for medical assistance and related services on  
1153 behalf of the following persons who are determined to be  
1154 eligible subject to the income, assets, and categorical  
1155 eligibility tests set forth in federal and state law. Payment on  
1156 behalf of these Medicaid eligible persons is subject to the  
1157 availability of moneys and any limitations established by the  
1158 General Appropriations Act or chapter 216.

1159 (2) A family, a pregnant woman, a child under age 21, a  
1160 person age 65 or over, or a blind or disabled person, who would



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1161 be eligible under any group listed in s. 409.903(1), (2), or  
 1162 (3), except that the income or assets of such family or person  
 1163 exceed established limitations. For a family or person in one of  
 1164 these coverage groups, medical expenses are deductible from  
 1165 income in accordance with federal requirements in order to make  
 1166 a determination of eligibility. A family or person eligible  
 1167 under the coverage known as the "medically needy," is eligible  
 1168 to receive the same services as other Medicaid recipients, with  
 1169 the exception of services in skilled nursing facilities and  
 1170 intermediate care facilities for the developmentally disabled.  
 1171 Effective October 1, 2015, persons eligible under "medically  
 1172 needy" shall be limited to children under the age of 21 and  
 1173 pregnant women. This subsection expires October 1, 2019.

1174 Section 17. Section 624.91, Florida Statutes, is amended to  
 1175 read:

1176 624.91 The Florida Healthy Kids Corporation Act.—

1177 (1) SHORT TITLE.—This section may be cited as the "William  
 1178 G. 'Doc' Myers Healthy Kids Corporation Act."

1179 (2) LEGISLATIVE INTENT.—

1180 (a) The Legislature finds that increased access to health  
 1181 care services could improve children's health and reduce the  
 1182 incidence and costs of childhood illness and disabilities among  
 1183 children in this state. Many children do not have comprehensive,  
 1184 affordable health care services available. It is the intent of  
 1185 the Legislature that the Florida Healthy Kids Corporation  
 1186 provide comprehensive health insurance coverage to such  
 1187 children. The corporation is encouraged to cooperate with any  
 1188 existing health service programs funded by the public or the  
 1189 private sector.

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1190 (b) It is the intent of the Legislature that the Florida  
1191 Healthy Kids Corporation serve as one of several providers of  
1192 services to children eligible for medical assistance under Title  
1193 XXI of the Social Security Act. Although the corporation may  
1194 serve other children, the Legislature intends the primary  
1195 recipients of services provided through the corporation be  
1196 school-age children with a family income below 200 percent of  
1197 the federal poverty level, who do not qualify for Medicaid. It  
1198 is also the intent of the Legislature that state and local  
1199 government Florida Healthy Kids funds be used to continue  
1200 coverage, subject to specific appropriations in the General  
1201 Appropriations Act, to children not eligible for federal  
1202 matching funds under Title XXI.

1203 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only residents  
1204 of this state are eligible ~~the following individuals are~~  
1205 ~~eligible~~ for state-funded assistance in paying Florida Healthy  
1206 Kids premiums pursuant to s. 409.814.‡

1207 ~~(a) Residents of this state who are eligible for the~~  
1208 ~~Florida Kidcare program pursuant to s. 409.814.~~

1209 ~~(b) Notwithstanding s. 409.814, legal aliens who are~~  
1210 ~~enrolled in the Florida Healthy Kids program as of January 31,~~  
1211 ~~2004, who do not qualify for Title XXI federal funds because~~  
1212 ~~they are not qualified aliens as defined in s. 409.811.~~

1213 (4) NONENTITLEMENT.—Nothing in this section shall be  
1214 construed as providing an individual with an entitlement to  
1215 health care services. No cause of action shall arise against the  
1216 state, the Florida Healthy Kids Corporation, or a unit of local  
1217 government for failure to make health services available under  
1218 this section.

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1219 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—  
 1220 (a) There is created the Florida Healthy Kids Corporation,  
 1221 a not-for-profit corporation.  
 1222 (b) The Florida Healthy Kids Corporation shall:  
 1223 1. Arrange for the collection of any individual, family,  
 1224 ~~local contributions~~, or employer payment or premium, in an  
 1225 amount to be determined by the board of directors, to provide  
 1226 for payment of premiums for comprehensive insurance coverage and  
 1227 for the actual or estimated administrative expenses.  
 1228 2. Arrange for the collection of any voluntary  
 1229 contributions to provide for payment of Florida Kidcare program  
 1230 or Florida Health Insurance Affordability Exchange Program  
 1231 ~~premiums for children who are not eligible for medical~~  
 1232 ~~assistance under Title XIX or Title XXI of the Social Security~~  
 1233 ~~Act.~~  
 1234 3. ~~Subject to the provisions of s. 409.8134, accept~~  
 1235 ~~voluntary supplemental local match contributions that comply~~  
 1236 ~~with the requirements of Title XXI of the Social Security Act~~  
 1237 ~~for the purpose of providing additional Florida Kidcare coverage~~  
 1238 ~~in contributing counties under Title XXI.~~  
 1239 4. Establish the administrative and accounting procedures  
 1240 for the operation of the corporation.  
 1241 ~~4.5.~~ Establish, with consultation from appropriate  
 1242 professional organizations, standards for preventive health  
 1243 services and providers and comprehensive insurance benefits  
 1244 appropriate to children, provided that such standards for rural  
 1245 areas shall not limit primary care providers to board-certified  
 1246 pediatricians.  
 1247 ~~5.6.~~ Determine eligibility for children seeking to

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1248 participate in the Title XXI-funded components of the Florida  
1249 Kidcare program consistent with the requirements specified in s.  
1250 409.814, ~~as well as the non-Title XXI-eligible children as~~  
1251 ~~provided in subsection (3).~~

1252 ~~6.7.~~ Establish procedures under which ~~providers of local~~  
1253 ~~match to,~~ applicants to and participants in the program may have  
1254 grievances reviewed by an impartial body and reported to the  
1255 board of directors of the corporation.

1256 ~~7.8.~~ Establish participation criteria and, if appropriate,  
1257 contract with an authorized insurer, health maintenance  
1258 organization, or third-party administrator to provide  
1259 administrative services to the corporation.

1260 ~~8.9.~~ Establish enrollment criteria that include penalties  
1261 or waiting periods of 30 days for reinstatement of coverage upon  
1262 voluntary cancellation for nonpayment of family or individual  
1263 premiums.

1264 ~~9.10.~~ Contract with authorized insurers or any provider of  
1265 health care services, meeting standards established by the  
1266 corporation, for the provision of comprehensive insurance  
1267 coverage to participants. Such standards shall include criteria  
1268 under which the corporation may contract with more than one  
1269 provider of health care services in program sites.

1270 a. Health plans shall be selected through a competitive bid  
1271 process. The Florida Healthy Kids Corporation shall purchase  
1272 goods and services in the most cost-effective manner consistent  
1273 with the delivery of quality medical care.

1274 b. The maximum administrative cost for a Florida Healthy  
1275 Kids Corporation contract shall be 15 percent. For health and  
1276 dental care contracts, the minimum medical loss ratio for a

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1277 Florida Healthy Kids Corporation contract shall be 85 percent.  
1278 The calculations must use uniform financial data collected from  
1279 all plans in a format established by the corporation and shall  
1280 be computed for each plan on a statewide basis. Funds shall be  
1281 classified in a manner consistent with 45 C.F.R. part 158 ~~For~~  
1282 ~~dental contracts, the remaining compensation to be paid to the~~  
1283 ~~authorized insurer or provider under a Florida Healthy Kids~~  
1284 ~~Corporation contract shall be no less than an amount which is 85~~  
1285 ~~percent of premium; to the extent any contract provision does~~  
1286 ~~not provide for this minimum compensation, this section shall~~  
1287 ~~prevail.~~

1288 c. The health plan selection criteria and scoring system,  
1289 and the scoring results, shall be available upon request for  
1290 inspection after the bids have been awarded.

1291 d. Effective July 1, 2016, health and dental services  
1292 contracts of the corporation must transition to the FHIX  
1293 marketplace under s. 409.722. Qualifying plans may enroll as  
1294 vendors with the FHIX marketplace to maintain continuity of care  
1295 for participants.

1296 ~~10.11.~~ Establish disenrollment criteria in the event ~~local~~  
1297 ~~matching~~ funds are insufficient to cover enrollments.

1298 ~~11.12.~~ Develop and implement a plan to publicize the  
1299 Florida Kidcare program, the eligibility requirements of the  
1300 program, and the procedures for enrollment in the program and to  
1301 maintain public awareness of the corporation and the program.

1302 ~~12.13.~~ Secure staff necessary to properly administer the  
1303 corporation. Staff costs shall be funded from state ~~and local~~  
1304 ~~matching funds~~ and such other private or public funds as become  
1305 available. The board of directors shall determine the number of

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1306 staff members necessary to administer the corporation.

1307 ~~13.14.~~ In consultation with the partner agencies, provide a  
1308 report on the Florida Kidcare program annually to the Governor,  
1309 the Chief Financial Officer, the Commissioner of Education, the  
1310 President of the Senate, the Speaker of the House of  
1311 Representatives, and the Minority Leaders of the Senate and the  
1312 House of Representatives.

1313 ~~14.15.~~ Provide information on a quarterly basis online to  
1314 the Legislature and the Governor which compares the costs and  
1315 utilization of the full-pay enrolled population and the Title  
1316 XXI-subsidized enrolled population in the Florida Kidcare  
1317 program. The information, at a minimum, must include:

- 1318 a. The monthly enrollment and expenditure for full-pay  
1319 enrollees in the Medikids and Florida Healthy Kids programs  
1320 compared to the Title XXI-subsidized enrolled population; and  
1321 b. The costs and utilization by service of the full-pay  
1322 enrollees in the Medikids and Florida Healthy Kids programs and  
1323 the Title XXI-subsidized enrolled population.

1324 ~~15.16.~~ Establish benefit packages that conform to the  
1325 provisions of the Florida Kidcare program, as created in ss.  
1326 409.810-409.821.

1327 16. Contract with other insurance affordability programs  
1328 and FHIX to provide customer service or other enrollment-focused  
1329 services.

1330 17. Annually develop performance metrics for the following  
1331 focus areas:

- 1332 a. Administrative functions.  
1333 b. Contracting with vendors.  
1334 c. Customer service.

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1335 d. Enrollee education.

1336 e. Financial services.

1337 f. Program integrity.

1338 (c) Coverage under the corporation's program is secondary  
1339 to any other available private coverage held by, or applicable  
1340 to, the participant child or family member. Insurers under  
1341 contract with the corporation are the payors of last resort and  
1342 must coordinate benefits with any other third-party payor that  
1343 may be liable for the participant's medical care.

1344 (d) The Florida Healthy Kids Corporation shall be a private  
1345 corporation not for profit, organized pursuant to chapter 617,  
1346 and shall have all powers necessary to carry out the purposes of  
1347 this act, including, but not limited to, the power to receive  
1348 and accept grants, loans, or advances of funds from any public  
1349 or private agency and to receive and accept from any source  
1350 contributions of money, property, labor, or any other thing of  
1351 value, to be held, used, and applied for the purposes of this  
1352 act.

1353 (6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

1354 (a) The Florida Healthy Kids Corporation shall operate  
1355 subject to the supervision and approval of a board of directors.  
1356 The board chair shall be an appointee designated by the  
1357 Governor, and the board shall be chaired by the Chief Financial  
1358 Officer or her or his designee, and composed of 12 other  
1359 members. The Senate shall confirm the designated chair and other  
1360 board appointees. The board members shall be appointed ~~selected~~  
1361 ~~for 3-year terms. of office as follows:~~

1362 ~~1. The Secretary of Health Care Administration, or his or~~  
1363 ~~her designee.~~

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1364 ~~2. One member appointed by the Commissioner of Education~~  
 1365 ~~from the Office of School Health Programs of the Florida~~  
 1366 ~~Department of Education.~~

1367 ~~3. One member appointed by the Chief Financial Officer from~~  
 1368 ~~among three members nominated by the Florida Pediatric Society.~~

1369 ~~4. One member, appointed by the Governor, who represents~~  
 1370 ~~the Children's Medical Services Program.~~

1371 ~~5. One member appointed by the Chief Financial Officer from~~  
 1372 ~~among three members nominated by the Florida Hospital~~  
 1373 ~~Association.~~

1374 ~~6. One member, appointed by the Governor, who is an expert~~  
 1375 ~~on child health policy.~~

1376 ~~7. One member, appointed by the Chief Financial Officer,~~  
 1377 ~~from among three members nominated by the Florida Academy of~~  
 1378 ~~Family Physicians.~~

1379 ~~8. One member, appointed by the Governor, who represents~~  
 1380 ~~the state Medicaid program.~~

1381 ~~9. One member, appointed by the Chief Financial Officer,~~  
 1382 ~~from among three members nominated by the Florida Association of~~  
 1383 ~~Counties.~~

1384 ~~10. The State Health Officer or her or his designee.~~

1385 ~~11. The Secretary of Children and Families, or his or her~~  
 1386 ~~designee.~~

1387 ~~12. One member, appointed by the Governor, from among three~~  
 1388 ~~members nominated by the Florida Dental Association.~~

1389 (b) A member of the board of directors serves at the  
 1390 pleasure of the Governor ~~may be removed by the official who~~  
 1391 ~~appointed that member.~~ The board shall appoint an executive  
 1392 director, who is responsible for other staff authorized by the



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1393 board.

1394 (c) Board members are entitled to receive, from funds of  
1395 the corporation, reimbursement for per diem and travel expenses  
1396 as provided by s. 112.061.

1397 (d) There shall be no liability on the part of, and no  
1398 cause of action shall arise against, any member of the board of  
1399 directors, or its employees or agents, for any action they take  
1400 in the performance of their powers and duties under this act.

1401 (e) Board members who are serving as of the effective date  
1402 of this act may remain on the board until January 1, 2016.

1403 (7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

1404 (a) The corporation shall not be deemed an insurer. The  
1405 officers, directors, and employees of the corporation shall not  
1406 be deemed to be agents of an insurer. Neither the corporation  
1407 nor any officer, director, or employee of the corporation is  
1408 subject to the licensing requirements of the insurance code or  
1409 the rules of the Department of Financial Services. However, any  
1410 marketing representative utilized and compensated by the  
1411 corporation must be appointed as a representative of the  
1412 insurers or health services providers with which the corporation  
1413 contracts.

1414 (b) The board has complete fiscal control over the  
1415 corporation and is responsible for all corporate operations.

1416 (c) The Department of Financial Services shall supervise  
1417 any liquidation or dissolution of the corporation and shall  
1418 have, with respect to such liquidation or dissolution, all power  
1419 granted to it pursuant to the insurance code.

1420 (8) TRANSITION PLANS.—The corporation shall confer with the  
1421 Agency for Health Care Administration, the Department of

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1422 Children and Families, and Florida Health Choices, Inc., to  
1423 develop transition plans for the Florida Health Insurance  
1424 Affordability Exchange Program as created under ss. 409.720-  
1425 409.731.

1426 Section 18. Section 624.915, Florida Statutes, is repealed.

1427 Section 19. The Division of Law Revision and Information is  
1428 directed to replace the phrase "the effective date of this act"  
1429 wherever it occurs in this act with the date the act becomes a  
1430 law.

1431 Section 20. This act shall take effect upon becoming a law.

# 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

Phone \_\_\_\_\_

Street

Tall FL 32301

Email dughi1@gtlaw.com

City

State

Zip

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.

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

Phone

Street

Tallahassee FL

32304

Email

City

State

Zip

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] 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.



## 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 1<sup>st</sup> for family business. I will arrive in Tallahassee Monday evening.

Sincerely,

A handwritten signature in cursive script that reads "Denise Grimsley".

Denise Grimsley  
State Senator, District 21

A handwritten signature in cursive script that reads "Andy Gardiner". Below the signature is a horizontal line with an "X" mark at the beginning.

**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](http://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,

A handwritten signature in black ink, appearing to read "Oscar Braynon II".

Senator Oscar Braynon II,  
District 36

A handwritten signature in black ink, appearing to read "Garrett Richter", with a small smiley face drawn below it.

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.flisenate.gov](http://www.flisenate.gov)

**ANDY GARDINER**  
President of the Senate

**GARRETT RICHTER**  
President Pro Tempore

# CourtSmart Tag Report

Room: KN 412

Caption: Senate Health Policy Committee

Case:

Judge:

Type:

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