By the Committees on Appropriations; and Appropriations

576-04984-13 20131816c1

1 A bill to be entitled
2 An act relating to health care; amending s. 409.811,
3 F.S.; revising and providing definitions; amending s.
4 409.813, F.S.; revising the components of the Florida
5 Kidcare program; prohibiting a cause of action from
6 arising against the Florida Healthy Kids Corporation
7 for failure to make health services available;
8 amending s. 409.8132, F.S.; revising the eligibility
9 of the Medikids program component; revising the
10 enrollment requirements of the Medikids program
11 component; amending s. 409.8134, F.S.; conforming
12 provisions to changes made by the act; amending s.
13 409.814, F.S.; revising eligibility requirements for
14 the Florida Kidcare program; amending s. 409.815,
15 F.S.; revising the minimum health benefits coverage
16 under the Florida Kidcare Act; deleting obsolete
17 provisions; amending ss. 409.816 and 409.8177, F.S.;
18 conforming provisions to changes made by the act;
19 repealing s. 409.817, F.S., relating to the approval
20 of health benefits coverage and financial assistance;
21 repealing s. 409.8175, F.S., relating to delivery of
22 services in rural counties; amending s. 409.818, F.S.;
23 revising the duties of the Department of Children and
24 Families and the Agency for Health Care Administration
25 with regard to the Florida Kidcare Act; deleting the
26 duties of the Department of Health and the Office of
27 Insurance Regulation with regard to the Florida
28 Kidcare Act; amending s. 409.820, F.S.; requiring the
29 Department of Health, in consultation with the agency

30 and the Florida Healthy Kids Corporation, to develop a
31 minimum set of pediatric and adolescent quality
32 assurance and access standards for all program
33 components; amending s. 624.91, F.S.; revising the
34 legislative intent of the Florida Healthy Kids
35 Corporation Act to include the Healthy Florida
36 program; revising participation guidelines for
37 nonsubsidized enrollees in the Healthy Kids program;
38 revising the medical loss ratio requirements for the
39 contracts for the Florida Healthy Kids Corporation;
40 modifying the membership of the Florida Healthy Kids
41 Corporation's board of directors; creating an
42 executive steering committee; requiring additional
43 corporate compliance requirements for the Florida
44 Healthy Kids Corporation; repealing s. 624.915, F.S.,
45 relating to the operating fund of the Florida Healthy
46 Kids Corporation; creating s. 624.917, F.S.; creating
47 the Healthy Florida program; providing definitions;
48 providing eligibility and enrollment requirements;
49 authorizing the Florida Healthy Kids Corporation to
50 contract with certain insurers, managed care
51 organizations, and provider service networks;
52 encouraging the corporation to contract with insurers
53 and managed care organizations that participate in
54 more than one insurance affordability program under
55 certain circumstances; requiring the corporation to
56 establish a benefits package and a process for payment
57 of services; authorizing the corporation to collect
58 premiums and copayments; requiring the corporation to

59 oversee the Healthy Florida program and to establish a
60 grievance process and integrity process; providing
61 applicability of certain state laws for administration
62 of the Healthy Florida program; requiring the
63 corporation to collect certain data and to submit
64 enrollment reports and interim independent evaluations
65 to the Legislature; providing for expiration of the
66 program; providing an implementation and
67 interpretation clause; amending s. 627.6474, F.S.;
68 prohibiting a contract between a health insurer and a
69 dentist from requiring the dentist to provide services
70 at a fee set by the insurer under certain
71 circumstances; providing that covered services are
72 those services listed as a benefit that the insured is
73 entitled to receive under a contract; prohibiting an
74 insurer from providing merely de minimis reimbursement
75 or coverage; requiring that fees for covered services
76 be set in good faith and not be nominal; prohibiting a
77 health insurer from requiring as a condition of a
78 contract that a dentist participate in a discount
79 medical plan; amending s. 636.035, F.S.; prohibiting a
80 contract between a prepaid limited health service
81 organization and a dentist from requiring the dentist
82 to provide services at a fee set by the organization
83 under certain circumstances; providing that covered
84 services are those services listed as a benefit that a
85 subscriber of a prepaid limited health service
86 organization is entitled to receive under a contract;
87 prohibiting a prepaid limited health service

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88 organization from providing merely de minimis
89 reimbursement or coverage; requiring that fees for
90 covered services be set in good faith and not be
91 nominal; prohibiting the prepaid limited health
92 service organization from requiring as a condition of
93 a contract that a dentist participate in a discount
94 medical plan; amending s. 641.315, F.S.; prohibiting a
95 contract between a health maintenance organization and
96 a dentist from requiring the dentist to provide
97 services at a fee set by the organization under
98 certain circumstances; providing that covered services
99 are those services listed as a benefit that a
100 subscriber of a health maintenance organization is
101 entitled to receive under a contract; prohibiting a
102 health maintenance organization from providing merely
103 de minimis reimbursement or coverage; requiring that
104 fees for covered services be set in good faith and not
105 be nominal; prohibiting the health maintenance
106 organization from requiring as a condition of a
107 contract that a dentist participate in a discount
108 medical plan; amending s. 766.1115, F.S.; revising a
109 definition; requiring a contract with a governmental
110 contractor for health care services to include a
111 provision for a health care provider licensed under
112 ch. 466, F.S., as an agent of the governmental
113 contractor, to allow a patient or a parent or guardian
114 of the patient to voluntarily contribute a fee to
115 cover costs of dental laboratory work related to the
116 services provided to the patient without forfeiting

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117 sovereign immunity; prohibiting the contribution from
118 exceeding the actual amount of the dental laboratory
119 charges; providing that the contribution complies with
120 the requirements of s. 766.1115, F.S.; providing for
121 applicability; providing appropriations; providing an
122 effective date.
123
124 Be It Enacted by the Legislature of the State of Florida:
125
126 Section 1. Section 409.811, Florida Statutes, is amended to
127 read:
128 409.811 Definitions relating to Florida Kidcare Act.—As
129 used in ss. 409.810-409.821, the term:
130 (1) “Actuarially equivalent” means that:
131 (a) The aggregate value of the benefits included in health
132 benefits coverage is equal to the value of the benefits in the
133 benchmark benefit plan; and
134 (b) The benefits included in health benefits coverage are
135 substantially similar to the benefits included in the benchmark
136 benefit plan, except that preventive health services must be the
137 same as in the benchmark benefit plan.
138 (2) “Agency” means the Agency for Health Care
139 Administration.
140 (3) “Applicant” means a parent or guardian of a child or a
141 child whose disability of nonage has been removed under chapter
142 743, who applies for determination of eligibility for health
143 benefits coverage under ss. 409.810-409.821.
144 (4) “Child benchmark benefit plan” means the form and level
145 of health benefits coverage established in s. 409.815.

146 (5) “Child” means any person younger than ~~under~~ 19 years of
147 age.
148 (6) “Child with special health care needs” means a child
149 whose serious or chronic physical or developmental condition
150 requires extensive preventive and maintenance care beyond that
151 required by typically healthy children. Health care utilization
152 by such a child exceeds the statistically expected usage of the
153 normal child adjusted for chronological age, and such a child
154 often needs complex care requiring multiple providers,
155 rehabilitation services, and specialized equipment in a number
156 of different settings.
157 (7) “Children’s Medical Services Network” or “network”
158 means a statewide managed care service system as defined in s.
159 391.021(1).
160 (8) “CHIP” means the Children’s Health Insurance Program as
161 authorized under Title XXI of the Social Security Act, and its
162 regulations, ss. 409.810-409.820, and as administered in this
163 state by the agency, the department, and the Florida Healthy
164 Kids Corporation, as appropriate to their respective
165 responsibilities.
166 (9) “Combined eligibility notice” means an eligibility
167 notice that informs an applicant, an enrollee, or multiple
168 family members of a household, when feasible, of eligibility for
169 each of the insurance affordability programs and enrollment into
170 a program or exchange plan. A combined eligibility form must be
171 issued by the last agency or department to make an eligibility,
172 renewal or denial determination. The form must meet all of the
173 federal and state law and regulatory requirements no later than
174 January 1, 2014.

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175 ~~(8) "Community rate" means a method used to develop~~
176 ~~premiums for a health insurance plan that spreads financial risk~~
177 ~~across a large population and allows adjustments only for age,~~
178 ~~gender, family composition, and geographic area.~~
179 <u>(10)</u>~~(9)~~ "Department" means the Department of Health.
180 <u>(11)</u>~~(10)~~ "Enrollee" means a child who has been determined
181 eligible for and is receiving coverage under ss. 409.810-
182 409.821.
183 ~~(11) "Family" means the group or the individuals whose~~
184 ~~income is considered in determining eligibility for the Florida~~
185 ~~Kidcare program. The family includes a child with a parent or~~
186 ~~caretaker relative who resides in the same house or living unit~~
187 ~~or, in the case of a child whose disability of nonage has been~~
188 ~~removed under chapter 743, the child. The family may also~~
189 ~~include other individuals whose income and resources are~~
190 ~~considered in whole or in part in determining eligibility of the~~
191 ~~child.~~
192 ~~(12) "Family income" means cash received at periodic~~
193 ~~intervals from any source, such as wages, benefits,~~
194 ~~contributions, or rental property. Income also may include any~~
195 ~~money that would have been counted as income under the Aid to~~
196 ~~Families with Dependent Children (AFDC) state plan in effect~~
197 ~~prior to August 22, 1996.~~
198 <u>(12)</u>~~(13)~~ "Florida Kidcare program," "Kidcare program," or
199 "program" means the health benefits program administered through
200 ss. 409.810-409.821.
201 <u>(13)</u>~~(14)~~ "Guarantee issue" means that health benefits
202 coverage must be offered to an individual regardless of the
203 individual's health status, preexisting condition, or claims

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204 history.

205 (14) ~~(15)~~ "Health benefits coverage" means protection that
206 provides payment of benefits for covered health care services or
207 that otherwise provides, either directly or through arrangements
208 with other persons, covered health care services on a prepaid
209 per capita basis or on a prepaid aggregate fixed-sum basis.

210 (15) ~~(16)~~ "Health insurance plan" means health benefits
211 coverage under the following:

212 (a) A health plan offered by any certified health
213 maintenance organization or authorized health insurer, except a
214 plan that is limited to the following: a limited benefit,
215 specified disease, or specified accident; hospital indemnity;
216 accident only; limited benefit convalescent care; Medicare
217 supplement; credit disability; dental; vision; long-term care;
218 disability income; coverage issued as a supplement to another
219 health plan; workers' compensation liability or other insurance;
220 or motor vehicle medical payment only; or

221 (b) An employee welfare benefit plan that includes health
222 benefits established under the Employee Retirement Income
223 Security Act of 1974, as amended.

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

229 (17) "Medicaid" means the medical assistance program
230 authorized by Title XIX of the Social Security Act, and
231 regulations thereunder, and ss. 409.901-409.920, as administered
232 in this state by the agency.

233 (18) “Medically necessary” means the use of any medical
234 treatment, service, equipment, or supply necessary to palliate
235 the effects of a terminal condition, or to prevent, diagnose,
236 correct, cure, alleviate, or preclude deterioration of a
237 condition that threatens life, causes pain or suffering, or
238 results in illness or infirmity and which is:
239 (a) Consistent with the symptom, diagnosis, and treatment
240 of the enrollee’s condition;
241 (b) Provided in accordance with generally accepted
242 standards of medical practice;
243 (c) Not primarily intended for the convenience of the
244 enrollee, the enrollee’s family, or the health care provider;
245 (d) The most appropriate level of supply or service for the
246 diagnosis and treatment of the enrollee’s condition; and
247 (e) Approved by the appropriate medical body or health care
248 specialty involved as effective, appropriate, and essential for
249 the care and treatment of the enrollee’s condition.
250 (19) “Medikids” means a component of the Florida Kidcare
251 program of medical assistance authorized by Title XXI of the
252 Social Security Act, and regulations thereunder, and s.
253 409.8132, as administered in the state by the agency.
254 (20) “Modified adjusted gross income” means the
255 individual’s or household’s annual adjusted gross income as
256 defined in s. 36B(d)(2) of the Internal Revenue Code of 1986
257 which is used to determine eligibility under the Florida Kidcare
258 program.
259 (21) “Patient Protection and Affordable Care Act” or “Act”
260 means the federal law enacted as Pub. L. No. 111-148, as further
261 amended by the federal Health Care and Education Reconciliation

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262 Act of 2010, Pub. L. No. 111-152, and any amendments,
263 regulations, or guidance issued under those acts.
264 (22) ~~(20)~~ "Preexisting condition exclusion" means, with
265 respect to coverage, a limitation or exclusion of benefits
266 relating to a condition based on the fact that the condition was
267 present before the date of enrollment for such coverage, whether
268 or not any medical advice, diagnosis, care, or treatment was
269 recommended or received before such date.
270 (23) ~~(21)~~ "Premium" means the entire cost of a health
271 insurance plan, including the administration fee or the risk
272 assumption charge.
273 (24) ~~(22)~~ "Premium assistance payment" means the monthly
274 consideration paid by the agency per enrollee in the Florida
275 Kidcare program towards health insurance premiums.
276 (25) ~~(23)~~ "Qualified alien" means an alien as defined in 8
277 U.S.C. s. 1641 (b) and (c) ~~s. 431 of the Personal Responsibility~~
278 ~~and Work Opportunity Reconciliation Act of 1996, as amended,~~
279 ~~Pub. L. No. 104-193~~.
280 (26) ~~(24)~~ "Resident" means a United States citizen, or
281 qualified alien, who is domiciled in this state.
282 (27) ~~(25)~~ "Rural county" means a county having a population
283 density of less than 100 persons per square mile, or a county
284 defined by the most recent United States Census as rural, in
285 which there is no prepaid health plan participating in the
286 Medicaid program as of July 1, 1998.
287 ~~(26) "Substantially similar" means that, with respect to~~
288 ~~additional services as defined in s. 2103(c)(2) of Title XXI of~~
289 ~~the Social Security Act, these services must have an actuarial~~
290 ~~value equal to at least 75 percent of the actuarial value of the~~

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291 ~~coverage for that service in the benchmark benefit plan and,~~
292 ~~with respect to the basic services as defined in s. 2103(c)(1)~~
293 ~~of Title XXI of the Social Security Act, these services must be~~
294 ~~the same as the services in the benchmark benefit plan.~~
295 Section 2. Section 409.813, Florida Statutes, is amended to
296 read:
297 409.813 Health benefits coverage; program components;
298 entitlement and nonentitlement.—
299 (1) The Florida Kidcare program includes health benefits
300 coverage provided to children through the following program
301 components, which shall be marketed as the Florida Kidcare
302 program:
303 (a) Medicaid;
304 (b) Medikids as created in s. 409.8132;
305 (c) The Florida Healthy Kids Corporation as created in s.
306 624.91; and
307 ~~(d) Employer-sponsored group health insurance plans~~
308 ~~approved under ss. 409.810-409.821; and~~
309 (d) ~~(e)~~ The Children's Medical Services network established
310 in chapter 391.
311 (2) Except for Title XIX-funded Florida Kidcare program
312 coverage under the Medicaid program, coverage under the Florida
313 Kidcare program is not an entitlement. No cause of action shall
314 arise against the state, the department, the Department of
315 Children and Families ~~Family Services~~, ~~or~~ the agency, or the
316 Florida Healthy Kids Corporation for failure to make health
317 services available to any person under ss. 409.810-409.821.
318 Section 3. Subsections (6) and (7) of section 409.8132,
319 Florida Statutes, are amended to read:

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320 409.8132 Medikids program component.—
321 (6) ELIGIBILITY.—
322 (a) A child who has attained the age of 1 year but who is
323 under the age of 5 years is eligible to enroll in the Medikids
324 program component of the Florida Kidcare program, if the child
325 is a member of a family that has a family income which exceeds
326 the Medicaid applicable income level as specified in s. 409.903,
327 but which is equal to or below 200 percent of the current
328 federal poverty level. In determining the eligibility of such a
329 child, an assets test is not required. ~~A child who is eligible~~
330 ~~for Medikids may elect to enroll in Florida Healthy Kids~~
331 ~~coverage or employer-sponsored group coverage. However, a child~~
332 ~~who is eligible for Medikids may participate in the Florida~~
333 ~~Healthy Kids program only if the child has a sibling~~
334 ~~participating in the Florida Healthy Kids program and the~~
335 ~~child's county of residence permits such enrollment.~~
336 (b) The provisions of s. 409.814 apply to the Medikids
337 program.
338 (7) ENROLLMENT.—Enrollment in the Medikids program
339 component may occur at any time throughout the year. A child may
340 not receive services under the Medikids program until the child
341 is enrolled in a managed care plan or MediPass. Once determined
342 eligible, an applicant may receive choice counseling and select
343 a managed care plan or MediPass. The agency may initiate
344 mandatory assignment for a Medikids applicant who has not chosen
345 a managed care plan or MediPass provider after the applicant's
346 voluntary choice period ends. An applicant may select MediPass
347 under the Medikids program component only in counties that have
348 fewer than two managed care plans available to serve Medicaid

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349 recipients ~~and only if the federal Health Care Financing~~
350 ~~Administration determines that MediPass constitutes "health~~
351 ~~insurance coverage" as defined in Title XXI of the Social~~
352 ~~Security Act~~.
353 Section 4. Subsection (2) of section 409.8134, Florida
354 Statutes, is amended to read:
355 409.8134 Program expenditure ceiling; enrollment.—
356 (2) The Florida Kidcare program may conduct enrollment
357 continuously throughout the year.
358 (a) Children eligible for coverage under the Title XXI-
359 funded Florida Kidcare program shall be enrolled on a first-
360 come, first-served basis using the date the enrollment
361 application is received. Enrollment shall immediately cease when
362 the expenditure ceiling is reached. Year-round enrollment shall
363 only be held if the Social Services Estimating Conference
364 determines that sufficient federal and state funds will be
365 available to finance the increased enrollment.
366 (b) The application for the Florida Kidcare program is
367 valid for a period of 120 days after the date it was received.
368 At the end of the 120-day period, if the applicant has not been
369 enrolled in the program, the application is invalid and the
370 applicant shall be notified of the action. The applicant may
371 reactivate the application after notification of the action
372 taken by the program.
373 (c) Except for the Medicaid program, whenever the Social
374 Services Estimating Conference determines that there are
375 presently, or will be by the end of the current fiscal year,
376 insufficient funds to finance the current or projected
377 enrollment in the Florida Kidcare program, all additional

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378 enrollment must cease and additional enrollment may not resume
379 until sufficient funds are available to finance such enrollment.
380 Section 5. Section 409.814, Florida Statutes, is amended to
381 read:
382 409.814 Eligibility.—A child who has not reached 19 years
383 of age whose household ~~family~~ income is equal to or below 200
384 percent of the federal poverty level is eligible for the Florida
385 Kidcare program as provided in this section. If an enrolled
386 individual is determined to be ineligible for coverage, he or
387 she must be immediately disenrolled from the respective Florida
388 Kidcare program component and referred to another insurance
389 affordability program, if appropriate, through a combined
390 eligibility notice.
391 (1) A child who is eligible for Medicaid coverage under s.
392 409.903 or s. 409.904 must be offered the opportunity to enroll
393 ~~enrolled~~ in Medicaid ~~and is not eligible to receive health~~
394 ~~benefits under any other health benefits coverage authorized~~
395 ~~under the Florida Kidcare program~~. A child who is eligible for
396 Medicaid and opts to enroll in CHIP may disenroll from CHIP at
397 any time and transition to Medicaid. This transition must occur
398 without any break in coverage.
399 (2) A child who is not eligible for Medicaid, but who is
400 eligible for the Florida Kidcare program, may obtain health
401 benefits coverage under any of the other components listed in s.
402 409.813 if such coverage is approved and available in the county
403 in which the child resides.
404 (3) A Title XXI-funded child who is eligible for the
405 Florida Kidcare program who is a child with special health care
406 needs, as determined through a medical or behavioral screening

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407 instrument, is eligible for health benefits coverage from and
408 shall be assigned to and may opt out of the Children's Medical
409 Services Network.
410 (4) The following children are not eligible to receive
411 Title XXI-funded premium assistance for health benefits coverage
412 under the Florida Kidcare program, except under Medicaid if the
413 child would have been eligible for Medicaid under s. 409.903 or
414 s. 409.904 as of June 1, 1997:
415 (a) A child who is covered under a family member's group
416 health benefit plan or under other private or employer health
417 insurance coverage, if the cost of the child's participation is
418 not greater than 5 percent of the household's ~~family's~~ income.
419 If a child is otherwise eligible for a subsidy under the Florida
420 Kidcare program and the cost of the child's participation in the
421 family member's health insurance benefit plan is greater than 5
422 percent of the household's ~~family's~~ income, the child may enroll
423 in the appropriate subsidized Kidcare program.
424 ~~(b) A child who is seeking premium assistance for the~~
425 ~~Florida Kidcare program through employer-sponsored group~~
426 ~~coverage, if the child has been covered by the same employer's~~
427 ~~group coverage during the 60 days before the family submitted an~~
428 ~~application for determination of eligibility under the program.~~
429 (b) ~~(c)~~ A child who is an alien, but who does not meet the
430 definition of qualified alien, in the United States.
431 (c) ~~(d)~~ A child who is an inmate of a public institution or
432 a patient in an institution for mental diseases.
433 (d) ~~(e)~~ A child who is otherwise eligible for premium
434 assistance for the Florida Kidcare program and has had his or
435 her coverage in an employer-sponsored or private health benefit

436 plan voluntarily canceled in the last 60 days, except those
437 children whose coverage was voluntarily canceled for good cause,
438 including, but not limited to, the following circumstances:
439 1. The cost of participation in an employer-sponsored
440 health benefit plan is greater than 5 percent of the household's
441 modified adjusted gross ~~family's~~ income;
442 2. The parent lost a job that provided an employer-
443 sponsored health benefit plan for children;
444 3. The parent who had health benefits coverage for the
445 child is deceased;
446 4. The child has a medical condition that, without medical
447 care, would cause serious disability, loss of function, or
448 death;
449 5. The employer of the parent canceled health benefits
450 coverage for children;
451 6. The child's health benefits coverage ended because the
452 child reached the maximum lifetime coverage amount;
453 7. The child has exhausted coverage under a COBRA
454 continuation provision;
455 8. The health benefits coverage does not cover the child's
456 health care needs; or
457 9. Domestic violence led to loss of coverage.
458 ~~(5) A child who is otherwise eligible for the Florida~~
459 ~~Kidcare program and who has a preexisting condition that~~
460 ~~prevents coverage under another insurance plan as described in~~
461 ~~paragraph (4)(a) which would have disqualified the child for the~~
462 ~~Florida Kidcare program if the child were able to enroll in the~~
463 ~~plan is eligible for Florida Kidcare coverage when enrollment is~~
464 ~~possible.~~

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465 (5)~~(6)~~ A child whose household's modified adjusted gross
466 ~~family~~ income is above 200 percent of the federal poverty level
467 or a child who is excluded under the provisions of subsection
468 (4) may participate in the Florida Kidcare program as provided
469 in s. 409.8132 or, if the child is ineligible for Medikids by
470 reason of age, in the Florida Healthy Kids program, subject to
471 the following:
472 (a) The family is not eligible for premium assistance
473 payments and must pay the full cost of the premium, including
474 any administrative costs.
475 (b) The board of directors of the Florida Healthy Kids
476 Corporation may offer a reduced benefit package to these
477 children in order to limit program costs for such families.
478 (c) By August 15, 2013, the Florida Healthy Kids
479 Corporation shall notify all current full-pay enrollees of the
480 availability of the exchange and how to access other insurance
481 affordability options. New applications for full-pay coverage
482 may not be accepted after September 30, 2013.
483 (6)~~(7)~~ Once a child is enrolled in the Florida Kidcare
484 program, the child is eligible for coverage for 12 months
485 without a redetermination or reverification of eligibility, if
486 the family continues to pay the applicable premium. Eligibility
487 for program components funded through Title XXI of the Social
488 Security Act terminates when a child attains the age of 19. A
489 child who has not attained the age of 5 and who has been
490 determined eligible for the Medicaid program is eligible for
491 coverage for 12 months without a redetermination or
492 reverification of eligibility.
493 (7)~~(8)~~ When determining or reviewing a child's eligibility

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494 under the Florida Kidcare program, the applicant shall be
495 provided with reasonable notice of changes in eligibility which
496 may affect enrollment in one or more of the program components.
497 If a transition from one program component to another is
498 authorized, there shall be cooperation between the program
499 components and the affected family which promotes continuity of
500 health care coverage. Any authorized transfers must be managed
501 within the program's overall appropriated or authorized levels
502 of funding. Each component of the program shall establish a
503 reserve to ensure that transfers between components will be
504 accomplished within current year appropriations. These reserves
505 shall be reviewed by each convening of the Social Services
506 Estimating Conference to determine the adequacy of such reserves
507 to meet actual experience.
508 (8) ~~(9)~~ In determining the eligibility of a child, an assets
509 test is not required. Each applicant shall provide documentation
510 during the application process and the redetermination process,
511 including, but not limited to, the following:
512 (a) Proof of household ~~family~~ income, which must be
513 verified electronically to determine financial eligibility for
514 the Florida Kidcare program. Written documentation, which may
515 include wages and earnings statements or pay stubs, W-2 forms,
516 or a copy of the applicant's most recent federal income tax
517 return, is required only if the electronic verification is not
518 available or does not substantiate the applicant's income. This
519 paragraph expires December 31, 2013.
520 (b) A statement from all applicable, employed household
521 ~~family~~ members that:
522 1. Their employers do not sponsor health benefit plans for

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523 employees;
524 2. The potential enrollee is not covered by an employer-
525 sponsored health benefit plan; or
526 3. The potential enrollee is covered by an employer-
527 sponsored health benefit plan and the cost of the employer-
528 sponsored health benefit plan is more than 5 percent of the
529 household's modified adjusted gross ~~family's~~ income.
530 (c) To enroll in the Children's Medical Services Network, a
531 completed application, including a clinical screening.
532 (d) Effective January 1, 2014, eligibility shall be
533 determined through electronic matching using the federally
534 managed data services hub and other resources. Written
535 documentation from the applicant may be accepted if the
536 electronic verification does not substantiate the applicant's
537 income or if there has been a change in circumstances.
538 (9) ~~(10)~~ Subject to paragraph (4)(a), the Florida Kidcare
539 program shall withhold benefits from an enrollee if the program
540 obtains evidence that the enrollee is no longer eligible,
541 submitted incorrect or fraudulent information in order to
542 establish eligibility, or failed to provide verification of
543 eligibility. The applicant or enrollee shall be notified that
544 because of such evidence program benefits will be withheld
545 unless the applicant or enrollee contacts a designated
546 representative of the program by a specified date, which must be
547 within 10 working days after the date of notice, to discuss and
548 resolve the matter. The program shall make every effort to
549 resolve the matter within a timeframe that will not cause
550 benefits to be withheld from an eligible enrollee.
551 (10) ~~(11)~~ The following individuals may be subject to

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552 prosecution in accordance with s. 414.39:
553 (a) An applicant obtaining or attempting to obtain benefits
554 for a potential enrollee under the Florida Kidcare program when
555 the applicant knows or should have known the potential enrollee
556 does not qualify for the Florida Kidcare program.
557 (b) An individual who assists an applicant in obtaining or
558 attempting to obtain benefits for a potential enrollee under the
559 Florida Kidcare program when the individual knows or should have
560 known the potential enrollee does not qualify for the Florida
561 Kidcare program.
562 Section 6. Paragraphs (g), (k), (q), and (w) of subsection
563 (2) of section 409.815, Florida Statutes, are amended to read:
564 409.815 Health benefits coverage; limitations.—
565 (2) BENCHMARK BENEFITS.—In order for health benefits
566 coverage to qualify for premium assistance payments for an
567 eligible child under ss. 409.810-409.821, the health benefits
568 coverage, except for coverage under Medicaid and Medikids, must
569 include the following minimum benefits, as medically necessary.
570 (g) *Behavioral health services.*—
571 1. Mental health benefits include:
572 a. Inpatient services~~, limited to 30 inpatient days per~~
573 ~~contract year~~ for psychiatric admissions, or residential
574 services in facilities licensed under s. 394.875(6) or s.
575 395.003 in lieu of inpatient psychiatric admissions~~; however, a~~
576 ~~minimum of 10 of the 30 days shall be available only for~~
577 ~~inpatient psychiatric services~~ if authorized by a physician; and
578 b. Outpatient services, including outpatient visits for
579 psychological or psychiatric evaluation, diagnosis, and
580 treatment by a licensed mental health professional~~, limited to~~

581 ~~40 outpatient visits each contract year~~.
582 2. Substance abuse services include:
583 a. Inpatient services~~, limited to 7 inpatient days per~~
584 ~~contract year~~ for medical detoxification only and ~~30 days of~~
585 residential services; and
586 b. Outpatient services, including evaluation, diagnosis,
587 and treatment by a licensed practitioner~~, limited to 40~~
588 ~~outpatient visits per contract year~~.
589
590 ~~Effective October 1, 2009,~~ Covered services include inpatient
591 and outpatient services for mental and nervous disorders as
592 defined in the most recent edition of the Diagnostic and
593 Statistical Manual of Mental Disorders published by the American
594 Psychiatric Association. Such benefits include psychological or
595 psychiatric evaluation, diagnosis, and treatment by a licensed
596 mental health professional and inpatient, outpatient, and
597 residential treatment of substance abuse disorders. Any benefit
598 limitations, including duration of services, number of visits,
599 or number of days for hospitalization or residential services,
600 shall not be any less favorable than those for physical
601 illnesses generally. The program may also implement appropriate
602 financial incentives, peer review, utilization requirements, and
603 other methods used for the management of benefits provided for
604 other medical conditions in order to reduce service costs and
605 utilization without compromising quality of care.
606 (k) *Hospice services.*—Covered services include reasonable
607 and necessary services for palliation or management of an
608 enrollee’s terminal illness~~, with the following exceptions:~~
609 ~~1. Once a family elects to receive hospice care for an~~

610 ~~enrollee, other services that treat the terminal condition will~~
611 ~~not be covered; and~~
612 ~~2. Services required for conditions totally unrelated to~~
613 ~~the terminal condition are covered to the extent that the~~
614 ~~services are included in this section~~.
615 (q) *Dental services.*~~—Effective October 1, 2009,~~ Dental
616 services shall be covered as required under federal law and may
617 also include those dental benefits provided to children by the
618 Florida Medicaid program under s. 409.906(6).
619 (w) *Reimbursement of federally qualified health centers and*
620 *rural health clinics.*~~—Effective October 1, 2009,~~ Payments for
621 services provided to enrollees by federally qualified health
622 centers and rural health clinics under this section shall be
623 reimbursed using the Medicaid Prospective Payment System as
624 provided for under s. 2107(e)(1)(D) of the Social Security Act.
625 If such services are paid for by health insurers or health care
626 providers under contract with the Florida Healthy Kids
627 Corporation, such entities are responsible for this payment. The
628 agency may seek any available federal grants to assist with this
629 transition.
630 Section 7. Section 409.816, Florida Statutes, is amended to
631 read:
632 409.816 Limitations on premiums and cost-sharing.—The
633 following limitations on premiums and cost-sharing are
634 established for the program.
635 (1) Enrollees who receive coverage under the Medicaid
636 program may not be required to pay:
637 (a) Enrollment fees, premiums, or similar charges; or
638 (b) Copayments, deductibles, coinsurance, or similar

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639 charges.

640 (2) Enrollees in households that have ~~families with~~ a
641 modified adjusted gross ~~family~~ income equal to or below 150
642 percent of the federal poverty level, who are not receiving
643 coverage under the Medicaid program, may not be required to pay:

644 (a) Enrollment fees, premiums, or similar charges that
645 exceed the maximum monthly charge permitted under s. 1916(b)(1)
646 of the Social Security Act; or

647 (b) Copayments, deductibles, coinsurance, or similar
648 charges that exceed a nominal amount, as determined consistent
649 with regulations referred to in s. 1916(a)(3) of the Social
650 Security Act. However, such charges may not be imposed for
651 preventive services, including well-baby and well-child care,
652 age-appropriate immunizations, and routine hearing and vision
653 screenings.

654 (3) Enrollees in households that have ~~families with~~ a
655 modified adjusted gross ~~family~~ income above 150 percent of the
656 federal poverty level who are not receiving coverage under the
657 Medicaid program or who are not eligible under s. 409.814(5) ~~s.~~
658 ~~409.814(6)~~ may be required to pay enrollment fees, premiums,
659 copayments, deductibles, coinsurance, or similar charges on a
660 sliding scale related to income, except that the total annual
661 aggregate cost-sharing with respect to all children in a
662 household ~~family~~ may not exceed 5 percent of the household’s
663 modified adjusted ~~family’s~~ income. However, copayments,
664 deductibles, coinsurance, or similar charges may not be imposed
665 for preventive services, including well-baby and well-child
666 care, age-appropriate immunizations, and routine hearing and
667 vision screenings.

668 Section 8. Section 409.817, Florida Statutes, is repealed.
669 Section 9. Section 409.8175, Florida Statutes, is repealed.
670 Section 10. Paragraph (c) of subsection (1) of section
671 409.8177, Florida Statutes, is amended to read:
672 409.8177 Program evaluation.—
673 (1) The agency, in consultation with the Department of
674 Health, the Department of Children and Families ~~Family Services~~,
675 and the Florida Healthy Kids Corporation, shall contract for an
676 evaluation of the Florida Kidcare program and shall by January 1
677 of each year submit to the Governor, the President of the
678 Senate, and the Speaker of the House of Representatives a report
679 of the program. In addition to the items specified under s. 2108
680 of Title XXI of the Social Security Act, the report shall
681 include an assessment of crowd-out and access to health care, as
682 well as the following:
683 (c) The characteristics of the children and families
684 assisted under the program, including ages of the children,
685 household ~~family~~ income, and access to or coverage by other
686 health insurance prior to the program and after disenrollment
687 from the program.
688 Section 11. Section 409.818, Florida Statutes, is amended
689 to read:
690 409.818 Administration.—In order to implement ss. 409.810-
691 409.821, the following agencies shall have the following duties:
692 (1) The Department of Children and Families ~~Family Services~~
693 shall:
694 (a) Maintain ~~Develop~~ a simplified eligibility determination
695 and renewal process ~~application mail-in form to be used for~~
696 ~~determining the eligibility of children for coverage~~ under the

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697 Florida Kidcare program, in consultation with the agency, the
698 Department of Health, and the Florida Healthy Kids Corporation.
699 The simplified eligibility process ~~application form~~ must include
700 ~~an item that provides~~ an opportunity for the applicant to
701 indicate whether coverage is being sought for a child with
702 special health care needs. Families applying for children's
703 Medicaid coverage must also be able to use the simplified
704 application process ~~form~~ without having to pay a premium.
705 (b) Establish and maintain the eligibility determination
706 process under the program except as specified in subsection (3),
707 which includes the following: ~~(5).~~
708 1. The department shall directly, or through the services
709 of a contracted third-party administrator, establish and
710 maintain a process for determining eligibility of children for
711 coverage under the program. The eligibility determination
712 process must be used solely for determining eligibility of
713 applicants for health benefits coverage under the program. The
714 eligibility determination process must include an initial
715 determination of eligibility for any coverage offered under the
716 program, as well as a redetermination or reverification of
717 eligibility each subsequent 6 months. ~~Effective January 1, 1999,~~
718 A child who has not attained the age of 5 and who has been
719 determined eligible for the Medicaid program is eligible for
720 coverage for 12 months without a redetermination or
721 reverification of eligibility. In conducting an eligibility
722 determination, the department shall determine if the child has
723 special health care needs.
724 2. The department, in consultation with the Agency for
725 Health Care Administration and the Florida Healthy Kids

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726 Corporation, shall develop procedures for redetermining
727 eligibility which enable applicants and enrollees ~~a family~~ to
728 easily update any change in circumstances which could affect
729 eligibility.
730 3. The department may accept changes in ~~a family's~~ status
731 as reported to the department by the Florida Healthy Kids
732 Corporation or the exchange without requiring a new application
733 ~~from the family~~. Redetermination of a child's eligibility for
734 Medicaid may not be linked to a child's eligibility
735 determination for other programs.
736 4. The department, in consultation with the agency and the
737 Florida Healthy Kids Corporation, shall develop a combined
738 eligibility notice to inform applicants and enrollees of their
739 application or renewal status, as appropriate. The content must
740 be coordinated to meet all federal and state requirements under
741 the federal Patient Protection and Affordable Care Act.
742 (c) Inform program applicants about eligibility
743 determinations and provide information about eligibility of
744 applicants to the Florida Kidcare program and to insurers and
745 their agents~~, through a centralized coordinating office~~.
746 (d) Adopt rules necessary for conducting program
747 eligibility functions.
748 ~~(2) The Department of Health shall:~~
749 ~~(a) Design an eligibility intake process for the program,~~
750 ~~in coordination with the Department of Children and Family~~
751 ~~Services, the agency, and the Florida Healthy Kids Corporation.~~
752 ~~The eligibility intake process may include local intake points~~
753 ~~that are determined by the Department of Health in coordination~~
754 ~~with the Department of Children and Family Services.~~

755 ~~(b) Chair a state-level Florida Kidcare coordinating~~
756 ~~council to review and make recommendations concerning the~~
757 ~~implementation and operation of the program. The coordinating~~
758 ~~council shall include representatives from the department, the~~
759 ~~Department of Children and Family Services, the agency, the~~
760 ~~Florida Healthy Kids Corporation, the Office of Insurance~~
761 ~~Regulation of the Financial Services Commission, local~~
762 ~~government, health insurers, health maintenance organizations,~~
763 ~~health care providers, families participating in the program,~~
764 ~~and organizations representing low-income families.~~
765 ~~(c) In consultation with the Florida Healthy Kids~~
766 ~~Corporation and the Department of Children and Family Services,~~
767 ~~establish a toll-free telephone line to assist families with~~
768 ~~questions about the program.~~
769 ~~(d) Adopt rules necessary to implement outreach activities.~~
770 (2)~~(3)~~ The Agency for Health Care Administration, under the
771 authority granted in s. 409.914(1), shall:
772 (a) Calculate the premium assistance payment necessary to
773 comply with the premium and cost-sharing limitations specified
774 in s. 409.816 and the federal Patient Protection and Affordable
775 Care Act. The premium assistance payment for each enrollee in a
776 health insurance plan participating in the Florida Healthy Kids
777 Corporation shall equal the premium approved by the Florida
778 Healthy Kids Corporation ~~and the Office of Insurance Regulation~~
779 ~~of the Financial Services Commission pursuant to ss. 627.410 and~~
780 ~~641.31,~~ less any enrollee's share of the premium established
781 within the limitations specified in s. 409.816. ~~The premium~~
782 ~~assistance payment for each enrollee in an employer-sponsored~~
783 ~~health insurance plan approved under ss. 409.810-409.821 shall~~

784 ~~equal the premium for the plan adjusted for any benchmark~~
785 ~~benefit plan actuarial equivalent benefit rider approved by the~~
786 ~~Office of Insurance Regulation pursuant to ss. 627.410 and~~
787 ~~641.31, less any enrollee's share of the premium established~~
788 ~~within the limitations specified in s. 409.816. In calculating~~
789 ~~the premium assistance payment levels for children with family~~
790 ~~coverage, the agency shall set the premium assistance payment~~
791 ~~levels for each child proportionately to the total cost of~~
792 ~~family coverage.~~
793 (b) Make premium assistance payments to health insurance
794 plans on a periodic basis. The agency may use its Medicaid
795 fiscal agent or a contracted third-party administrator in making
796 these payments. The agency may require health insurance plans
797 that participate in the Medikids program ~~or employer-sponsored~~
798 ~~group health insurance~~ to collect premium payments from an
799 enrollee's family. Participating health insurance plans shall
800 report premium payments collected on behalf of enrollees in the
801 program to the agency in accordance with a schedule established
802 by the agency.
803 (c) Monitor compliance with quality assurance and access
804 standards developed under s. 409.820 and in accordance with s.
805 2103(f) of the Social Security Act, 42 U.S.C. s. 1397cc(f).
806 (d) Establish a mechanism for investigating and resolving
807 complaints and grievances from program applicants, enrollees,
808 and health benefits coverage providers, and maintain a record of
809 complaints and confirmed problems. In the case of a child who is
810 enrolled in a managed care ~~health maintenance~~ organization, the
811 agency must use the provisions of s. 641.511 to address
812 grievance reporting and resolution requirements.

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813 ~~(c) Approve health benefits coverage for participation in~~
814 ~~the program, following certification by the Office of Insurance~~
815 ~~Regulation under subsection (4).~~
816 (e)~~(f)~~ Adopt rules necessary for ~~calculating premium~~
817 ~~assistance payment levels, making premium assistance payments,~~
818 monitoring access and quality assurance standards and~~,~~
819 investigating and resolving complaints and grievances~~,~~
820 ~~administering the Medikids program, and approving health~~
821 ~~benefits coverage~~.
822 (f) Contract with the Florida Healthy Kids Corporation for
823 the administration of the Florida Kidcare program and the
824 Healthy Florida program and to facilitate the release of any
825 federal and state funds.
826
827 The agency is designated the lead state agency for Title XXI of
828 the Social Security Act for purposes of receipt of federal
829 funds, for reporting purposes, and for ensuring compliance with
830 federal and state regulations and rules.
831 ~~(4) The Office of Insurance Regulation shall certify that~~
832 ~~health benefits coverage plans that seek to provide services~~
833 ~~under the Florida Kidcare program, except those offered through~~
834 ~~the Florida Healthy Kids Corporation or the Children's Medical~~
835 ~~Services Network, meet, exceed, or are actuarially equivalent to~~
836 ~~the benchmark benefit plan and that health insurance plans will~~
837 ~~be offered at an approved rate. In determining actuarial~~
838 ~~equivalence of benefits coverage, the Office of Insurance~~
839 ~~Regulation and health insurance plans must comply with the~~
840 ~~requirements of s. 2103 of Title XXI of the Social Security Act.~~
841 ~~The department shall adopt rules necessary for certifying health~~

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842 ~~benefits coverage plans.~~
843 <u>(3)</u>~~(5)~~ The Florida Healthy Kids Corporation shall retain
844 its functions as authorized in s. 624.91, including eligibility
845 determination for participation in the Healthy Kids program.
846 <u>(4)</u>~~(6)~~ The agency, the Department of Health, the Department
847 of Children and <u>Families</u> ~~Family Services~~, <u>and</u> the Florida
848 Healthy Kids Corporation, ~~and the Office of Insurance~~
849 ~~Regulation,~~ after consultation with and approval of the Speaker
850 of the House of Representatives and the President of the Senate,
851 <u>may</u> ~~are authorized to~~ make program modifications that are
852 necessary to overcome any objections of the United States
853 Department of Health and Human Services to obtain approval of
854 the state's child health insurance plan under Title XXI of the
855 Social Security Act.
856 Section 12. Section 409.820, Florida Statutes, is amended
857 to read:
858 409.820 Quality assurance and access standards.—Except for
859 Medicaid, the Department of Health, in consultation with the
860 agency and the Florida Healthy Kids Corporation, shall develop a
861 minimum set of <u>pediatric and adolescent</u> quality assurance and
862 access standards for all program components. The standards must
863 include a process for granting exceptions to specific
864 requirements for quality assurance and access. Compliance with
865 the standards shall be a condition of program participation by
866 health benefits coverage providers. These standards shall comply
867 with the provisions of this chapter and chapter 641 and Title
868 XXI of the Social Security Act.
869 Section 13. Section 624.91, Florida Statutes, is amended to
870 read:

871 624.91 The Florida Healthy Kids Corporation Act.—
872 (1) SHORT TITLE.—This section may be cited as the "William
873 G. 'Doc' Myers Healthy Kids Corporation Act."
874 (2) LEGISLATIVE INTENT.—
875 (a) The Legislature finds that increased access to health
876 care services could improve children's health and reduce the
877 incidence and costs of childhood illness and disabilities among
878 children in this state. Many children do not have comprehensive,
879 affordable health care services available. It is the intent of
880 the Legislature that the Florida Healthy Kids Corporation
881 provide comprehensive health insurance coverage to such
882 children. The corporation is encouraged to cooperate with any
883 existing health service programs funded by the public or the
884 private sector.
885 (b) It is the intent of the Legislature that the Florida
886 Healthy Kids Corporation serve as one of several providers of
887 services to children eligible for medical assistance under Title
888 XXI of the Social Security Act. Although the corporation may
889 serve other children, the Legislature intends the primary
890 recipients of services provided through the corporation be
891 school-age children with a family income below 200 percent of
892 the federal poverty level, who do not qualify for Medicaid. It
893 is also the intent of the Legislature that state and local
894 government Florida Healthy Kids funds be used to continue
895 coverage, subject to specific appropriations in the General
896 Appropriations Act, to children not eligible for federal
897 matching funds under Title XXI.
898 <u>(c) It is further the intent of the Legislature that the</u>
899 <u>Florida Healthy Kids Corporation administer and manage services</u>

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900 for Healthy Florida, a health care program for uninsured adults
901 using a unique network of providers and contracts. Enrollees in
902 Healthy Florida will receive comprehensive health care services
903 from private, licensed health insurers who meet standards
904 established by the corporation. It is further the intent of the
905 Legislature that these enrollees participate in their own health
906 care decisionmaking and contribute financially toward their
907 medical costs. The Legislature intends to provide an alternative
908 benefit package that includes a full range of services which
909 meet the needs of residents of this state. As a new program, the
910 Legislature shall also ensure that a comprehensive evaluation is
911 conducted to measure the overall impact of the program and
912 identify whether to renew the program after an initial 3-year
913 term.
914 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only the
915 following individuals are eligible for state-funded assistance
916 in paying premiums for Healthy Florida or Florida Healthy Kids
917 ~~premiums~~:
918 (a) Residents of this state who are eligible for the
919 Florida Kidcare program pursuant to s. 409.814 or the Healthy
920 Florida pursuant to s. 624.917.
921 (b) Notwithstanding s. 409.814, legal aliens who are
922 enrolled in the Florida Healthy Kids program as of January 31,
923 2004, who do not qualify for Title XXI federal funds because
924 they are not qualified aliens as defined in s. 409.811.
925 (4) NONENTITLEMENT.—Nothing in this section shall be
926 construed as providing an individual with an entitlement to
927 health care services. No cause of action shall arise against the
928 state, the Florida Healthy Kids Corporation, or a unit of local

929 government for failure to make health services available under
930 this section.
931 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—
932 (a) There is created the Florida Healthy Kids Corporation,
933 a not-for-profit corporation.
934 (b) The Florida Healthy Kids Corporation shall:
935 1. Arrange for the collection of any family, individual, or
936 local contributions~~, or employer payment or premium~~, in an
937 amount to be determined by the board of directors, to provide
938 for payment of premiums for comprehensive insurance coverage and
939 for the actual or estimated administrative expenses.
940 2. Arrange for the collection of any voluntary
941 contributions to provide for payment of premiums for enrollees
942 in the Florida Kidcare program or Healthy Florida ~~premiums for~~
943 ~~children who are not eligible for medical assistance under Title~~
944 ~~XIX or Title XXI of the Social Security Act~~.
945 3. Subject to the provisions of s. 409.8134, accept
946 voluntary supplemental local match contributions that comply
947 with the requirements of Title XXI of the Social Security Act
948 for the purpose of providing additional Florida Kidcare coverage
949 in contributing counties under Title XXI.
950 4. Establish the administrative and accounting procedures
951 for the operation of the corporation.
952 5. Establish, with consultation from appropriate
953 professional organizations, standards for preventive health
954 services and providers and comprehensive insurance benefits
955 appropriate to children, provided that such standards for rural
956 areas shall not limit primary care providers to board-certified
957 pediatricians.

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958 6. Determine eligibility for children seeking to
959 participate in the Title XXI-funded components of the Florida
960 Kidcare program consistent with the requirements specified in s.
961 409.814, as well as the non-Title-XXI-eligible children as
962 provided in subsection (3).
963 7. Establish procedures under which providers of local
964 match to, applicants to and participants in the program may have
965 grievances reviewed by an impartial body and reported to the
966 board of directors of the corporation.
967 8. Establish participation criteria and, if appropriate,
968 contract with an authorized insurer, health maintenance
969 organization, or third-party administrator to provide
970 administrative services to the corporation.
971 9. Establish enrollment criteria that include penalties or
972 waiting periods of 30 days for reinstatement of coverage upon
973 voluntary cancellation for nonpayment of family and individual
974 premiums under the programs.
975 10. Contract with authorized insurers or any provider of
976 health care services, meeting standards established by the
977 corporation, for the provision of comprehensive insurance
978 coverage to participants. Such standards shall include criteria
979 under which the corporation may contract with more than one
980 provider of health care services in program sites.
981 a. Health plans shall be selected through a competitive bid
982 process.
983 b. The Florida Healthy Kids Corporation shall purchase
984 goods and services in the most cost-effective manner consistent
985 with the delivery of quality medical care. The maximum
986 administrative cost for a Florida Healthy Kids Corporation

987 contract shall be 15 percent. For <u>all</u> health care contracts, the
988 minimum medical loss ratio <u>is</u> ~~for a Florida Healthy Kids~~
989 ~~Corporation contract shall be~~ 85 percent. <u>The calculations must</u>
990 <u>use uniform financial data collected from all plans in a format</u>
991 <u>established by the corporation and shall be computed for each</u>
992 <u>insurer on a statewide basis. Funds shall be classified in a</u>
993 <u>manner consistent with 45 C.F.R. part 158</u> ~~For dental contracts,~~
994 ~~the remaining compensation to be paid to the authorized insurer~~
995 ~~or provider under a Florida Healthy Kids Corporation contract~~
996 ~~shall be no less than an amount which is 85 percent of premium;~~
997 ~~to the extent any contract provision does not provide for this~~
998 ~~minimum compensation, this section shall prevail~~.
999 <u>c.</u> The health plan selection criteria and scoring system,
1000 and the scoring results, shall be available upon request for
1001 inspection after the bids have been awarded.
1002 11. Establish disenrollment criteria in the event local
1003 matching funds are insufficient to cover enrollments.
1004 12. Develop and implement a plan to publicize the Florida
1005 Kidcare program <u>and Healthy Florida</u>, the eligibility
1006 requirements of the <u>programs</u> ~~program~~, and the procedures for
1007 enrollment in the program and to maintain public awareness of
1008 the corporation and the <u>programs</u> ~~program~~.
1009 13. Secure staff necessary to properly administer the
1010 corporation. Staff costs shall be funded from state and local
1011 matching funds and such other private or public funds as become
1012 available. The board of directors shall determine the number of
1013 staff members necessary to administer the corporation.
1014 14. In consultation with the partner agencies, <u>annually</u>
1015 provide a report on the Florida Kidcare program ~~annually~~ to the

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1016 Governor, the Chief Financial Officer, the Commissioner of
1017 Education, the President of the Senate, the Speaker of the House
1018 of Representatives, and the Minority Leaders of the Senate and
1019 the House of Representatives.
1020 15. Provide information on a quarterly basis to the
1021 Legislature and the Governor which compares the costs and
1022 utilization of the full-pay enrolled population and the Title
1023 XXI-subsidized enrolled population in the Florida Kidcare
1024 program. The information, at a minimum, must include:
1025 a. The monthly enrollment and expenditure for full-pay
1026 enrollees in the Medikids and Florida Healthy Kids programs
1027 compared to the Title XXI-subsidized enrolled population; and
1028 b. The costs and utilization by service of the full-pay
1029 enrollees in the Medikids and Florida Healthy Kids programs and
1030 the Title XXI-subsidized enrolled population. <u>This subparagraph</u>
1031 <u>is repealed effective December 31, 2013.</u>
1032
1033 ~~By February 1, 2010, the Florida Healthy Kids Corporation shall~~
1034 ~~provide a study to the Legislature and the Governor on premium~~
1035 ~~impacts to the subsidized portion of the program from the~~
1036 ~~inclusion of the full-pay program, which shall include~~
1037 ~~recommendations on how to eliminate or mitigate possible impacts~~
1038 ~~to the subsidized premiums.~~
1039 <u>16. By August 15, 2013, the corporation shall notify all</u>
1040 <u>current full-pay enrollees of the availability of the exchange,</u>
1041 <u>as defined in the federal Patient Protection and Affordable Care</u>
1042 <u>Act, and how to access other insurance affordability options.</u>
1043 <u>New applications for full-pay coverage may not be accepted after</u>
1044 <u>September 30, 2013.</u>

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1045 17.~~16.~~ Establish benefit packages that conform to the
1046 provisions of the Florida Kidcare program, as created in ss.
1047 409.810-409.821.
1048 (c) Coverage under the corporation's program is secondary
1049 to any other available private coverage held by, or applicable
1050 to, the participant ~~child~~ or family member. Insurers under
1051 contract with the corporation are the payors of last resort and
1052 must coordinate benefits with any other third-party payor that
1053 may be liable for the participant's medical care.
1054 (d) The Florida Healthy Kids Corporation shall be a private
1055 corporation not for profit, registered, incorporated, and
1056 organized pursuant to chapter 617, and shall have all powers
1057 necessary to carry out the purposes of this act, including, but
1058 not limited to, the power to receive and accept grants, loans,
1059 or advances of funds from any public or private agency and to
1060 receive and accept from any source contributions of money,
1061 property, labor, or any other thing of value, to be held, used,
1062 and applied for the purposes of this act. The corporation and
1063 any committees it forms shall act in compliance with part III of
1064 chapter 112, and chapters 119 and 286.
1065 (6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—
1066 (a) The Florida Healthy Kids Corporation shall operate
1067 subject to the supervision and approval of a board of directors
1068 chaired by an appointee designated by the Governor ~~Chief~~
1069 ~~Financial Officer or her or his designee,~~ and composed of 15 ~~12~~
1070 other members. The Senate shall confirm the designated chair and
1071 other board appointees ~~selected~~ for 3-year terms of office as
1072 follows:
1073 1. The Secretary of Health Care Administration, or his or

1074 her designee, as an ex-officio member.
1075 2. The State Surgeon General, or his or her designee, as an
1076 ex-officio member ~~One member appointed by the Commissioner of~~
1077 ~~Education from the Office of School Health Programs of the~~
1078 ~~Florida Department of Education~~.
1079 3. The Secretary of Children and Families, or his or her
1080 designee, as an ex-officio member ~~One member appointed by the~~
1081 ~~Chief Financial Officer from among three members nominated by~~
1082 ~~the Florida Pediatric Society~~.
1083 4. Four members ~~One member,~~ appointed by the Governor~~, who~~
1084 ~~represents the Children's Medical Services Program~~.
1085 5. Two members ~~One member~~ appointed by the President of the
1086 Senate ~~Chief Financial Officer from among three members~~
1087 ~~nominated by the Florida Hospital Association~~.
1088 6. Two members ~~One member,~~ appointed by the Senate Minority
1089 Leader ~~Governor, who is an expert on child health policy~~.
1090 7. Two members ~~One member,~~ appointed by the Speaker of the
1091 House of Representatives ~~Chief Financial Officer, from among~~
1092 ~~three members nominated by the Florida Academy of Family~~
1093 ~~Physicians~~.
1094 8. Two members ~~One member,~~ appointed by the House Minority
1095 Leader ~~Governor, who represents the state Medicaid program~~.
1096 ~~9. One member, appointed by the Chief Financial Officer,~~
1097 ~~from among three members nominated by the Florida Association of~~
1098 ~~Counties.~~
1099 ~~10. The State Health Officer or her or his designee.~~
1100 ~~11. The Secretary of Children and Family Services, or his~~
1101 ~~or her designee.~~
1102 ~~12. One member, appointed by the Governor, from among three~~

1103 ~~members nominated by the Florida Dental Association.~~
1104 (b) A member of the board of directors may be removed by
1105 the official who appointed that member. The board shall appoint
1106 an executive director, who is responsible for other staff
1107 authorized by the board.
1108 (c) Board members are entitled to receive, from funds of
1109 the corporation, reimbursement for per diem and travel expenses
1110 as provided by s. 112.061.
1111 (d) There shall be no liability on the part of, and no
1112 cause of action shall arise against, any member of the board of
1113 directors, or its employees or agents, for any action they take
1114 in the performance of their powers and duties under this act.
1115 (e) Board members who are serving on or before the date of
1116 enactment of this act or similar legislation may remain until
1117 July 1, 2013.
1118 (f) An executive steering committee is created to provide
1119 management direction and support and to make recommendations to
1120 the board on the programs. The steering committee is composed of
1121 the Secretary of Health Care Administration, the Secretary of
1122 Children and Families, and the State Surgeon General. Committee
1123 members may not delegate their membership or attendance.
1124 (7) LICENSING NOT REQUIRED; FISCAL OPERATION.—
1125 (a) The corporation shall not be deemed an insurer. The
1126 officers, directors, and employees of the corporation shall not
1127 be deemed to be agents of an insurer. Neither the corporation
1128 nor any officer, director, or employee of the corporation is
1129 subject to the licensing requirements of the insurance code or
1130 the rules of the Department of Financial Services or Office of
1131 Insurance Regulation. However, any marketing representative

1132 utilized and compensated by the corporation must be appointed as
1133 a representative of the insurers or health services providers
1134 with which the corporation contracts.
1135 (b) The board has complete fiscal control over the
1136 corporation and is responsible for all corporate operations.
1137 (c) The Department of Financial Services shall supervise
1138 any liquidation or dissolution of the corporation and shall
1139 have, with respect to such liquidation or dissolution, all power
1140 granted to it pursuant to the insurance code.
1141 Section 14. Section 624.915, Florida Statutes, is repealed.
1142 Section 15. Section 624.917, Florida Statutes, is created
1143 to read:
1144 624.917 Healthy Florida program.—
1145 (1) PROGRAM CREATION.—There is created Healthy Florida, a
1146 health care program for lower income, uninsured adults who meet
1147 the eligibility guidelines established under s. 624.91. The
1148 Florida Healthy Kids Corporation shall administer the program
1149 under its existing corporate governance and structure.
1150 (2) DEFINITIONS.—As used in this section, the term:
1151 (a) "Actuarially equivalent" means:
1152 1. The aggregate value of the benefits included in health
1153 benefits coverage is equal to the value of the benefits in the
1154 child benchmark benefit plan as defined in s. 409.811; and
1155 2. The benefits included in health benefits coverage are
1156 substantially similar to the benefits included in the child
1157 benchmark benefit plan, except that preventive health services
1158 do not include dental services.
1159 (b) "Agency" means the Agency for Health Care
1160 Administration.

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1161 (c) “Applicant” means the individual who applies for
1162 determination of eligibility for health benefits coverage under
1163 this section.
1164 (d) “Child benchmark benefit plan” means the form and level
1165 of health benefits coverage established in s. 409.815.
1166 (e) “Child” means any person younger than 19 years of age.
1167 (f) “Corporation” means the Florida Healthy Kids
1168 Corporation.
1169 (g) “Enrollee” means an individual who has been determined
1170 eligible for and is receiving coverage under this section.
1171 (h) “Florida Kidcare program” or “Kidcare program,” means
1172 the health benefits program administered through ss. 409.810-
1173 409.821.
1174 (i) “Health benefits coverage” means protection that
1175 provides payment of benefits for covered health care services or
1176 that otherwise provides, either directly or through arrangements
1177 with other persons, covered health care services on a prepaid
1178 per capita basis or on a prepaid aggregate fixed-sum basis.
1179 (j) “Healthy Florida” means the program created by this
1180 section which is administered by the Florida Healthy Kids
1181 Corporation.
1182 (k) “Healthy Kids” means the Florida Kidcare program
1183 component created under s. 624.91 for children who are 5 through
1184 18 years of age.
1185 (l) “Household income” means the group or the individual
1186 whose income is considered in determining eligibility for the
1187 Healthy Florida program. The term “household” has the same
1188 meaning as provided in s. 36B(d)(2) of the Internal Revenue Code
1189 of 1986.

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1190 (m) “Medicaid” means the medical assistance program
1191 authorized by Title XIX of the Social Security Act, and
1192 regulations thereunder, and ss. 409.901-409.920, as administered
1193 in this state by the agency.
1194 (n) “Medically necessary” means the use of any medical
1195 treatment, service, equipment, or supply necessary to palliate
1196 the effects of a terminal condition, or to prevent, diagnose,
1197 correct, cure, alleviate, or preclude deterioration of a
1198 condition that threatens life, causes pain or suffering, or
1199 results in illness or infirmity and which is:
1200 1. Consistent with the symptom, diagnosis, and treatment of
1201 the enrollee’s condition;
1202 2. Provided in accordance with generally accepted standards
1203 of medical practice;
1204 3. Not primarily intended for the convenience of the
1205 enrollee, the enrollee’s family, or the health care provider;
1206 4. The most appropriate level of supply or service for the
1207 diagnosis and treatment of the enrollee’s condition; and
1208 5. Approved by the appropriate medical body or health care
1209 specialty involved as effective, appropriate, and essential for
1210 the care and treatment of the enrollee’s condition.
1211 (o) “Modified adjusted gross income” means the individual
1212 or household’s annual adjusted gross income as defined in s.
1213 36B(d)(2) of the Internal Revenue Code of 1986 which is used to
1214 determine eligibility under the Florida Kidcare program.
1215 (p) “Patient Protection and Affordable Care Act” or “Act”
1216 means the federal law enacted as Pub. L. No. 111-148, as further
1217 amended by the federal Health Care and Education Reconciliation
1218 Act of 2010, Pub. L. No. 111-152, and any amendments,

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1219 regulations or guidance thereunder, issued under those acts.
1220 (q) "Premium" means the entire cost of a health insurance
1221 plan, including the administration fee or the risk assumption
1222 charge.
1223 (r) "Premium assistance payment" means the monthly
1224 consideration paid by the agency per enrollee in the Florida
1225 Kidcare program towards health insurance premiums.
1226 (s) "Qualified alien" means an alien as defined in 8 U.S.C.
1227 s. 1641(b) and (c).
1228 (t) "Resident" means a United States citizen or qualified
1229 alien who is domiciled in this state.
1230 (3) ELIGIBILITY.—To be eligible and remain eligible for the
1231 Healthy Florida program, an individual must be a resident of
1232 this state and meet the following additional criteria:
1233 (a) Be identified as newly eligible, as defined in s.
1234 1902(a)(10)(A)(i)(VIII) of the Social Security Act or s. 2001 of
1235 the federal Patient Protection and Affordable Care Act, and as
1236 may be further defined by federal regulation.
1237 (b) Maintain eligibility with the corporation and meet all
1238 renewal requirements as established by the corporation.
1239 (c) Renew eligibility on at least an annual basis.
1240 (4) ENROLLMENT.—The corporation may begin the enrollment of
1241 applicants in the Healthy Florida program on October 1, 2013.
1242 Enrollment may occur directly, through the services of a third-
1243 party administrator, referrals from the Department of Children
1244 and Families, and the exchange as defined by the federal Patient
1245 Protection and Affordable Care Act. As an enrollee disenrolls,
1246 the corporation must also provide the enrollee with information
1247 about other insurance affordability programs and electronically

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1248 refer the enrollee to the exchange or other programs, as
1249 appropriate. The earliest coverage effective date under the
1250 program shall be January 1, 2014.
1251 (5) DELIVERY OF SERVICES.—The corporation shall contract
1252 with authorized insurers licensed under chapter 627; managed
1253 care organizations authorized under chapter 641; and provider
1254 service networks authorized under ss. 409.912(4)(d) and
1255 409.962(13) which are prepaid plans. These insurers, managed
1256 care organizations, and provider service networks must meet
1257 standards established by the corporation to provide
1258 comprehensive health care services to enrollees who qualify for
1259 services under this section. The corporation may contract for
1260 such services on a statewide or regional basis. To encourage
1261 continuity of care among enrollees who may transition across
1262 multiple insurance affordability programs, the corporation is
1263 encouraged to contract with those insurers and managed care
1264 organizations that participate in more than one such program.
1265 (a) The corporation shall establish access and network
1266 standards for such contracts and ensure that contracted
1267 providers have sufficient providers to meet enrollee needs.
1268 Quality standards must be developed by the corporation, specific
1269 to the adult population, which take into consideration
1270 recommendations from the National Committee on Quality
1271 Assurance, stakeholders, and other existing performance
1272 indicators from both public and commercial populations. The
1273 corporation and its contracted health plans shall develop
1274 policies that minimize the disruption of enrollee medical homes
1275 when enrollees transition between insurance affordability plans.
1276 (b) The corporation shall provide an enrollee a choice of

1277 plans. The corporation may select a plan if no selection has
1278 been received before the coverage start date. Once enrolled, an
1279 enrollee has an initial 90-day, free-look period before a lock-
1280 in period of not more than 12 months is applied. Exceptions to
1281 the lock-in period must be offered to an enrollee for reasons
1282 based upon good cause or qualifying events.
1283 (c) The corporation may consider contracts that provide
1284 family plans that would allow members from multiple state and
1285 federally funded programs to remain together under the same
1286 plan.
1287 (d) All contracts must meet the medical loss ratio
1288 requirements under s. 624.91.
1289 (6) BENEFITS.—The corporation shall establish a benefits
1290 package that is actuarially equivalent to the benchmark benefit
1291 plan offered under s. 409.815(2), excluding dental, and meets
1292 the alternative benefits package requirements under s. 1937 of
1293 the Social Security Act. Benefits must be offered as an
1294 integrated, single package.
1295 (a) In addition to benchmark benefits, health reimbursement
1296 accounts or a comparable health savings account for each
1297 enrollee must be established through the corporation or the
1298 contracts managed by the corporation. Enrollees must be rewarded
1299 for healthy behaviors, wellness program adherence, and other
1300 activities established by the corporation which demonstrate
1301 compliance with preventive care or disease management
1302 guidelines. Funds deposited into these accounts may be used to
1303 pay cost-sharing obligations or to purchase over-the-counter
1304 health-related items to the extent allowed under federal law or
1305 regulation.

1306 (b) Enhanced services may be offered if the cost of such
1307 additional services provides savings to the overall plan.
1308 (c) The corporation shall establish a process for the
1309 payment of wrap-around services not covered by the benchmark
1310 benefit plan through a separate subcapitation process to its
1311 contracted providers if it is determined that such services are
1312 required by federal law. Such services would be covered when
1313 deemed medically necessary on an individual basis. The
1314 subcapitation pool is subject to a separate reconciliation
1315 process under the medical loss ratio provisions in s. 624.91.
1316 (d) A prior authorization process and other utilization
1317 controls may be established by the plan for any benefit if
1318 approved by the corporation.
1319 (7) COST SHARING.—The corporation may collect premiums and
1320 copayments from enrollees in accordance with federal law.
1321 Amounts to be collected for the Healthy Florida program must be
1322 established annually in the General Appropriations Act.
1323 (a) Payment of a monthly premium may be required before the
1324 establishment of an enrollee’s coverage start date and to retain
1325 monthly coverage.
1326 (b) An enrollee who has a family income above the federal
1327 poverty level may be required to make nominal copayments, in
1328 accordance with federal rule, as a condition of receiving a
1329 health care service.
1330 (c) A provider is responsible for the collection of point-
1331 of-service cost-sharing obligations. The enrollee’s cost-sharing
1332 contribution is considered part of the provider’s total
1333 reimbursement. Failure to collect an enrollee’s cost sharing
1334 reduces the provider’s share of the reimbursement.

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1335 (8) PROGRAM MANAGEMENT.—The corporation is responsible for
1336 the oversight of the Healthy Florida program. The agency shall
1337 seek a state plan amendment or other appropriate federal
1338 approval to implement the Healthy Florida program. The agency
1339 shall consult with the corporation in the amendment's
1340 development and submit by June 14, 2013, the state plan
1341 amendment to the federal Department of Health and Human
1342 Services. The agency shall contract with the corporation for the
1343 administration of the Healthy Florida program and for the timely
1344 release of federal and state funds. The agency retains its
1345 authorities as provided in ss. 409.902 and 409.963.
1346 (a) The corporation shall establish a process by which
1347 grievances can be resolved and Healthy Florida recipients can be
1348 informed of their rights under the Medicaid Fair Hearing
1349 Process, as appropriate, or any alternative resolution process
1350 adopted by the corporation.
1351 (b) The corporation shall establish a program integrity
1352 process to ensure compliance with program guidelines. At a
1353 minimum, the corporation shall withhold benefits from an
1354 applicant or enrollee if the corporation obtains evidence that
1355 the applicant or enrollee is no longer eligible, submitted
1356 incorrect or fraudulent information in order to establish
1357 eligibility, or failed to provide verification of eligibility.
1358 The corporation shall notify the applicant or enrollee that,
1359 because of such evidence, program benefits must be withheld
1360 unless the applicant or enrollee contacts a designated
1361 representative of the corporation by a specified date, which
1362 must be within 10 working days after the date of notice, to
1363 discuss and resolve the matter. The corporation shall make every

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1364 effort to resolve the matter within a timeframe that will not
1365 cause benefits to be withheld from an eligible enrollee. The
1366 following individuals may be subject to specific prosecution in
1367 accordance with s. 414.39:
1368 1. An applicant who obtains or attempts to obtain benefits
1369 for a potential enrollee under the Healthy Florida program when
1370 the applicant knows or should have known that the potential
1371 enrollee does not qualify for the Healthy Florida program.
1372 2. An individual who assists an applicant in obtaining or
1373 attempting to obtain benefits for a potential enrollee under the
1374 Healthy Florida program when the individual knows or should have
1375 known that the potential enrollee does not qualify for the
1376 Healthy Florida program.
1377 (9) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
1378 provisions of ss. 409.902, 409.9128, and 409.920 apply to the
1379 administration of the Healthy Florida program.
1380 (10) PROGRAM EVALUATION.—The corporation shall collect both
1381 eligibility and enrollment data from program applicants and
1382 enrollees as well as encounter and utilization data from all
1383 contracted entities during the program term. The corporation
1384 shall submit monthly enrollment reports to the President of the
1385 Senate, the Speaker of the House of Representative, and the
1386 Minority Leaders of the Senate and the House of Representatives.
1387 The corporation shall submit an interim independent evaluation
1388 of the Healthy Florida program to the presiding officers no
1389 later than July 1, 2015, with annual evaluations due July 1 each
1390 year thereafter. The evaluations must address, at a minimum,
1391 application and enrollment trends and issues, utilization and
1392 cost data, and customer satisfaction.

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1393 (11) PROGRAM EXPIRATION.—The Healthy Florida program shall
1394 expire at the end of the state fiscal year in which any of these
1395 conditions occur, whichever occurs first:
1396 (a) The federal match contribution falls below 90 percent.
1397 (b) The federal match contribution falls below the
1398 increased FMAP for medical assistance for newly eligible
1399 mandatory individuals as specified in the federal Patient
1400 Protection and Affordable Care Act, Pub. L. No. 111-148, as
1401 amended by the federal Health Care and Education Reconciliation
1402 Act of 2010, Pub. L. No. 111-152.
1403 (c) The federal match for the Healthy Florida program and
1404 the Medicaid program are blended under federal law or regulation
1405 in such a way that causes the overall federal contribution to
1406 diminish when compared to separate, nonblended federal
1407 contributions.
1408 Section 16. The Florida Healthy Kids Corporation may make
1409 changes to comply with the objections of the federal Department
1410 of Health and Human Services to gain approval of the Healthy
1411 Florida program in compliance with the federal Patient
1412 Protection and Affordable Care Act, upon giving notice to the
1413 Senate and the House of Representatives of the proposed changes.
1414 If there is a conflict between a provision in this section and
1415 the federal Patient Protection and Affordable Care Act, Pub. L.
1416 No. 111-148, as amended by the federal Health Care and Education
1417 Reconciliation Act of 2010, Pub. L. No. 111-152, the provision
1418 must be interpreted and applied so as to comply with the
1419 requirement of the federal law.
1420 Section 17. Section 627.6474, Florida Statutes, is amended
1421 to read:

627.6474 Provider contracts.—

(1) A health insurer may ~~shall~~ not require a contracted health care practitioner as defined in s. 456.001(4) to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or health maintenance organization, under common management and control with the insurer, including Medicare and Medicaid practitioner contracts and those authorized by s. 627.6471, s. 627.6472, s. 636.035, or s. 641.315, except for a practitioner in a group practice as defined in s. 456.053 who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this section is void. A violation of this subsection ~~section~~ is not subject to the criminal penalty specified in s. 624.15.

(2)(a) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not contain any provision that requires the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract.

(b) Covered services are those services that are listed as a benefit that the insured is entitled to receive under the contract. An insurer may not provide merely de minimis reimbursement or coverage in order to avoid the requirements of this section. Fees for covered services shall be set in good faith and must not be nominal.

(c) A health insurer may not require as a condition of the contract that the dentist participate in a discount medical plan

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1451 under part II of chapter 636.
1452 Section 18. Subsection (13) is added to section 636.035,
1453 Florida Statutes, to read:
1454 636.035 Provider arrangements.—
1455 (13)(a) A contract between a prepaid limited health service
1456 organization and a dentist licensed under chapter 466 for the
1457 provision of services to a subscriber of the prepaid limited
1458 health service organization may not contain any provision that
1459 requires the dentist to provide services to the subscriber of
1460 the prepaid limited health service organization at a fee set by
1461 the prepaid limited health service organization unless such
1462 services are covered services under the applicable contract.
1463 (b) Covered services are those services that are listed as
1464 a benefit that the subscriber is entitled to receive under the
1465 contract. A prepaid limited health service organization may not
1466 provide merely de minimis reimbursement or coverage in order to
1467 avoid the requirements of this section. Fees for covered
1468 services shall be set in good faith and must not be nominal.
1469 (c) A prepaid limited health service organization may not
1470 require as a condition of the contract that the dentist
1471 participate in a discount medical plan under part II of this
1472 chapter.
1473 Section 19. Subsection (11) is added to section 641.315,
1474 Florida Statutes, to read:
1475 641.315 Provider contracts.—
1476 (11)(a) A contract between a health maintenance
1477 organization and a dentist licensed under chapter 466 for the
1478 provision of services to a subscriber of the health maintenance
1479 organization may not contain any provision that requires the

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1480 dentist to provide services to the subscriber of the health
1481 maintenance organization at a fee set by the health maintenance
1482 organization unless such services are covered services under the
1483 applicable contract.
1484 (b) Covered services are those services that are listed as
1485 a benefit that the subscriber is entitled to receive under the
1486 contract. A health maintenance organization may not provide
1487 merely de minimis reimbursement or coverage in order to avoid
1488 the requirements of this section. Fees for covered services
1489 shall be set in good faith and must not be nominal.
1490 (c) A health maintenance organization may not require as a
1491 condition of the contract that the dentist participate in a
1492 discount medical plan under part II of chapter 636.
1493 Section 20. Paragraph (a) of subsection (3) of section
1494 766.1115, Florida Statutes, is amended, and paragraph (h) is
1495 added to subsection (4) of that section, to read:
1496 766.1115 Health care providers; creation of agency
1497 relationship with governmental contractors.—
1498 (3) DEFINITIONS.—As used in this section, the term:
1499 (a) "Contract" means an agreement executed in compliance
1500 with this section between a health care provider and a
1501 governmental contractor which allows~~. This contract shall allow~~
1502 the health care provider to deliver health care services to low-
1503 income recipients as an agent of the governmental contractor.
1504 The contract must be for volunteer, uncompensated services. For
1505 services to qualify as volunteer, uncompensated services under
1506 this section, the health care provider must receive no
1507 compensation from the governmental contractor for ~~any~~ services
1508 provided under the contract and must not bill or accept

1509 compensation from the recipient, or a ~~any~~ public or private
1510 third-party payor, for the specific services provided to the
1511 low-income recipients covered by the contract.
1512 (4) CONTRACT REQUIREMENTS.—A health care provider that
1513 executes a contract with a governmental contractor to deliver
1514 health care services on or after April 17, 1992, as an agent of
1515 the governmental contractor is an agent for purposes of s.
1516 768.28(9), while acting within the scope of duties under the
1517 contract, if the contract complies with the requirements of this
1518 section and regardless of whether the individual treated is
1519 later found to be ineligible. A health care provider under
1520 contract with the state may not be named as a defendant in any
1521 action arising out of medical care or treatment provided on or
1522 after April 17, 1992, under contracts entered into under this
1523 section. The contract must provide that:
1524 (h) As an agent of the governmental contractor for purposes
1525 of s. 768.28(9), while acting within the scope of duties under
1526 the contract, a health care provider licensed under chapter 466
1527 may allow a patient or a parent or guardian of the patient to
1528 voluntarily contribute a fee to cover costs of dental laboratory
1529 work related to the services provided to the patient. This
1530 contribution may not exceed the actual cost of the dental
1531 laboratory charges and is deemed in compliance with this
1532 section.
1533
1534 A governmental contractor that is also a health care provider is
1535 not required to enter into a contract under this section with
1536 respect to the health care services delivered by its employees.
1537 Section 21. The amendments to ss. 627.6474, 636.035, and

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1538 641.315, Florida Statutes, apply to contracts entered into or
1539 renewed on or after July 1, 2013.
1540 Section 22. (1) The sum of $1,258,054,808 from the Medical
1541 Care Trust Fund is appropriated to the Agency for Health Care
1542 Administration beginning in the 2013-2014 fiscal year to provide
1543 coverage for individuals who enroll in the Healthy Florida
1544 Program.
1545 (2) The sum of $254,151 from the General Revenue Fund and
1546 $18,235,833 from the Medical Care Trust Fund is appropriated to
1547 the Agency for Health Care Administration beginning in the 2013-
1548 2014 fiscal year to comply with federal regulations to
1549 compensate insurers and managed care organizations that contract
1550 with the Healthy Florida Program for the imposition of the
1551 annual fee on health insurance providers under section 9010 of
1552 the federal Patient Protection and Affordable Care Act, Pub. L.
1553 No. 111-148, as amended by the federal Health Care and Education
1554 Reconciliation Act of 2010, Pub. L. No. 111-152.
1555 (3) The sum of $10,676,377 from the General Revenue Fund
1556 and $10,676,377 from the Medical Care Trust Fund is appropriated
1557 beginning in the 2013-2014 fiscal year to the Agency for Health
1558 Care Administration to contract with the Florida Healthy Kids
1559 Corporation under s. 409.818(2)(f), Florida Statutes, to fund
1560 administrative costs necessary for implementing and operating
1561 the Healthy Florida Program.
1562 (4) The Agency for Health Care Administration may submit
1563 budget amendments to the Legislative Budget Commission pursuant
1564 to chapter 216, Florida Statutes, to fund the Healthy Florida
1565 Program for the coverage of children who transfer from the
1566 Florida Kidcare Program to the Healthy Florida Program, or to

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1567 provide additional spending authority from the Medical Care
1568 Trust Fund under subsection (1) for the coverage of individuals
1569 who enroll in the Healthy Florida Program, during the 2013-2014
1570 fiscal year.
1571 Section 23. This act shall take effect upon becoming a law.