

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Appropriations

BILL: SPB 2512

INTRODUCER: For consideration by the Appropriations Committee

SUBJECT: Medicaid

DATE: March 24, 2015

REVISED: _____

ANALYST

Brown

STAFF DIRECTOR

Kynoch

REFERENCE

ACTION

Pre-meeting

I. Summary:

SPB 2512 revises various aspects of the Medicaid program including:

- The definition of rural hospitals;
- Reimbursement of Medicaid Providers;
- The Statewide Medicaid Residency Program;
- The Low-Income Pool and Disproportionate Share Hospital programs; and
- Statewide Medicaid Managed Care.

The bill also creates the “Florida Health Insurance Affordability Exchange Program” (FHIX) under ss. 409.710 - 409.731, F.S., as a multi-phased, consumer-driven approach to providing access to high-quality, affordable health care coverage to low-income, uninsured Floridians who are not currently eligible to enroll in Medicaid. The FHIX will begin operations by providing coverage to persons eligible for Medicaid under s. 1902(a)(10)(A)(i)(VIII) of the Social Security Act or s. 2001 of the federal Patient Protection and Affordable Care Act, eligible to participate in the Florida Healthy Kids program, or who meet and maintain the responsibilities outlined in the bill.

The bill conforms Medicaid-related statutes to the Senate proposed General Appropriations Bill, for Fiscal Year 2015-2016, SPB 2500.

II. Present Situation:

Rural Hospitals

Part III of ch. 395, F.S., governs rural hospitals. A rural hospital is defined in s. 395.602(2)(e), F.S., as a licensed, acute care hospital having 100 or fewer licensed beds and an emergency room which is:

- The sole provider in a county with a population density no greater than 100 persons per square mile;

- An acute care hospital in a county with a population density no greater than 100 persons per square mile which is at least 30 minutes of travel time from any other acute care hospital in the same county;
- A hospital supported by a tax district or sub-district whose boundaries encompass an area of 100 persons or fewer per square mile;
- A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92 which has up to 340 licensed beds;
- A hospital with a service area of fewer than 100 persons per square mile, with service area being defined as the fewest number of zip codes that account for 75 percent of the hospital’s discharges for the most recent five-year period; or
- A hospital designated as a critical access hospital under s. 408.07(15).¹

An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of the definition will be granted rural hospital status upon submitting an application, including supporting documentation, to the Agency for Health Care Administration (AHCA).²

Currently, 30 hospitals meet the statutory definition of rural hospitals:

Rural Hospital	County	City	Beds
Baptist Medical Center - Nassau	Nassau	Fernandina Beach	54
Calhoun-Liberty Hospital	Calhoun	Blountstown	25
Campbellton-Graceville Hospital	Jackson	Graceville	25
Desoto Memorial Hospital	Desoto	Arcadia	49
Doctors Memorial Hospital	Holmes	Bonifay	20
Doctors’ Memorial Hospital Inc.	Taylor	Perry	48
Ed Fraser Memorial Hospital	Baker	MacClenny	25
Fishermen’s Hospital	Monroe	Marathon	25
Flagler Hospital	St. Johns	St. Augustine	335
Florida Hospital Flagler	Flagler	Palm Coast	99
Florida Hospital Wauchula	Hardee	Wauchula	25
George E Weems Memorial Hospital	Franklin	Apalachicola	25
Healthmark Regional Medical Center	Walton	Defuniak Springs	50
Hendry Regional Medical Center	Hendry	Clewiston	25
Jackson Hospital	Jackson	Marianna	100
Jay Hospital	Santa Rosa	Jay	55
Lake Butler Hospital Hand Surgery Center	Union	Lake Butler	25
Lakeside Medical Center	Palm Beach	Belle Glade	70
Lower Keys Medical Center	Monroe	Key West	118
Madison County Memorial Hospital	Madison	Madison	25
Mariners Hospital	Monroe	Tavernier	25
Northwest Florida Community Hospital	Washington	Chipley	59
Putnam Community Medical Center	Putnam	Palatka	99
Raulerson Hospital	Okeechobee	Okeechobee	100
Regional General Hospital Williston ³	Levy	Williston	40

¹ Section 408.07(15), F.S., defines a critical access hospital as “a hospital that meets the definition of ‘critical access hospital’ in s. 1861(mm)(1) of the Social Security Act and that is certified by the Secretary of Health and Human Services as a critical access hospital.”

² See s. 395.602(2)(e), F.S.

³ Formerly known as Tri County Hospital - Williston.

Rural Hospital	County	City	Beds
Sacred Heart Hospital On The Emerald Coast	Walton	Miramar Beach	58
Sacred Heart Hospital On The Gulf	Gulf	Port Saint Joe	19
Shands Lake Shore Regional Medical Center	Columbia	Lake City	99
Shands Live Oak Regional Medical Center	Suwannee	Live Oak	25
Shands Starke Regional Medical Center	Bradford	Starke	25

Rural hospitals are eligible to participate in Medicaid’s rural hospital financial assistance programs under s. 409.9116, F.S. Rural hospitals may also receive special consideration in the General Appropriations Act for Medicaid reimbursement due to their rural status.

Sole Community Hospitals

The federal Medicare program classifies a hospital as a “sole community hospital” based on criteria specified in title 42, s. 412.92, of the Code of Federal Regulations, including whether the hospital is situated in a federally-designated rural area, the hospital’s capacity, and the hospital’s distance from other hospitals. A sole community hospital is given special treatment and is eligible for payment adjustments from the Medicare program due to the federal government’s consideration of the hospital’s accessibility to residents of rural areas who have limited options for hospital services.

Florida contains seven sole community hospitals.⁴ In 2014, the Legislature amended the definition of rural hospital to include hospitals classified as sole community hospitals having up to 340 licensed beds, beginning in the 2014-2015 fiscal year.⁵ Prior to the 2014-2015 fiscal year, two of Florida’s sole community hospitals did not qualify under Florida statutes as rural hospitals.⁶

Low-Income Pool

The Low-Income Pool (LIP) was created as a result of the original Medicaid waiver that established the Medicaid Managed Care Pilot Program, which was implemented in 2006. Pursuant to s. 409.91211(1)(b), F.S., waiver authority for the pilot was “contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state’s ability to use intergovernmental transfers, and provisions to protect the disproportionate share program.” The statute further required that under a LIP, state matching funds required for the program must be provided by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations.

The LIP was designed to fund supplemental payments to hospitals that provide services to Medicaid recipients, the uninsured, and underinsured individuals. The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally

⁴ The sole community hospitals in Florida are: Desoto Memorial Hospital (Arcadia); Doctors’ Memorial Hospital (Perry); Ed Fraser Memorial Hospital (MacClenny); Flagler Hospital (St. Augustine); Raulerson Hospital (Okeechobee); Jackson Hospital (Marianna); and Lower Keys Medical Center (Key West).

⁵ See ch. 2014-57, Laws of Florida.

⁶ Flagler Hospital and Lower Keys Medical Center.

qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured, and the underinsured.

Statutory authority for the LIP under a Medicaid waiver as described above expired October 1, 2014, when s. 409.91211, F.S., was repealed.⁷

Chapter 2011-134, L.O.F., created s. 409.97, F.S., to, in part, require the Agency for Health Care Administration (AHCA) to establish and maintain a LIP in a manner authorized by federal waiver to support enhanced access to services by offsetting shortfalls in Medicaid reimbursement, paying for otherwise uncompensated care, and financing coverage for the uninsured.⁸ Under s. 409.97(1), F.S., the AHCA is authorized, beginning in the 2014-2015 fiscal year, to accept voluntary transfers of local taxes and other qualified revenue from counties, municipalities, and special taxing districts, and such transfers must be contributed to advance the general goals of the Florida Medicaid program without restriction. However, under ch. 2014-53, L.O.F., the provisions of s. 409.97, F.S., were made effective beginning in the 2015-2016 fiscal year, notwithstanding the provisions of s. 409.97(1), F.S., authorizing implementation during the 2014-2015 fiscal year.

Therefore, under current law, the AHCA's statutory authority to seek a LIP waiver under s. 409.91211, F.S., has expired, and such authority under s. 409.97, F.S., has been delayed until July 1, 2015.

On July 31, 2014, the federal Centers for Medicare & Medicaid Services extended Florida's Medicaid waiver authority to operate the LIP during the 2014-2015 fiscal year only, with an expiration date of July 1, 2015.

Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)

Medicaid reimburses ICF/DD providers through a cost-based reimbursement methodology. Cost-based reimbursement is accomplished through establishing a reimbursement rate based upon each individual ICF/DD's historic cost of providing services, which is then indexed using pre-determined health care inflation indices to provide an inflationary increase. The AHCA collects the cost data from annual cost reports submitted by the ICF/DD providers to use in calculating and setting cost-based reimbursement rates. Other provider types that are reimbursed using a cost-based methodology include nursing homes, hospital outpatient services, rural health clinics, county health departments, hospices, and federally qualified health centers. These provider types may be subject to specified reimbursement ceilings and targets.

In 2008, the Legislature directed the AHCA to establish provider rates for hospitals, nursing homes, county health departments, community intermediate care facilities for the developmentally disabled, and prepaid health plans in a manner that would ensure no automatic increase in statewide expenditures resulting from a change in unit costs for a period of two fiscal years beginning July 1, 2009.⁹ In 2011, the Legislature revised this provision to ensure no

⁷ See ch. 2011-135, s. 20, Laws of Florida.

⁸ See s. 409.97(2), F.S.

⁹ See ch. 2008-143, Laws of Florida.

automatic increase in statewide expenditures resulting from a change in unit costs based on the July 1, 2011, unit costs.¹⁰ The 2011 revision was made effective in perpetuity.

Graduate Medical Education and the Statewide Medicaid Residency Program

In 2013, the Legislature created the Statewide Medicaid Residency Program (SMRP) to fund graduate medical education (GME).¹¹ GME is the education and training of physicians following graduation from a medical school in which physicians refine the clinical skills necessary to practice in a specific medical field (surgery, dermatology, family practice, etc.). GME or “residency” programs for allopathic and osteopathic physicians include internships, residency training, and fellowships, and can range from three to six years or more in length of time.¹²

Graduate medical education is significant because:¹³

- GME training has a direct impact on the quality and adequacy of the state’s physician specialty and sub-specialty workforce and the geographic distribution of physicians.
- The support and expansion of residency programs in critical-need areas could result in more primary care practitioners and specialists practicing in Florida.
- Medical residents are more likely to practice in the state where they completed their graduate medical education training than where they went to medical school.
- Quality, prestigious programs will attract the best students, who are more likely to stay as practicing physicians.
- Medical residents act as “safety nets” of care for indigent, uninsured, and under-served patients in the state.

Under the SMRP:

- A resident is defined as a medical intern, fellow, or resident enrolled in a program accredited by the Accreditation Council for Graduate Medical Education, the American Association of Colleges of Osteopathic Medicine, or the American Osteopathic Association.
- A full-time equivalent (FTE) is defined as a resident who is in his or her initial residency period, not to exceed five years. A resident training beyond the initial residency period is counted as one-half of one FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as one FTE. For the SMRP, primary care specialties include:
 - Family medicine;
 - General internal medicine;
 - General pediatrics;
 - Preventive medicine;
 - Geriatric medicine;
 - Osteopathic general practice;
 - Obstetrics and gynecology; and
 - Emergency medicine.

¹⁰ See ch. 2011-61, Laws of Florida.

¹¹ See ch. 2013-48, Laws of Florida.

¹² Florida Department of Health, *Annual Report on Graduate Medical Education in Florida*, January 2010.

¹³ *Id.*

- Medicaid payments are defined as payments made to reimburse a hospital for direct inpatient services, as determined by the AHCA, during the fiscal year preceding the date on which calculations for the program's allocations take place for any fiscal year.
- On or before September 15 of each year, the AHCA is required to calculate an allocation fraction for each hospital participating in the program based on a formula defined in statute.
- A hospital's annual allocation equals the funds appropriated for the SMRP in the GAA multiplied by its allocation fraction. However, if the calculation results in an annual allocation that exceeds \$50,000 per FTE resident, the hospital's annual allocation must be reduced to a sum that equals \$50,000 per FTE resident and the excess funds must be redistributed to participating hospitals whose annual allocation does not exceed \$50,000 per FTE resident.
- The AHCA is required to distribute to each participating hospital one-fourth of that hospital's annual allocation on the final business day of each quarter of a state fiscal year.

Disproportionate Share Hospital Programs

Federal law requires state Medicaid programs to make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid recipients and uninsured individuals. The federal government annually provides a limited DSH allotment to each state. States may appropriate these federal funds based on the amount of state dollars appropriated as matching funds for the federal DSH allotment, up to but not exceeding the federal limit. The Legislature delineates how DSH funds will be distributed to each eligible facility in the General Appropriations Act.

For states to receive DSH payments, federal law requires states to submit an independent certified audit and an annual report to the secretary of the federal Department of Health and Human Services, describing DSH payments made to each DSH hospital. Florida law requires the AHCA to use audited data from specified years to determine the amount of Medicaid and charity care to be used in calculating DSH payments.¹⁴

Statewide Medicaid Managed Care and Reconciliation for Nursing Home Payments

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care program (SMMC). The program, authorized by a federal Medicaid waiver, is designed for the AHCA to issue invitations to negotiate¹⁵ and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTCMC).

¹⁴ See s. 409.911(2), F.S.

¹⁵ An "invitation to negotiate" is a written or electronically posted solicitation for vendors to submit competitive, sealed replies for the purpose of selecting one or more vendors with which to commence negotiations for the procurement of commodities or contractual services. See s. 287.012(17), F.S.

The LTCMC component began enrolling Medicaid recipients in August 2013 and its state-wide roll-out was completed in March 2014.¹⁶ The MMA component began enrolling Medicaid recipients in May 2014 and finished its roll-out in August 2014.¹⁷

Under LTCMC, the long-term care managed care plans must offer a network contract to nursing homes, hospices, and aging network providers who previously participated in certain home and community based waivers. Nursing home and hospice providers must participate in all selected plans that offer them contracts. The plans and the providers are required to negotiate mutually acceptable payment terms and rates.

However, the AHCA is required to establish nursing-facility-specific payment rates for each licensed nursing home, based on facility costs and adjusted as authorized in the General Appropriations Act.¹⁸ Payments to LTCMC plans must be reconciled to reimburse actual payments to nursing facilities.¹⁹ These provisions are also applied by the AHCA to payments relating to hospice providers to the effect that both nursing home and hospice providers receive a reimbursement rate from LTCMC plans based upon historical data as provided in each facility's Medicaid cost report. Current law does not define the specific parameters upon which the reconciliation must be based.

Uninsured in Florida

In 2013, the American Community Survey (ACS) of the federal Census Bureau, estimated that four million Floridians were uninsured.²⁰ Of that number, 594,000 were projected to be children.²¹ Approximately 900,000 adults in Florida were estimated to have incomes under 100 percent of the federal poverty level (FPL), according to statistics for 2013.²²

Beginning January 1, 2014, health insurance coverage in Florida became available through the federal health insurance exchange²³ created under the Patient Protection and Affordable Care Act to persons with incomes above 100 percent of the FPL. Also, on January 1, 2014, Florida Medicaid coverage to children up to age 18 was extended to 133 percent of the FPL.

¹⁶ See < http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC >, last visited March 21, 2015.

¹⁷ See < http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA >, last visited March 21, 2015.

¹⁸ See s. 409.983(6), F.S.

¹⁹ *Id.*

²⁰ Office of Economic and Demographic Research, Florida Legislature, *Economic Analysis of PPACA and Medicaid Expansion*, Presentation to Senate Select Committee on Patient Protection and Affordable Care Act (Mar. 4, 2013), http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2071.pdf (last visited Mar. 8, 2015).

²¹ *Id.*

²² Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of the Non-Elderly (0-64) with Income Below 100% Federal Poverty Level (FPL)* <http://kff.org/other/state-indicator/nonelderly-up-to-139-fpl/> (Mar. 7, 2015).

²³ President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. The first open enrollment was held starting on October 1, 2013, and a second one was held from November 15, 2014, through February 15, 2015. Florida does not operate its own exchange, so Floridians purchase coverage through the federal exchange at www.healthcare.gov.

The Census Bureau's March 2014 Supplement to the Current Population Survey showed that Florida's overall uninsured number had dropped to 3.6 million and the children's number to 504,900.^{24,25} The survey was conducted from January through April 2014.²⁶

Florida Medicaid

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

Florida Medicaid is administered by the AHCA and is financed with federal and state funds. The Department of Children and Families (DCF) determines eligibility for the Medicaid program and transmits that information to the AHCA. The AHCA is designated as the single state Medicaid agency and has the lead responsibility for the overall program.²⁷

Over 3.7 million Floridians are currently enrolled in Medicaid²⁸ and the program's estimated expenditures for the 2014-2015 fiscal year are \$23.4 billion.²⁹ The federal government currently pays 59.56 percent of the costs of Medicaid services with the state paying 40.44 percent. Florida has the fourth largest Medicaid program in the country.³⁰

Medicaid currently covers:

- 20 percent of Florida's population;
- 27 percent of Florida's children;
- 62.2 percent of Florida's births;
- 69 percent of Florida's nursing homes days.³¹

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

²⁴ Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of the Total Population (2013)*, <http://kff.org/other/state-indicator/total-population/> (last visited Mar. 7, 2015).

²⁵ Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of Children 0-18*, <http://kff.org/other/state-indicator/children-0-18/> (last visited Mar. 7, 2015).

²⁶ More current, reliable estimates of the number of uninsured Floridians is not available at this time.

²⁷ See s. 409.963, F.S.

²⁸ Agency for Health Care Administration, *Report of Medicaid Eligibles - January 31, 2015*, http://ahca.myflorida.com/medicaid/about/pdf/age_assistance_category_2015-01-31.pdf (last visited Mar. 9, 2015).

²⁹ Office of Economic and Demographic Research, *Social Services Estimating Conference Medicaid Expenditures* (December 12, 2014) <http://edr.state.fl.us/Content/conferences/medicaid/medhistory.pdf> (last visited Mar. 6, 2015).

³⁰ Agency for Health Care Administration, Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - An Overview (Jan. 22, 2015)*, Slide 9, http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2759.pdf (last visited: Mar. 6, 2015).

³¹ Id at 10.

s. 409.903, F.S. (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.³² Applicants must also agree to cooperate with Child Support Enforcement during the application process.³³

Florida’s Current Medicaid and CHIP Eligibility Levels in Florida ³⁴ (With Income Disregards and Modified Adjusted Gross Income)						
Children’s Medicaid			CHIP (Kidcare)	Pregnant Women	Parents	Childless Adults
Age 0-1	Age 1-5	Age 6-18	Ages 0-18	Medicaid		
206% FPL	140% FPL	133% FPL	210% FPL	191% FPL	30% FPL	0% FPL

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

Federal Poverty Guidelines for 2015 ³⁵ Annual Income (rounded)				
Family Size	100%	133%	150%	200%
1	\$11,770	\$15,654	\$17,655	\$23,540
2	\$15,930	\$21,187	\$23,895	\$31,860
3	\$20,090	\$26,720	\$30,135	\$40,180
4	\$24,250	\$32,252	\$36,375	\$48,500
5	\$28,410	\$37,785	\$42,615	\$56,820
	Add \$4,160 each additional person after 5			

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.³⁶ States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.³⁷ For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services, which are those health care and diagnostic services and treatment and measures that may be

³² Florida Department of Children and Families, *Family-Related Medicaid Programs Fact Sheet*, (January 2015), p.3, <http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf> (last visited: Mar. 8, 2015).

³³ Id.

³⁴ U.S. Centers for Medicare and Medicaid Services, Medicaid.gov, *Florida*, <http://www.medicaid.gov/medicaid-chip-program-information/by-state/florida.html> (last visited Mar. 7, 2015).

³⁵ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid and CHIP Program Information - 2015 Federal Poverty Level Charts* <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf> (last visited Mar. 7, 2015).

³⁶ Section 409.905, F.S.

³⁷ Section 409.906, F.S.

needed to correct or ameliorate defects or physical and mental illnesses and conditions discovered by screening services, consistent with federal law.³⁸

For the MMA component of SMMC, 13 non-specialty managed care plans contract with AHCA across 11 different regions. Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans. Most plans supplemented the required benefits and offered enhanced options, such as adult dental, hearing and vision coverage, outpatient hospital coverage and physician services.

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

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

- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities under s. 394.455(32), F.S.;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.³⁹

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

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

The MMA component is authorized by a Medicaid waiver granted by federal CMS that was originally designed for the Medicaid Reform Pilot Project. The five-year waiver was approved in 2005 and has been extended twice. The MMA component is currently operating under a three-year waiver extension granted on July 31, 2014, which expires June 30, 2017.⁴⁰

³⁸ See Section 1905 9(r) of the Social Security Act.

³⁹ Section 409.972, F.S.

⁴⁰ Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid 1115 Demonstration Fact Sheet* (July 31, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf> (last visited Mar. 8, 2015).

Florida Kidcare Program

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

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

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

Kidcare is funded by Medicaid funds under Title XIX of the Social Security Act, state funds from General Revenue and the Tobacco Settlement Trust Fund, and family contributions.⁴¹ The CHIP has an enhanced federal matching rate that is more favorable than Medicaid. For the period of October 2014 through June 2015, the federal match rate is 71.80 percent.⁴²

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

The CHIP was re-authorized by Congress in 2009 until federal Fiscal Year 2019, but federal funding was only re-authorized until September 30, 2015. Re-authorization bills are pending in Congress, including a bipartisan discussion draft led by the House Energy and Commerce Chair Fred Upton, House Health Subcommittee Chair Joe Pitts and the Senate Finance Committee

⁴¹ Florida Kidcare Coordinating Council, *2014 Annual Report and Recommendations*, p. 14, http://www.floridakidcare.org/council/wp-content/uploads/2014/08/2014_Annual_Report.pdf (last reviewed Mar. 8, 2015).

⁴² Office of Economic and Demographic Research, *Social Services Estimating Conference - Kidcare Program (November 21, 2014 Conference Results)* <http://edr.state.fl.us/Content/conferences/kidcare/kidcaredetail.pdf> (last viewed Mar. 8, 2015).

Chair and original CHIP bill sponsor, Orrin Hatch.⁴³ The discussion draft does not provide an extension period but extends funding for at least 1 year while seeking stakeholder feedback.

Another proposal, *Protecting & Retaining Our Children's Health Insurance Program Act of 2015 (PRO-CHIP)* has also been introduced and would extend CHIP funding through 2019 and the other components of the program. The proposal, Senate Bill 522, is sponsored by Senator Sherrod Brown with Senators Stabenow, Wyden, Casey and Minority Leader Reid and more than 40 other Senators.^{44,45}

Florida Healthy Kids Corporation

The Florida Healthy Kids Program is authorized under s. 624.91, F.S., which is also known as the "William G. 'Doc' Myers Healthy Kids Corporation Act." The FHKC was created as a private, not-for-profit corporation by the 1990 Florida Legislature in an effort to increase access to health insurance for school-aged children.⁴⁶

Eligibility for the state-funded assistance is prescribed under s. 624.91(3), F.S., and provides cross references to the Florida Kidcare Act. The Healthy Kids program is also identified as a non-entitlement program.⁴⁷

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

- Collect contributions from families, local sources or employer based premiums;
- Establish administrative and accounting procedures;
- Establish preventive health standards for children that do not limit participation to pediatricians in rural areas with consultation from appropriate experts;
- Determine eligibility for children seeking enrollment in Title XXI funded and non-Title XXI components;
- Establish grievance processes;
- Establish participation criteria for administrative services for the FHKC;
- Establish enrollment criteria that include penalties or waiting periods for non-payment of premiums of 30 days;
- Contract with authorized insurers and other health care providers meeting standards established by the FHKC for the delivery of services and select health plans through a competitive bid process;

⁴³ U.S. House Energy and Commerce Committee, *Extending Funding for the State's Children Health Insurance Program*, (Feb. 24, 2015), <http://energycommerce.house.gov/fact-sheet/extending-funding-state-children%E2%80%99s-health-insurance-program> (last visited: Mar. 5, 2015).

⁴⁴ U.S. Senate Committee on Finance, *Wyden Joins Sens. Brown, Casey and Stabenow on Legislation to Extend the Children's Health Insurance Program*, (February 12, 2015) <http://www.finance.senate.gov/newsroom/ranking/release/?id=20c6ac77-77af-424f-bb3e-dc84a92af22d> (last visited: Mar. 5, 2015).

⁴⁵ S. 522, 114th Congress (2015).

⁴⁶ Florida Healthy Kids Corporation, *History*, <https://www.healthykids.org/healthykids/history/> (last visited Mar. 7, 2015).

⁴⁷ A non-entitlement program means that funding may be limited. If more applicants or enrollees apply or enroll for the program than funding allows, an enrollee is not entitled to enrollment, even if eligible.

- Purchase goods and services in a cost effective manner with a minimum medical loss ratio of 85 percent for health plan contracts;
- Establish disenrollment criteria for insufficient funding levels;
- Develop a plan to publicize the program;
- Secure staff and the necessary funds to administer the program;
- Provide an annual Kidcare report, in consultation with partner agencies, to the Governor, Chief Financial Officer, Commissioner of Education, President of the Senate, Speaker of the House of Representatives, and minority leaders of the Senate and House of Representatives;
- Provide quarterly enrollment information on the full pay population; and
- Establish benefit packages that conform to the Florida Kidcare benchmark benefit.

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

Enrollees also have copayments for non-preventive services that range from \$5 per prescription to \$10 for an inappropriate use of the emergency room visit. There are no copayments for visits related to well-child, preventive health, or dental care.⁴⁸

The FHKC is governed by a 13-member board of directors, chaired by Florida's Chief Financial Officer or his or her designee.⁴⁹ The 12 other board members are:

- Secretary of the AHCA;
- One member appointed by the Commissioner of Education from the Office of School Health Programs from the Department of Education;
- One member, appointed by the Chief Financial Officer from among three members nominated by the Florida Pediatric Society;
- One member, appointed by the Governor, who represents the Children's Medical Services Program;
- One member appointed by the Chief Financial Officer from among three members nominated by the Florida Hospital Association;
- One member, appointed by the Governor, who is an expert on child health policy;
- One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Academy of Family Physicians;
- One member, appointed by the Governor, who represents the state Medicaid program;
- One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Association of Counties;
- The state health officer or his or her designee;
- The Secretary of the DCF, or his or her designee; and

⁴⁸ See State of Florida, Florida KidCare Program, Title XXI State Child Health Insurance Plan, Amendment #22, July 1, 2012, pp.98-101., <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/CHIP-SPAs/FL-CSPA-22-FINAL.pdf> (last visited: Mar. 17, 2013).

⁴⁹ See s. 624.91(6), F.S.

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

Board members do not receive compensation for their service but may receive reimbursement for per diem and travel expenses in accordance with s. 112.061, F.S.⁵⁰

The FHKC is not an insurer and is not subject to the licensing requirements of the Department of Financial Services. In addition, the FHKC board is also granted complete fiscal control over the FHKC and responsibility for all fiscal operations. Any liquidation of the FHKC would be supervised by the Department of Financial Services.⁵¹

Florida Health Choices Corporation, Inc. (Corporation)

In 2008, the Florida Legislature created the Florida Health Choices Program to address the issue of Florida's uninsured.⁵² The corporation is a private, non-profit, corporation under s. 408.910, F.S., and operates in compliance with part III of chapter 112 (Public Officers and Employees) and chapter 119 (Public Records), 286 (Public Business), and 617 (Corporations Not for Profit).

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

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

Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations (HMOs), prepaid service providers, or any other entity or affiliate or subsidiary of eligible vendors. Board members may not serve for more than nine years, and members must disclose any conflicts of interest that would prohibit him or her from participating in any decision that would inure to the member's benefit or the member's organization. The board selects a chief executive officer for the corporation who is responsible for the selection of other staff, as authorized by an operating budget.

⁵⁰ See s. 624.91(5), F.S.

⁵¹ See s. 624.91(7), F.S.

⁵² See Chapter Law 2008-32.

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

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

The corporation is authorized to collect premiums and other payments from employers. The law further specifies who may participate as either an employer or an individual. Employers eligible to enroll include employers that meet criteria established by the corporation and their individual employees and other individuals meeting criteria established by the corporation.⁵³

The corporation is required to:

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

The corporation's Florida Health Insurance Marketplace (marketplace) currently includes individual health plans, discount plans, and limited benefit plans. The marketplace offers options that are compliant with the Patient Protection and Affordable Care Act (PPACA)⁵⁴ across the

⁵³ See s. 408.910(4)(a), F.S.

⁵⁴ To be compliant with PPACA, plans must eliminate any pre-existing condition exclusions, annual or lifetime dollar limits on the essential benefits, prohibit rescissions, provide preventive services without cost sharing, include emergency services

different metal ranges, dental-only plans, vision and hearing plans, telemedicine plans, discount plans, and prescription drug plans.⁵⁵ Additional marketplace platforms for group health plans for small employers and associations are planned.

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

During its most recent open enrollment – January 5, 2015, through February 15, 2015 – the corporation reported 51 total individual product enrollments covering 56 adults and children with 66 applications started. Of those that purchased coverage, 85 percent purchased individual coverage and 15 percent purchased spouse or family coverage.⁵⁶ The marketplace recorded 4,800 visits during its January open enrollment.⁵⁷

The corporation offers a minimum of 20 plans per county from two different companies with a maximum of 46 plans in a county from six different companies as of March 2015.⁵⁸

The Patient Protection and Affordable Care Act of 2010

In March 2010, the Congress passed and the President signed two pieces of legislation: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 that are together called PPACA.⁵⁹ Under PPACA, one of the key components required the states to expand Medicaid to a minimum national eligibility threshold of 133 percent of the FPL, or, as it is sometimes expressed, 138 percent of the FPL with application of an automatic five percent income disregard, effective January 1, 2014.⁶⁰ While the funding for the newly eligible under this expansion would be initially funded at 100 percent federal funds for the first three calendar years (2014, 2015, and 2016), the states would gradually be required to pay a share of the costs, starting at five percent in calendar year 2017 before leveling off at 10 percent in 2020.⁶¹ As enacted, the PPACA provided that states refusing to expand to the new national eligibility threshold faced the loss of *all* of their federal Medicaid funding.⁶²

without prior authorization, establish an appeals process, provide access to pediatricians and OB/GYNs, extend dependent coverage to age 26 and provide the essential health benefits. For a checklist, see Nat'l Assn. of Insurance Commissioners Compliance Summary: http://www.naic.org/documents/index_health_reform_ppaca_uniform_compliance_summary.pdf (last visited: Mar. 9, 2015).

⁵⁵Florida Office of Insurance Regulation, *Cover Florida Health Care Access Program Annual Report (March 2015)*, (last visited Mar. 7, 2015).

⁵⁶Florida Health Choices Corporation, *Florida Health Choices Reports Zero Glitches with New Online Marketplace Launched in January* (February 20, 2015) <http://www.myfloridachoice.org/florida-health-choices-reports-zero-glitches-with-new-online-marketplace-launched-in-january/> (last visited Mar. 7, 2015).

⁵⁷ Id.

⁵⁸ Conversation with Rose Naff, CEO, Florida Health Choices, Inc., (Mar. 9, 2015).

⁵⁹ Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010) and (Pub. Law No. 111-152, 111th Cong. (Mar. 30, 2010).

⁶⁰ 42 U.S.C. s. 1396a(1).

⁶¹ 42 U.S.C. s. 1396d(y)(1).

⁶² 42 U.S.C. s. 1396c

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

Florida, along with 25 other states, challenged the constitutionality of the law. In *NFIB v. Sebelius*, the Supreme Court found the enforcement provisions of the Medicaid expansion unconstitutional.⁶³ As a result, states can voluntarily expand their Medicaid eligibility thresholds to PPACA standards and receive the enhanced federal match for the expansion population, but states cannot be penalized for not doing so.⁶⁴

Since the decision in *NFIB v. Sebelius*, federal guidance has emphasized state flexibility in how states expand coverage to those defined as the newly eligible population. In a letter to the National Governors Association January 14, 2013, then-Health and Human Services Secretary Kathleen Sebelius reminded states of their ability to design flexible benefit packages without the need for waivers and the alternative benefit plans that are available.⁶⁵ This letter was preceded by the Frequently Asked Questions document on Exchange, Market Reforms and Medicaid, issued on December 10, 2012, that discussed promotion of personal responsibility, wellness benefits, and state flexibility to design benefits.⁶⁶

Individual and Employer Mandates

A letter issued on November 20, 2012 (ACA #21) to state Medicaid directors further addressed state options for the adult Medicaid expansion group and the alternative benefit plans available under Section 1937 of the Social Security Act.⁶⁷ Under Section 1937, state Medicaid programs have the option of providing certain groups with benchmark or benchmark equivalent coverage based on four products: (1) the standard Blue Cross/Blue Shield Preferred Provider option offered to federal employees; (2) state employee coverage that is generally offered to all state employees; (3) the commercial HMO with the largest insured, non-Medicaid enrollment in the state or (4) Secretary-approved coverage.⁶⁸ For children under the age of 21, the coverage must include the Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT). Other aspects of the essential health benefit requirements of the PPACA, as discussed further below, may also be applicable, depending on the benefit package utilized.

⁶³ *National Federation of Independent Business (NFIB) v. Sebelius, Secretary of Health and Human Services*, 648 F. 3d 1235, affirmed in part, reversed in part.

⁶⁴ Department of Health and Human Services, *Secretary Sebelius Letter to Governors*, (July 10, 2012), <http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf> (last visited Mar. 7, 2015).

⁶⁵ *Letter to National Governor's Association from Secretary Sebelius*, January 14, 2013 (copy on file with Senate Health Policy Committee).

⁶⁶ Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, pp. 15-16, (December 10, 2012), <http://cciio.cms.gov/resources/factsheets/index.html>, (last visited Mar. 17, 2013).

⁶⁷ Centers for Medicare and Medicaid Services, *State Medicaid Director Letter: Essential Health Benefits in the Medicaid Program* (November 20, 2012), <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf> (last visited Mar. 17, 2013).

⁶⁸ *Id.*

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

Under the provisions, employers with more than 50 full-time employees that do not offer coverage meeting the essential benefits coverage standard and who does not offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and at least one employee receive a premium tax credit through the PPACA exchange, the employer will be assessed a fee of \$2,000 per full time employee, with the first 30 employees, including those who have minimum essential coverage.⁶⁹ Or, if an employer does offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and at least one employee receives a premium tax credit through the federal exchange because the employer's coverage was not affordable, did not provide minimum value, or because the employee was not one of the 95 percent of the employees offered coverage, the employer is assessed the lesser of \$3,000 per employee receiving the credit.⁷⁰ The large employer can only be assessed under one of the scenarios, not both.

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

- Information reporting requirements applicable to insurers, self-insuring employers and certain other providers of minimum essential coverage;
- Information reporting requirements applicable to large employers; and
- Employer shared responsibilities.⁷¹

The notice indicated the delay was intended to give additional time to provide input by employers and other reporting entities and to allow all parties to adapt their reporting systems. The transition relief states that it has no impact on other PPACA provisions.⁷²

Individuals may be exempt from the requirement to acquire minimum essential coverage if the minimum amount the individual must pay for that coverage is more than eight percent of his or her household income or he or she qualifies to receive a hardship exemption.⁷³ Some of the reasons that may qualify an individual for a hardship exemption include, but are not limited to:

⁶⁹ Internal Revenue Service, Employer Shared Responsibilities, <http://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions> (last visited Mar. 7, 2015).

⁷⁰ Id.

⁷¹ Internal Revenue Service, Not-129718-13, *Transition Relief for 2014 Under §§6055 (§6055 Information Reporting), §6056 (Information Reporting) and 4980H (Employer Responsibility Provisions)*, <http://www.irs.gov/pub/irs-drop/n-13-45.pdf> (last visited: Mar. 7, 2015).

⁷² Id.

⁷³ Internal Revenue Service, *Individual Shared Responsibility Provision*, <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision> (last visited Mar. 7, 2015).

- Being ineligible for Medicaid because the individual lives in a state that decided not to expand Medicaid under the PPACA;
- Spending less than three consecutive months without minimum essential health coverage;
- Buying coverage would pose a hardship;
- Having gross income below the applicable tax return filing threshold;
- Finding no affordable coverage on the exchange that meets the minimum value standard; and
- Being eligible for services through Indian Health Care Services.⁷⁴

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

- One percent of a taxpayer's household income that is above the tax return filing threshold for the taxpayer's filing status, or
- A flat dollar amount for the taxpayer's family, which is \$95 per adult and \$47.50 per adult, limited to a family maximum of \$285.⁷⁵

The amount is calculated based on the national average for a premium payment for a bronze level health plan in the exchange for 2014. For 2014, the annual national average premium for a bronze level health plan was \$2,448 per individual, but \$12,240 for a family with five or more members.⁷⁶

Exchanges

A health insurance exchange is intended to create an organized and competitive market for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the health care options available to them.⁷⁷ To facilitate coverage, the PPACA authorized the state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges. These exchanges can be administered by governmental agencies or non-profit organizations. The exchanges, at a minimum, must:⁷⁸

- Certify, re-certify and de-certify plans participating on the exchange;
- Operate a toll-free hotline;
- Maintain a website;
- Provide plan information and plan benefit options;
- Interact with the state's Medicaid and CHIP programs and provide information on eligibility and determination of eligibility for these programs;
- Certify individuals that gain exemptions from the individual responsibility requirement; and,
- Establish a navigator program.

⁷⁴Internal Revenue Service, *Shared Responsibility Provision*, <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision> (last visited Mar. 7, 2015).

⁷⁵ Internal Revenue Service, *Individual Shared Responsibility Provision - Reporting and Calculating the Payment*, <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment> (last visited Mar. 7, 2015).

⁷⁶ Id.

⁷⁷ Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Exchanges* (April 2010) <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7908-02.pdf> (last visited Mar. 7, 2015).

⁷⁸Centers for Medicare and Medicaid Services, *Initial Guidance to States on Exchanges*, (November 18, 2010), http://www.cms.gov/CCIIO/Resources/Files/guidance_to_states_on_exchanges.html (last visited Mar. 7, 2015).

On November 16, 2012, Florida Governor Rick Scott notified then-HHS Secretary Sebelius that Florida had too many unanswered questions to commit to a state-based exchange under the PPACA for the first enrollment period on January 1, 2014.⁷⁹ Florida has since opted to use the federal exchange.

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

Exchange Benefits

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

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

Qualified Health Plans

In order to receive a health care tax credit, an individual must be enrolled in a qualified health plan.⁸⁰ Qualified health plans are certified by the federal exchange and meet specific requirements:

- Provide essential health benefits;
- Follow the established limits on cost sharing; and
- Meet all other requirements.⁸¹

These plans are available on the federal exchange or may also be available directly from an insurance company or one of the state’s qualified health plans.⁸²

⁷⁹ Letter from Governor Rick Scott to Health and Human Services Secretary Kathleen Sebelius, (November 16, 2012) <http://www.flgov.com/2012/11/16/letter-from-governor-rick-scott-to-u-s-secretary-of-health-and-human-services-kathleen-sebelius/> (last visited Mar. 6, 2015).

⁸⁰ Internal Revenue Service, *Health Care Tax Credits: Qualified Health Plan Requirements*, <http://www.irs.gov/Individuals/HCTC:-Qualified-Health-Plan-Requirements> (last viewed Mar. 8, 2015).

⁸¹ U.S. Department of Health and Human Services, Healthcare.gov, *Qualified Health Plan*, <https://www.healthcare.gov/glossary/qualified-health-plan/> (last viewed Mar. 8, 2015).

⁸² Id.

Each plan sold must also be one of the following actuarial values⁸³ or “metal levels:”

- Bronze: 60 percent actuarial value;
- Silver: 70 percent actuarial value;
- Gold: 80 percent actuarial value; and
- Platinum: 90 percent actuarial value.

Premium Tax Credits and Cost Sharing Subsidies

Premium credits and other cost sharing subsidies are available to United States citizens and legal immigrants within certain income limits for coverage purchased through the exchange. Legal immigrants with incomes at or below 100 percent of the FPL who are not eligible for Medicaid are eligible for premium credits.⁸⁴ Premium credits are set on a sliding scale based on the percent of FPL for the household and reduce the out-of-pocket costs incurred by individuals and families.

The amount for premium tax credits, as a percentage of income, are set in section 36B of the Internal Revenue Code follows:⁸⁵

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

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

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

⁸³ Actuarial value is calculated by computing the ratio of total expected payments by the plan for essential health benefits and costing sharing rules with the total costs of the essential health benefits the standard population is expected to incur. For example, a health plan with an actuarial value of 70 percent would be expected to pay an average of 70 percent of the standard population’s expected medical expenses for the essential health benefits. Individuals covered by the plan would then be expected to pay the remaining 30 percent, on average through cost sharing such as deductibles, co-pays and co-insurance.

⁸⁴ 26 U.S.C. s. 36B(c).

⁸⁵ 26 U.S.C. s. 36B(b).

Cost Sharing Subsidies⁸⁶	
FPL Level	Cost Sharing Subsidy
100% - 150%	94%
150% - 200%	87%
200% - 250%	73%
250% - 400%	70%

Cost sharing limitations are based on the limits placed on Health Savings Accounts under the Internal Revenue Code.⁸⁷ The maximum out of pocket costs for any federal exchange plan in 2015 are \$6,600 for an individual and \$13,200 for a family plan, even with a catastrophic plan.⁸⁸

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

High Deductible Plans

High deductible plans are paired with health savings accounts.⁸⁹ To qualify as a high deductible plan, the annual deductible must be at least \$1,250 for single plans and \$2,500 for family coverage. The employer and the employee make annual contributions⁹⁰ to a limit of \$3,250 for single coverage and \$6,250 for family coverage. For 2014, total out-of-pocket spending is capped at \$6,350 for individual and \$12,700 for family.⁹¹ The employer and the employee contributions are not subject to federal income tax on the employee's income. Unused funds roll over automatically every year. A health savings account is owned by the employee and is portable.

Alternative Medicaid Expansion in Other States

Arkansas

Arkansas received approval for a Medicaid Section 1115 demonstration waiver to implement its Medicaid expansion in September 2013. Under its waiver, Arkansas uses Medicaid funds as premium assistance to purchase coverage in the federal exchange for its newly eligible adults up to 138 percent FPL. All newly eligible adults will primarily purchase coverage and enroll in a

⁸⁶ 42 U.S.C. s. 18071(c)(1)(B)

⁸⁷ CFR 45 §126.130; *See also* Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended for self only coverage for 2014; or for other than self-only coverage, the annual dollar amount in section 223(c)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended, for non-self only coverage that is in effect for 2014.

⁸⁸ U.S. Department of Health and Human Services, healthcare.gov, *Out of pocket costs*, <https://www.healthcare.gov/choose-a-plan/out-of-pocket-costs/> (last visit Mar. 7, 2015).

⁸⁹ Internal Revenue Code, 26 U.S.C. sec. 223.

⁹⁰ The IRS annually sets the contribution limit as adjusted by inflation.

⁹¹ Internal Revenue Services, *Health Savings Accounts and Other Tax-Favored Health Plans (Pub. 969)(2013)* <http://www.irs.gov/publications/p969/index.html> (last visited Mar. 7, 2015).

plan through the federal exchange to receive their coverage. Any services not covered through their plans are provided through the state’s fee-for-service Medicaid delivery system.⁹²

Individuals excluded from enrolling in the federal exchange include American Indians or Alaskan Natives and the medically frail, who may receive services directly through the state. For all other enrollees affected by the demonstration, enrollment in a QHP is a condition of receiving benefits.⁹³

Arkansas’ Approved Monthly Premiums - Medicaid Expansion Waiver⁹⁴		
Less than 50%	50% - 100%	100 - 138% FPL
None	\$5 to IA	\$10-\$25 to IA

All beneficiaries with incomes between 50 percent and 133 percent of the FPL will be assigned an Independence Account (IA). The individual will receive a credit or debit card to access the amounts in that account to cover copayments and coinsurance. Both the state and the participant are required to make contributions to this account.⁹⁵

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

Enrollees under 50 percent of the FPL have no additional cost sharing. Those enrollees above 50 percent of the FPL have cost sharing consistent with Medicaid requirements that does exceed more than five percent of family monthly or quarterly income.⁹⁶

Iowa

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

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

⁹² Centers for Medicare and Medicaid Services, *Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration Fact Sheet*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-fs.pdf> (last visited Mar. 7, 2015).

⁹³ Centers for Medicare and Medicaid Services, *Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration*, pp.14-15, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf> (last visited Mar. 7, 2015).

⁹⁴ Centers for Medicare and Medicaid Services, *Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration*, pp.7 & 21, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf> (last visited Mar. 7, 2015).

⁹⁵ Centers for Medicare and Medicaid Services, *Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration*, p.7, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf> (last visited Mar. 7, 2015).

⁹⁶ Id at 16.

Premiums were not imposed during the first year of the program but will be in the second year for enrollees above 50 percent of the FPL. Enrollees have the opportunity to have the premiums waived if they complete healthy behaviors, and the premiums can continue to be waived in subsequent years if enrollees meet requirements for the incentives. At the state’s option, the non-payment of a premium can result in a collectible debt but not a loss of coverage.⁹⁷

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

Individuals in the Wellness Plan (Medicaid Managed Care) receive a Medicaid alternative benefits plan that is at least equivalent to the state employee benefit plan, except for an enhanced dental plan with access to additional dental benefits with prior authorization.⁹⁸ Those in the exchange plan receive an essential health benefit plan that is at least equivalent to those provided on the commercial essential health benefits benchmark.⁹⁹ Wrap-around services are provided by the Medicaid agency for family planning services at non-network providers and for EPSDT services for 19 and 20 year old enrollees. Iowa is not required to provide non-emergency transportation. The waiver was initially granted in year one of the demonstration and continued through July 31, 2015.¹⁰⁰

Indiana

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

- HIP Basic - an ABP for individuals that includes all of the essential health benefits and does not require a premium payment;
- HIP Plus - a comprehensive ABP for individuals who contribute to a POWER account with additional benefits not available in HIP Basic; and
- HIP Link Program - a voluntary premium assistance program for individuals above age 21 with access to cost effective employer sponsored insurance that meets qualification criteria.¹⁰¹

⁹⁷ Centers for Medicare and Medicaid Services, Special Terms and Conditions with Iowa Department of Human Services - Iowa Wellness Plan (11-W-00289/5) http://dhs.iowa.gov/sites/default/files/WellnessSTCsTechnicalCorrections_020215.pdf (last visited Mar. 7, 2015).

⁹⁸ Iowa Department of Human Services, Medicaid 1115 Waiver Application, Iowa Wellness Plan, p.5, http://dhs.iowa.gov/sites/default/files/IAWellnessPlan1115_Final.pdf (last visited Mar. 7, 2015).

⁹⁹ Iowa Department of Human Services, Medicaid 1115 Waiver, Iowa Marketplace Choice Plan, p.5, http://dhs.iowa.gov/sites/default/files/IAMktplaceChoice1115_Final.pdf (last visited Mar. 7, 2015)

¹⁰⁰ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Iowa Marketplace Choice Plan - Section 1115 Demonstration Fact Sheet*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-fs.pdf> (last visited: Mar. 9, 2015).

¹⁰¹ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Healthy Indiana Plan 2.0 Section 1115 Medicaid Demonstration Fact Sheet (January 27, 2015)*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-fs.pdf> (last visited: Mar. 7, 2015).

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

In addition to health benefits coverage, individuals who contribute to a Personal Wellness and Responsibility (POWER) account have access to additional benefits. Contributions to a POWER account are a condition of eligibility for those with incomes above 100 percent of the FPL.¹⁰² Funds in the POWER accounts are used to pay for some of beneficiaries’ health care expenses. With the exception of inappropriate use of the emergency room fee, no other cost sharing is charged under the HIP Plus component.

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

Indiana HIP Basic Co-Pay Schedule¹⁰³	
Service	Per Visit/Service
Preventive Care Services (including family planning and maternity services)	\$0
Outpatient Services	\$4
Inpatient Services	\$75
Preferred Drugs	\$4
Non-Preferred Drugs	\$8
Non-Emergent ER Use (HIP Basic and HIP Plus)	\$8 - 1st visit \$25 - Recurrent

Enrollees above 100 percent of the FPL who do not make contributions or who cease transition to the HIP Basic program after a 60-day grace period are disqualified from the HIP Plus program for six months.¹⁰⁴ There are exceptions to the lock-out period for the medically frail and other special circumstances.

Indiana Maximum Monthly POWER Contributions¹⁰⁵					
<5% FPL	<22%	22% - 50%	51% -75%	76%-100%	101%-138%
\$1	\$4.32	\$9.82	\$14.72	\$19.62	\$27.39
<ul style="list-style-type: none"> - Represents approximately 2% of enrollee’s income; - When enrollee leaves the program, the member amount is refunded to the member; and - When enrollee remains in the program, the member portion rolls over at the end of the year; can double if member completes required preventive services. 					

¹⁰² U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Approval Letter and Special Terms and Conditions (January 27, 2015) <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf> (last visited Mar. 7, 2015).

¹⁰³ Id at 35 and 36.

¹⁰⁴ Id.

¹⁰⁵ Healthy Indiana Plan 2.0, Presentation to Senate Health Policy Committee (March 4, 2015), slides 16 & 17 (on file with the Senate Committee on Health Policy).

The POWER accounts function like a health savings account and hold both beneficiary and state contributions. The POWER account funds pay for the first \$2,500 in claims; claims beyond that amount are covered through capitation or other payments made by the state. The funds are not for copayments under the HIP Plus accounts. For HIP Link enrollees, the POWER account funds are used to pay premium and cost sharing amounts.¹⁰⁶

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

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

III. Effect of Proposed Changes:

Section 1 amends s. 395.602, F.S., to revise the definition of "rural hospital" by deleting the provision allowing a hospital to qualify as a rural hospital by being classified as a sole community hospital having up to 340 licensed beds. However, sole community hospitals may still qualify as rural hospitals under one of the definition's other criteria.

The bill also extends the expiration of two statutory provisions that deem hospitals to be rural hospitals if they previously received funds under the rural disproportionate share hospital program, or were licensed as rural hospitals, during certain periods of time. Under the bill, such hospitals will continue to be deemed rural hospitals through June 30, 2021.

Section 2 amends s. 409.908, F.S., effective upon the bill becoming law, to consolidate provisions relating to Medicaid reimbursement of hospitals for inpatient and outpatient services utilizing funds donated to the Agency for Health Care Administration (AHCA) from specified state entities, including local governments, within a new paragraph (c) of s. 409.908(1), F.S. The bill provides that the AHCA may receive such donations in the form of intergovernmental transfers (IGTs) for the purpose of making special exception payments or to enhance hospital reimbursement.

The bill also directs the AHCA to seek Medicaid waiver authority to use IGTs for the advancement of the Medicaid program and for enhancing provider reimbursement delivered by fee-for-service payments or under Statewide Medicaid Managed Care in ways that incent donations of IGTs and prevent providers from being penalized in the calculations of Medicaid cost limits by virtue of having donated IGTs.

Section 3 amends s. 409.908, F.S., to remove community intermediate care facilities for the developmentally disabled from the list of providers for which the AHCA is required to set rates at levels that ensure no increase in statewide expenditures resulting from changes in unit costs.

¹⁰⁶ Id.

Section 4 amends s. 404.909, F.S., relating to the Statewide Medicaid Residency Program (SMRP), to provide that:

- Residency specialties must be reported using the current residency code in the Intern and Resident Information System required by Medicare.
- Annual allocations calculated under the SMRP must be capped at two times the average per-resident allocation amount for all hospitals.
- A Graduate Medical Education Startup Bonus Program is created. In any fiscal year in which funds are appropriated for the startup bonus program, hospitals eligible to participate in the SMRP may apply for up to \$100,000 per newly created residency slot that is dedicated to a physician specialty in statewide supply/demand deficit. Such physician specialties and subspecialties are those identified in the General Appropriations Act.

Section 5 amends s. 409.911, F.S., relating to the disproportionate share hospital program (DSH), by requiring the AHCA to use the average of the 2007, 2008, and 2009 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2015-2016 fiscal year, as opposed to the average of the 2005, 2006, and 2007 data.

Section 6 repeals s. 409.97, F.S., relating to intergovernmental transfers, the Low-Income Pool, and hospital rate distribution within Statewide Medicaid Managed Care.

Section 7 amends s. 409.983, F.S., relating to payments in the Long-Term Care Managed Care (LTCMC) component of Statewide Medicaid Managed Care, to provide that when payments to LTCMC plans are reconciled to reimburse plans for actual payments to nursing facilities, the reconciliations must result from changes in nursing home per diem rates and that payments may not be reconciled to actual nursing home bed-days experienced by the LTCMC plans.

Section 8 amends s. 408.07, F.S., to correct a cross-reference.

Sections 9 through 23 pertain to the Florida Health Insurance Affordability Exchange Program and are effective upon the bill becoming law.

The bill directs the Division of Law Revision and Information to rename part II of chapter 409, Florida Statutes, as "Insurance Affordability Programs," instead of "Kidcare," and to incorporate the newly created sections of ss. 409.720-409.731, F.S., under this part. The "Florida Health Insurance Affordability Exchange Program" or "FHIX" is established under ss. 409.720 through 409.731, Florida Statutes, as a new program under part II of ch. 409, F.S.

The FHIX program is placed within the AHCA for the purpose of assisting Floridians in purchasing health benefits coverage and gaining access to health services. The FHIX is based on seven principles:

- Fair Value;
- Consumer Choice;
- Simplicity;
- Portability;
- Promotes Employment;
- Consumer Empowerment; and

- Risk Adjustment.

Definitions specific for the FHIIX program are:

- “Agency” means the Agency for Health Care Administration;
- “Applicant” means an individual who applies for determination of eligibility for health benefits coverage under this part;
- “Corporation” means Florida Health Choices, Inc.;
- “Enrollee” means an individual who has been determined eligible for and is receiving health benefits coverage under this part;
- “Florida Health Insurance Affordability Exchange” or “FHIIX” means the program created under ss. 409.720-409.731, F.S.;
- “Florida Healthy Kids Corporation” means the entity created under s. 624.91, F.S.;
- “Florida Kidcare Program” or “Kidcare” means the program created under ss. 409,810-409.821, F.S.;
- “Health benefits coverage” means the payment of benefits for covered health care services or the availability, directly or through arrangements with other persons, of covered health care services on prepaid or per capita basis or a prepaid aggregate fixed sum basis;
- “Inactive status” means the enrollment status of a participant previously enrolled in health benefits coverage in the FHIIX marketplace, who lost coverage through non-payment, but maintains access to his or her balance in a health savings account or health reimbursement account;
- “Medicaid” means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and part III and IV of ch. 409, F.S., as administered by the AHCA;
- “Modified adjusted gross income” means the individual’s or household’s adjusted gross income as defined in s. 36B(d)(2) of the Internal Revenue Code of 1986 and which is used to determine eligibility for FHIIX;
- “Patient Protection and Affordable Care Act” or “Affordable Care Act” means Public Law No. 111-148, as further amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and amendments to, and regulations or guidance under, those acts;
- “Premium credit” means the monthly amount paid by the AHCA per enrollee in the FHIIX toward health benefits coverage;
- “Qualified alien” means an alien as defined in 8 U.S.C. s. 1641(b) or (c);¹⁰⁷ and
- “Resident” means a United States citizen or qualified alien who is domiciled in this state.

Eligibility

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

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

¹⁰⁷ “Qualified alien” means an alien as defined in s. 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.

- Meet and maintain the responsibilities under participant responsibilities; and
- Qualify as a participant in the Florida Healthy Kids program under s. 624.91, F.S., subject to the implementation of Phase Three under s. 409.727, F.S.

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

Enrollment

To enroll in FHIX, applicants will apply using the same process used today for Medicaid eligibility through the Department of Children and Families (DCF). The DCF is responsible for processing applications, determining eligibility and transmitting information to the AHCA or the corporation, depending on the phase on each applicant’s eligibility status. An application is only deemed complete when it has met all of the requirements under participant responsibilities.

The DCF will also be responsible for corresponding with the participant on an ongoing basis regarding the participant’s status and shall review the eligibility status at least every 12 months.

Participant Rights

A participant has certain rights under FHIX:

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

Participant Responsibilities

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

- Complete an initial application for health benefits coverage and annual renewal process that includes proof of employment, on-the-job training, or placement activities, or pursuit of educational opportunities at certain hourly levels based on status;
- Learn and remain informed about the choices available on the FHIX marketplace and the uses of credit in the individual accounts;
- Execute a contract with the DCF that acknowledges that FHIX is not an entitlement, state and federal funding may end at any time, failure to pay cost sharing may result in a transition to inactive status, and noncompliance with other requirements may also result in a transition to inactive status;

- Select plans and other products in a timely manner;
- Comply with program rules and prohibitions against fraud;
- Make monthly premium payments and other cost sharing by their respective deadline; and
- Meet minimum coverage requirements by selecting a high deductible health plan combined with a health savings or health reimbursement account if not selecting a plan with more extensive coverage.

Beginning with Phase Two, requirements for employment, on-the-job training, or pursuit of educational opportunities will be implemented. Minimum hourly rates will vary by a participant’s individual circumstances in order to maintain an active status on the FHIX marketplace. For a parent of a child younger than 18, the minimum hourly requirements for pursuit of these activities or employment is 20 hours weekly. For a childless adult, the minimum weekly hourly requirement is 30. A disabled adult or the caregiver of a disabled child or adult may seek an exemption from these requirements through the corporation on an annual basis.

Cost Sharing

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

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

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

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

Available Assistance

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

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

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

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

An ongoing education campaign coordinated by the AHCA, the corporation, and the Florida Healthy Kids Corporation must include:

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

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

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

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

Available Products and Services

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

- Authorized products and services that are offered on the Florida Health Choices, Inc., marketplace (409.910, F.S.);

- Medicaid managed care plans under part IV of ch. 409, F.S., that qualify to participate;
- Authorized products under the Florida Healthy Kids Corporation; and
- Employer-sponsored plans.

Program Accountability

The plans and products that participate in FHIX will be required to meet certain accountability standards under s. 409.726, F.S. All managed care plans must collect and maintain encounter data in the same manner as under Statewide Medicaid Managed Care and will be subject to the accompanying penalties under s. 409.967(2)(h)2, F.S., for the failure to meet those standards. The AHCA will be responsible for the collection and maintenance of that data.

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

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

An annual report is due by July 1 to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The minimum components of the report include enrollment and application data, customer satisfaction, utilization and cost data, enrollee use of funds in reimbursement accounts, types of plans and products purchased, and recommendations for program improvement.

Implementation Schedule

The implementation schedule for FHIX is based on each phase passing a readiness review before implementation under s. 409.727, F.S. The AHCA is identified as the lead agency for FHIX, as the state’s designated Medicaid agency. The AHCA, the corporation, the DCF, and the Florida Healthy Kids Corporation are directed to begin implementation upon SPB 2512 becoming law, with statewide implementation of the FHIX marketplace by January 1, 2016.

Implementation Activities			
Phase	Start Date	Activities	Enrollee Requirements
Readiness	Effective Date - Ongoing Based on Phase/Region	Implementation Activities	None

Implementation Activities			
Phase	Start Date	Activities	Enrollee Requirements
One	July 1, 2015	-Enroll newly eligible, low-income, uninsured into Medicaid managed care plans -Corporation readies for implementation of FHIX marketplace for Phase Two -Healthy Kids prepares for customer service, financial support and choice counseling in Phase Two and Three	-Complete application -Select MMA plan -Utilize health savings or health reimbursement account
Two	January 1, 2016*	1. Enroll newly eligible, low-income, uninsured into FHIX 2. Transition Phase One enrollees from MMA plans to FHIX by April 1, 2016 3. Renew existing enrollees at annual enrollment date 3. Healthy Kids prepares to transition enrollees to FHIX under Phase Three	-Complete application -Meet work or educational requirements or seek an exemption -Pay required premium or transition to inactive status -Select plans products, or services from FHIX -Execute contract -Comply with program rules -Meet minimum coverage requirements -Utilize health savings or health reimbursement account
Three	July 1, 2016*	1. Enroll newly eligible, low-income, uninsured into FHIX 2. Renew existing enrollees at annual enrollment date 3. Healthy Kids transitions enrollees to FHIX under Phase Three	-Complete application -Meet work or educational requirements or seek an exemption -Pay required premium or transition to inactive status -Select plans products, or services from FHIX -Execute contract -Comply with program rules -Meet minimum coverage requirements -Utilize health savings or health reimbursement account

**Phase Two implementation is contingent upon federal approval*

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

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

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

Phase One begins on July 1, 2015, and requires the AHCA, corporation, and the Florida Healthy Kids Corporation to coordinate activities. To be eligible during this phase, an enrollee is only required to meet the definition of “newly eligible.” An enrollee is not be required to meet the work or educational search requirements or make premium payments during this phase.

Responsibilities of Agencies by Implementation Phase			
Activity	Phase One	Phase Two	Phase Three
Eligibility Determination	DCF	DCF	DCF
Benefits/Plan Delivery	AHCA	FHIX	FHIX
Choice Counseling	AHCA	Healthy Kids	Healthy Kids
Customer Service	AHCA	Healthy Kids	Healthy Kids
Financial Service	AHCA	Healthy Kids	Healthy Kids
Program Oversight	AHCA	AHCA	AHCA

Enrollees in Phase One receive benefits and services through the Medicaid managed care plans in part IV of this chapter. At least two plans per region will be available to an enrollee to select from during this phase. Choice counseling and customer service will be provided by the AHCA.

Phase Two’s implementation is contingent upon federal approval and is planned to start no later than January 1, 2016. Participants will enroll or transition from Medicaid managed care plans to services and products on the FHIX marketplace. To be eligible during this phase, an enrollee must be “newly eligible,” meet the work or educational search requirements, learn and be informed of the FHIX marketplace choices, execute a DCF contract, select plans in a timely manner, comply with all program rules and prohibitions, make monthly premium payments and any other cost sharing payments, and meet minimum coverage requirements.

Enrollees moving from Phase One coverage must complete the process by April 1, 2016, or they will transition to inactive status. There is no automatic enrollment in the FHIX. Choice counseling during Phase Two will be provided in coordination by the AHCA and the corporation with customer support by the Florida Healthy Kids Corporation.

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

June 30, 2016. An enrollee will be responsible for any difference in costs. Any unexpended funds from the premium credit may be used on the FHIX marketplace for supplemental benefits.

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

Program Operation and Management

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

Specific Program Operations and Management Duties for FHIX			
Agency for Health Care Admin.	Dept. of Children and Families	Florida Health Choices, Inc.	Florida Healthy Kids
Contract with Fla Health Choices for FHIX for implementation, development and administration and release of funds	Coordinate with other agencies and corporations	Begin implementation of FHIX in Phase One	Retain duties in Phase One and Two
Administer Phase One	Determine eligibility and renewals	Implement FHIX for Phase Two and Three	Provide customer service to FHIX
Provide administrative support to FHIX Workgroup	Transmit eligibility determinations to AHCA and corporation	Offer health benefits coverage compliant with PPACA	Collect and transfer family funds to FHIX
Transition Phase One Enrollees to FHIX no later than April 1, 2016		Offer at least 2 plans at each metal level	Conduct financial reporting
Transmit enrollee information to FHIX		Provide opportunity for MMA plans to participate on FHIX in Phase Three	Coordinate activities with partner agencies
With Phase Two, determine risk adjusted rates annually based on specific statutory criteria		Offer enhanced or customized benefits	
Transfer funds to FHIX for premium credits		Provide sufficient staff and resources	
Encourage Medicaid Managed Assistance (MMA) plans to participate on FHIX		Provide opportunity for Healthy Kids plans to participate at FHIX	

Long Term Reorganization

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

- Recommend a Phase Two implementation plan no later than October 1, 2015;
- Review network and access standards for plans and products;
- Assess readiness and recommend actions needed to reorganize the state's insurance affordability programs for each phase or region;
- Recommend any proposed change to Title XIX-funded or Title XXI-funded programs based on the availability of federal funding;
- Identify duplication of services among the corporation, the AHCA, and the FHKC currently and under FHIX's proposed Phase Three program;
- Evaluate fiscal impacts based on proposed Phase Three transition plan;
- Compile schedule of impacted contracts, leases, and other assets;
- Determine staff requirements for Phase Three; and
- Develop and present a final transition plan no later than December 1, 2015, to the Governor, President of the Senate, and Speaker of the House of Representatives.

Federal Authorities

The bill authorizes the AHCA to seek federal approval to implement FHIX. Obtaining federal approval may be a multi-step process.

The bill establishes triggers for expiration of the FHIX program under certain conditions. FHIX expires at the end of Phase One if the state does not receive federal approval for Phase Two or at the end of the state fiscal year in which any of these conditions occur:

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

Florida Health Choices Program

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

Definitions are added to include the "Florida Health Insurance Affordability Exchange Program" or "FHIX" and to include the potential availability of Medicaid managed care plans under the existing definition of "Insurer." A definition for the "Patient Protection and Affordable Care Act" or "Affordable Care Act" is also added.

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

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

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

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

Section 24 amends 409.904, F.S., to provide that, effective October 1, 2015, persons eligible under the Medically Needy program will be limited to children under the age of 21 and pregnant women. Under the bill, the Medically Needy program will end on October 1, 2019.

Sections 25 and 26 pertain to the Florida Healthy Kids Corporation and are effective upon the bill becoming law.

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

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

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

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

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

The board of directors is re-configured with the chair being an appointee designated by the Governor and composed of 12 other members appointed by the Governor and confirmed by the Senate for three-year terms. The board members serve at the pleasure of the Governor. Those

members who are serving as of the effective date of this act may remain on the board until January 1, 2016.

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

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

Section 27 creates an undesignated section of law that directs the Division of Law Revision and Information to replace the phrase “the effective date of this act” wherever it occurs in the bill with the date the act becomes law.

Section 28 provides that the bill has an effective date of July 1, 2015, except as otherwise provided in the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SPB 2512 may provide cost savings to Floridians and stimulate economic growth. The following two organizations have published estimates:

- The Florida Chamber of Commerce estimates that Florida’s families and business pay \$1.4 billion in hidden health care taxes to cover the costs of the uninsured.¹⁰⁸ As an example, the Chamber has estimated that every insured Floridian pays about \$2,000 for every hospital stay to cover the cost of the uninsured.¹⁰⁹

¹⁰⁸ Florida Chamber of Commerce, *Smarter Healthcare Coverage in Florida*, p.3, <http://www.flchamber.com/wp-content/uploads/FL-Chamber-Plan-for-Smarter-Healthcare-Coverage.pdf> (last visited Mar. 8, 2015).

¹⁰⁹ Id.

- The Florida Hospital Association (FHA) has also conducted research on the impact of extending health insurance coverage to this population. By covering 1 million or more Floridians, the FHA has projected 121,000 new jobs, savings of more than \$2.5 billion in state general revenue, and \$541 million a year in local government revenue.¹¹⁰

The Affordable Care Act imposes an employer mandate effective in 2015 for businesses that employ 100 or more people. Those employers must provide affordable health insurance coverage or face penalties of \$2,000 or \$3,000 per person. This may also have an impact on Florida's economy if additional options are not available and more individuals are not covered.¹¹¹

C. Government Sector Impact:

The proposed Senate General Appropriations Bill for Fiscal Year 2015-2016, SPB 2500, contains:

- An appropriation of \$8,938,589 from the General Revenue Fund, \$849,077,555 from the Grants and Donations Trust Fund, and \$1,309,952,189 from the Medical Care Trust Fund for the Low-Income Pool, for which the Agency for Health Care Administration is authorized to seek a federal Medicaid waiver under the bill.
- An appropriation of \$500,000 from the General Revenue Fund and \$766,143 from the Medical Care Trust Fund for the Graduate Medical Education Startup Bonus Program created under the bill.
- Appropriations to the Agency for Health Care Administration totaling \$8,741,162 from the General Revenue Fund and \$2,808,431,291 from the Medical Care Trust Fund for implementation of the Florida Health Insurance Affordability Exchange Program (FHIX) created under the bill.
- Appropriations to the Department of Children and Families totaling \$912,292 from the General Revenue Fund and \$3,306,265 from the Federal Grants Trust Fund and 60 full-time equivalent positions, for implementation of the FHIX program.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.602, 408.07, 408.910, 409.904, 409.908, 409.909, 409.911, 409.983, and 624.91.

¹¹⁰ Florida Hospital Association, *A Healthy Florida Works*, <http://ahealthyfloridaworks.com/v6/wp-content/uploads/2014/10/AHealthyFloridaIGv10.pdf> (last visited Mar. 8, 2015).

¹¹¹ Id.

This bill creates the following sections of the Florida Statutes: 409.720 through 409.731.

This bill repeals the following sections of the Florida Statutes: 408.70, 409.97, and 624.915.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.
