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Proposed Committee Substitute by the Committee on Appropriations (Appropriations Subcommittee on Health and Human Services)

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

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28 s. 408.910, F.S.; revising legislative intent;
29 redefining terms; revising the scope of the Florida
30 Health Choices Program and the pricing of services
31 under the program; providing requirements for
32 operation of the marketplace; providing additional
33 duties for the corporation to perform; requiring an
34 annual report to the Governor and the Legislature;
35 amending s. 409.904, F.S.; establishing a date when
36 new enrollment in the Medically Needy program is
37 suspended; providing an expiration date for the
38 program; amending s. 624.91, F.S.; revising
39 eligibility requirements for state-funded assistance;
40 revising the duties and powers of the Florida Healthy
41 Kids Corporation; revising provisions for the
42 appointment of members of the board of the Florida
43 Healthy Kids Corporation; requiring transition plans;
44 repealing s. 624.915, F.S., relating to the operating
45 fund of the Florida Healthy Kids Corporation;
46 providing an effective date.
47
48 Be It Enacted by the Legislature of the State of Florida:
49
50 Section 1. The Division of Law Revision and Information is
51 directed to rename part II of chapter 409, Florida Statutes, as
52 “Insurance Affordability Programs” and to incorporate ss.
53 409.720-409.731, Florida Statutes, under this part.
54 Section 2. Section 409.720, Florida Statutes, is created to
55 read:
56 409.720 Short title.—Sections 409.720-409.731 may be cited

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57 as the “Florida Health Insurance Affordability Exchange Program”
58 or “FHIX.”
59 Section 3. Section 409.721, Florida Statutes, is created to
60 read:
61 409.721 Program authority.—The Florida Health Insurance
62 Affordability Exchange Program, or FHIX, is created in the
63 agency to assist Floridians in purchasing health benefits
64 coverage and gaining access to health services. The products and
65 services offered by FHIX are based on the following principles:
66 (1) FAIR VALUE.—Financial assistance will be rationally
67 allocated regardless of differences in categorical eligibility.
68 (2) CONSUMER CHOICE.—Participants will be offered
69 meaningful choices in the way they can redeem the value of the
70 available assistance.
71 (3) SIMPLICITY.—Obtaining assistance will be consumer-
72 friendly, and customer support will be available when needed.
73 (4) PORTABILITY.—Participants can continue to access the
74 services and products of FHIX despite changes in their
75 circumstances.
76 (5) PROMOTES EMPLOYMENT.—Assistance will be offered in a
77 way that incentivizes employment.
78 (6) CONSUMER EMPOWERMENT.—Assistance will be offered in a
79 manner that maximizes individual control over available
80 resources.
81 (7) RISK ADJUSTMENT.—The amount of assistance will reflect
82 participants’ medical risk.
83 Section 4. Section 409.722, Florida Statutes, is created to
84 read:
85 409.722 Definitions.—As used in ss. 409.720-409.731, the

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86 term:
87 (1) “Agency” means the Agency for Health Care
88 Administration.
89 (2) “Applicant” means an individual who applies for
90 determination of eligibility for health benefits coverage under
91 this part.
92 (3) “Corporation” means Florida Health Choices, Inc., as
93 established under s. 408.910.
94 (4) “Enrollee” means an individual who has been determined
95 eligible for and is receiving health benefits coverage under
96 this part.
97 (5) “FHIX marketplace” or “marketplace” means the single,
98 centralized market established under s. 408.910 which
99 facilitates health benefits coverage.
100 (6) “Florida Health Insurance Affordability Exchange
101 Program” or “FHIX” means the program created under ss. 409.720-
102 409.731.
103 (7) “Florida Healthy Kids Corporation” means the entity
104 created under s. 624.91.
105 (8) “Florida Kidcare program” or “Kidcare program” means
106 the health benefits coverage administered through ss. 409.810-
107 409.821.
108 (9) “Health benefits coverage” means the payment of
109 benefits for covered health care services or the availability,
110 directly or through arrangements with other persons, of covered
111 health care services on a prepaid per capita basis or on a
112 prepaid aggregate fixed-sum basis.
113 (10) “Inactive status” means the enrollment status of a
114 participant previously enrolled in health benefits coverage

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115 through the FHIX marketplace who lost coverage through the
116 marketplace for non-payment, but maintains access to his or her
117 balance in a health savings account or health reimbursement
118 account.
119 (11) “Medicaid” means the medical assistance program
120 authorized by Title XIX of the Social Security Act, and
121 regulations thereunder, and part III and part IV of this
122 chapter, as administered in this state by the agency.
123 (12) “Modified adjusted gross income” means the
124 individual’s or household’s annual adjusted gross income as
125 defined in s. 36B(d)(2) of the Internal Revenue Code of 1986 and
126 which is used to determine eligibility for FHIX.
127 (13) “Patient Protection and Affordable Care Act” or
128 “Affordable Care Act” means Pub. L. No. 111-148, as further
129 amended by the Health Care and Education Reconciliation Act of
130 2010, Pub. L. No. 111-152, and any amendments to, and
131 regulations or guidance under, those acts.
132 (14) “Premium credit” means the monthly amount paid by the
133 agency per enrollee in the Florida Health Insurance
134 Affordability Exchange Program toward health benefits coverage.
135 (15) “Qualified alien” means an alien as defined in 8
136 U.S.C. s. 1641(b) or (c).
137 (16) “Resident” means a United States citizen or qualified
138 alien who is domiciled in this state.
139 Section 5. Section 409.723, Florida Statutes, is created to
140 read:
141 409.723 Participation.—
142 (1) ELIGIBILITY.—In order to participate in FHIX, an
143 individual must be a resident and must meet the following

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144 requirements, as applicable:
145 (a) Qualify as a newly eligible enrollee, who must be an
146 individual as described in s. 1902(a)(10)(A)(i)(VIII) of the
147 Social Security Act or s. 2001 of the Affordable Care Act and as
148 may be further defined by federal regulation.
149 (b) Meet and maintain the responsibilities under subsection
150 (4).
151 (c) Qualify as a participant in the Florida Healthy Kids
152 program under s. 624.91, subject to the implementation of Phase
153 Three under s. 409.727.
154 (2) ENROLLMENT.—To enroll in FHIX, an applicant must submit
155 an application to the department for an eligibility
156 determination.
157 (a) Applications may be submitted by mail, fax, online, or
158 any other method permitted by law or regulation.
159 (b) The department is responsible for any eligibility
160 correspondence and status updates to the participant and other
161 agencies.
162 (c) The department shall review a participant's eligibility
163 every 12 months.
164 (d) An application or renewal is deemed complete when the
165 participant has met all the requirements under subsection (4).
166 (3) PARTICIPANT RIGHTS.—A participant has all of the
167 following rights:
168 (a) Access to the FHIX marketplace to select the scope,
169 amount, and type of health care coverage and other services to
170 purchase.
171 (b) Continuity and portability of coverage to avoid
172 disruption of coverage and other health care services when the

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173 participant's economic circumstances change.
174 (c) Retention of applicable unspent credits in the
175 participant's health savings or health reimbursement account
176 following a change in the participant's eligibility status.
177 Credits are valid for an inactive status participant for up to 5
178 years after the participant first enters an inactive status.
179 (d) Ability to select more than one product or plan on the
180 FHIX marketplace.
181 (e) Choice of at least two health benefits products that
182 meet the requirements of the Affordable Care Act.
183 (4) PARTICIPANT RESPONSIBILITIES.—A participant has all of
184 the following responsibilities:
185 (a) Complete an initial application for health benefits
186 coverage and an annual renewal process;
187 (b) Annually provide evidence of participation in one of
188 the following activities at the levels required under paragraph
189 (c):
190 1. Proof of employment.
191 2. On-the-job training or job placement activities.
192 3. Pursuit of educational opportunities.
193 (c) Engage in the activities required under paragraph (b)
194 at the following minimum levels:
195 1. For a parent of a child younger than 18 years of age, a
196 minimum of 20 hours weekly.
197 2. For a childless adult, a minimum of 30 hours weekly.
198
199 A participant who is a disabled adult or a caregiver of a
200 disabled child or adult may submit a request for an exception to
201 these requirements to the corporation and, thereafter, shall

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202 annually submit to the department a request to renew the
203 exception to the hourly level requirements.
204 (d) Learn and remain informed about the choices available
205 on the FHIX marketplace and the uses of credits in the
206 individual accounts.
207 (e) Execute a contract with the department to acknowledge
208 that:
209 1. FHIX is not an entitlement and state and federal funding
210 may end at any time;
211 2. Failure to pay required premiums or cost sharing will
212 result in a transition to inactive status; and
213 3. Noncompliance with work or educational requirements will
214 result in a transition to inactive status.
215 (f) Select plans and other products in a timely manner.
216 (g) Comply with program rules and the prohibitions against
217 fraud, as described in s. 414.39.
218 (h) Timely make monthly premium and any other cost-sharing
219 payments.
220 (i) Meet minimum coverage requirements by selecting a high-
221 deductible health plan combined with a health savings or health
222 reimbursement account if not selecting a plan offering more
223 extensive coverage.
224 (5) COST SHARING.—
225 (a) Enrollees are assessed monthly premiums based on their
226 modified adjusted gross income. The maximum monthly premium
227 payments are set at the following income levels:
228 1. At or below 22 percent of the federal poverty level: $3.
229 2. Greater than 22 percent, but at or below 50 percent, of
230 the federal poverty level: $8.

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231 3. Greater than 50 percent, but at or below 75 percent, of
232 the federal poverty level: $15.
233 4. Greater than 75 percent, but at or below 100 percent, of
234 the federal poverty level: $20.
235 5. Greater than 100 percent of the federal poverty level:
236 $25.
237 (b) Depending on the products and services selected by the
238 enrollee, the enrollee may also incur additional cost-sharing,
239 such as copayments, deductibles, or other out-of-pocket costs.
240 (c) An enrollee may be subject to an inappropriate
241 emergency room visit charge of up to $8 for the first visit and
242 up to $25 for any subsequent visit, based on the enrollee's
243 benefit plan, to discourage inappropriate use of the emergency
244 room.
245 (d) Cumulative annual cost sharing per enrollee may not
246 exceed 5 percent of an enrollee's annual modified adjusted gross
247 income.
248 (e) If, after a 30-day grace period, a full premium payment
249 has not been received, the enrollee shall be transitioned from
250 coverage to inactive status and may not reenroll for a minimum
251 of 6 months, unless a hardship exception has been granted.
252 Enrollees may seek a hardship exception under the Medicaid Fair
253 Hearing Process.
254 Section 6. Section 409.724, Florida Statutes, is created to
255 read:
256 409.724 Available assistance.—
257 (1) PREMIUM CREDITS.—
258 (a) Standard amount.—The standard monthly premium credit is
259 equivalent to the applicable risk-adjusted capitation rate paid

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260 to Medicaid managed care plans under part IV of this chapter.
261 (b) Supplemental funding.—Subject to federal approval,
262 additional resources may be made available to enrollees and
263 incorporated into FHIX.
264 (c) Savings accounts.—In addition to the benefits provided
265 under this section, the corporation must offer each enrollee
266 access to an individual account that qualifies as a health
267 reimbursement account or a health savings account. Eligible
268 unexpended funds from the monthly premium credit must be
269 deposited into each enrollee's individual account in a timely
270 manner. Enrollees may also be rewarded for healthy behaviors,
271 adherence to wellness programs, and other activities established
272 by the corporation which demonstrate compliance with prevention
273 or disease management guidelines. Funds deposited into these
274 accounts may be used to pay cost-sharing obligations or to
275 purchase other health-related items to the extent permitted
276 under federal law.
277 (d) Enrollee contributions.—The enrollee may make deposits
278 to his or her account at any time to supplement the premium
279 credit, to purchase additional FHIX products, or to offset other
280 cost-sharing obligations.
281 (e) Third parties.—Third parties, including, but not
282 limited to, an employer or relative, may also make deposits on
283 behalf of the enrollee into the enrollee's FHIX marketplace
284 account. The enrollee may not withdraw any funds as a refund,
285 except those funds the enrollee has deposited into his or her
286 account.
287 (2) CHOICE COUNSELING.—The agency and the corporation shall
288 work together to develop a choice counseling program for FHIX.

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289 The choice counseling program must ensure that participants have
290 information about the FHIX marketplace program, products, and
291 services and that participants know where and whom to call for
292 questions or to make their plan selections. The choice
293 counseling program must provide culturally sensitive materials
294 and must take into consideration the demographics of the
295 projected population.
296 (3) EDUCATION CAMPAIGN.—The agency, the corporation, and
297 the Florida Healthy Kids Corporation must coordinate an ongoing
298 enrollee education campaign beginning in Phase One, as provided
299 in s. 409.27, informing participants, at a minimum:
300 (a) How the transition process to the FHIX marketplace will
301 occur and the timeline for the enrollee's specific transition.
302 (b) What plans are available and how to research
303 information about available plans.
304 (c) Information about other available insurance
305 affordability programs for the individual and his or her family.
306 (d) Information about health benefits coverage, provider
307 networks, and cost sharing for available plans in each region.
308 (e) Information on how to complete the required annual
309 renewal process, including renewal dates and deadlines.
310 (f) Information on how to update eligibility if the
311 participant's data have changed since his or her last renewal or
312 application date.
313 (4) CUSTOMER SUPPORT.—Beginning in Phase Two, the Florida
314 Healthy Kids Corporation shall provide customer support for
315 FHIX, shall address general program information, financial
316 information, and customer service issues, and shall provide
317 status updates on bill payments. Customer support must also

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318 provide a toll-free number and maintain a website that is
319 available in multiple languages and that meets the needs of the
320 enrollee population.
321 (5) INACTIVE PARTICIPANTS.—The corporation must inform the
322 inactive participant about other insurance affordability
323 programs and electronically refer the participant to the federal
324 exchange or other insurance affordability programs, as
325 appropriate.
326 Section 7. Section 409.725, Florida Statutes, is created to
327 read:
328 409.725 Available products and services.—The FHIX
329 marketplace shall offer the following products and services:
330 (1) Authorized products and services pursuant to s.
331 408.910.
332 (2) Medicaid managed care plans under part IV of this
333 chapter.
334 (3) Authorized products under the Florida Healthy Kids
335 Corporation pursuant to s. 624.91.
336 (4) Employer-sponsored plans.
337 Section 8. Section 409.726, Florida Statutes, is created to
338 read:
339 409.726 Program accountability.—
340 (1) All managed care plans that participate in FHIX must
341 collect and maintain encounter level data in accordance with the
342 encounter data requirements under s. 409.967(2)(d) and are
343 subject to the accompanying penalties under s. 409.967(2)(h)2.
344 The agency is responsible for the collection and maintenance of
345 the encounter level data.
346 (2) The corporation, in consultation with the agency, shall

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347 establish access and network standards for contracts on the FHIX
348 marketplace and shall ensure that contracted plans have
349 sufficient providers to meet enrollee needs. The corporation, in
350 consultation with the agency, shall develop quality of coverage
351 and provider standards specific to the adult population.
352 (3) The department shall develop accountability measures
353 and performance standards to be applied to applications and
354 renewal applications for FHIX which are submitted online, by
355 mail, by fax, or through referrals from a third party. The
356 minimum performance standards are:
357 (a) Application processing speed.—Ninety percent of all
358 applications, from all sources, must be processed within 45
359 days.
360 (b) Applications processing speed from online sources.—
361 Ninety-five percent of all applications received from online
362 sources must be processed within 45 days.
363 (c) Renewal application processing speed.—Ninety percent of
364 all renewals, from all sources, must be processed within 45
365 days.
366 (d) Renewal application processing speed from online
367 sources.—Ninety-five percent of all applications received from
368 online sources must be processed within 45 days.
369 (4) The agency, the department, and the Florida Healthy
370 Kids Corporation must meet the following standards for their
371 respective roles in the program:
372 (a) Eighty-five percent of calls must be answered in 20
373 seconds or less.
374 (b) One hundred percent of all contacts, which include, but
375 are not limited to, telephone calls, faxed documents and

376 requests, and e-mails, must be handled within 2 business days.
377 (c) Any self-service tools available to participants, such
378 as interactive voice response systems, must be operational 7
379 days a week, 24 hours a day, at least 98 percent of each month.
380 (5) The agency, the department, and the Florida Healthy
381 Kids Corporation must conduct an annual satisfaction survey to
382 address all measures that require participant input specific to
383 the FHIX marketplace program. The parties may elect to
384 incorporate these elements into the annual report required under
385 subsection (7).
386 (6) The agency and the corporation shall post online
387 monthly enrollment reports for FHIX.
388 (7) An annual report is due no later than July 1 to the
389 Governor, the President of the Senate, and the Speaker of the
390 House of Representatives. The annual report must be coordinated
391 by the agency and the corporation and must include, but is not
392 limited to:
393 (a) Enrollment and application trends and issues.
394 (b) Utilization and cost data.
395 (c) Customer satisfaction.
396 (d) Funding sources in health savings accounts or health
397 reimbursement accounts.
398 (e) Enrollee use of funds in health savings accounts or
399 health reimbursement accounts.
400 (f) Types of products and plans purchased.
401 (g) Movement of enrollees across different insurance
402 affordability programs.
403 (h) Recommendations for program improvement.
404 Section 9. Section 409.727, Florida Statutes, is created to

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405 read:

406 409.727 Implementation schedule.—The agency, the
407 corporation, the department, and the Florida Healthy Kids
408 Corporation shall begin implementation of FHIX by the effective
409 date of this act, with statewide implementation in all regions,
410 as described in s. 409.966(2), by January 1, 2016.

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

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

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

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

421 (d) Availability of customer support.

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

423 (2) PHASE ONE.—

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

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

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

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434 (d) An enrollee shall have a choice of at least two managed
435 care plans in each region.
436 (e) Choice counseling and customer service must be provided
437 in accordance with s. 409.724(2).
438 (3) PHASE TWO.—
439 (a) Beginning no later than January 1, 2016, and contingent
440 upon federal approval, participants may enroll or transition to
441 health benefits coverage under the FHIX marketplace.
442 (b) To be eligible during this phase, a participant must
443 meet the requirements under s. 409.723(1)(a) and (b).
444 (c) An enrollee may select any benefit, service, or product
445 available.
446 (d) The corporation shall notify an enrollee of his or her
447 premium credit amount and how to access the FHIX marketplace
448 selection process.
449 (e) A Phase One enrollee must be transitioned to the FHIX
450 marketplace by April 1, 2016. An enrollee who does not select a
451 plan or service on the FHIX marketplace by that deadline shall
452 be moved to inactive status.
453 (f) An enrollee shall have a choice of at least two managed
454 care plans in each region which meet or exceed the Affordable
455 Care Act's requirements and which qualify for a premium credit
456 on the FHIX marketplace.
457 (g) Choice counseling and customer service must be provided
458 in accordance with s. 409.724(2) and (4).
459 (4) PHASE THREE.—
460 (a) No later than July 1, 2016, the corporation and the
461 Florida Healthy Kids Corporation must begin the transition of
462 enrollees under s. 624.91 to the FHIX marketplace.

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463 (b) Eligibility during this phase is based on meeting the
464 requirements of Phase Two and s. 409.723(1)(c).
465 (c) An enrollee may select any benefit, service, or product
466 available under s. 409.725.
467 (d) A Florida Healthy Kids enrollee who selects a FHIX
468 marketplace plan must be provided a premium credit equivalent to
469 the average capitation rate paid in his or her county of
470 residence under Florida Healthy Kids as of June 30, 2016. The
471 enrollee is responsible for any difference in costs and may use
472 any remaining funds for supplemental benefits on the FHIX
473 marketplace.
474 (e) The corporation shall notify an enrollee of his or her
475 premium credit amount and how to access the FHIX marketplace
476 selection process.
477 (f) Choice counseling and customer service must be provided
478 in accordance with s. 409.724(2) and (4).
479 (g) Enrollees under s. 624.91 must transition to the FHIX
480 marketplace by September 30, 2016.
481 Section 10. Section 409.728, Florida Statutes, is created
482 to read:
483 409.728 Program operation and management.—In order to
484 implement ss. 409.720-409.731:
485 (1) The Agency for Health Care Administration shall do all
486 of the following:
487 (a) Contract with the corporation for the development,
488 implementation, and administration of the Florida Health
489 Insurance Affordability Exchange Program and for the release of
490 any federal, state, or other funds appropriated to the
491 corporation.

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492 (b) Administer Phase One of FHIX.
493 (c) Provide administrative support to the FHIX Workgroup
494 under s. 409.729.
495 (d) Transition the FHIX enrollees to the FHIX marketplace
496 beginning January 1, 2016, in accordance with the transition
497 workplan. Stakeholders that serve low-income individuals and
498 families must be consulted during the implementation and
499 transition process through a public input process. All regions
500 must complete the transition no later than April 1, 2016.
501 (e) Timely transmit enrollee information to the
502 corporation.
503 (f) Beginning with Phase Two, determine annually the risk-
504 adjusted rate to be paid per month based on historical
505 utilization and spending data for the medical and behavioral
506 health of this population, projected forward, and adjusted to
507 reflect the eligibility category, medical and dental trends,
508 geographic areas, and the clinical risk profile of the
509 enrollees.
510 (g) Transfer to the corporation such funds as approved in
511 the General Appropriations Act for the premium credits.
512 (h) Encourage Medicaid managed care plans to apply as
513 vendors to the marketplace to facilitate continuity of care and
514 family care coordination.
515 (2) The Department of Children and Families shall, in
516 coordination with the corporation, the agency, and the Florida
517 Healthy Kids Corporation, determine eligibility of applications
518 and application renewals for FHIX in accordance with s. 409.902
519 and shall transmit eligibility determination information on a
520 timely basis to the agency and corporation.

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521 (3) The Florida Healthy Kids Corporation shall do all of
522 the following:
523 (a) Retain its duties and responsibilities under s. 624.91
524 for Phase One and Phase Two of the program.
525 (b) Provide customer service for the FHIX marketplace, in
526 coordination with the agency and the corporation.
527 (c) Transfer funds and provide financial support to the
528 FHIX marketplace, including the collection of monthly cost
529 sharing.
530 (d) Conduct financial reporting related to such activities,
531 in coordination with the corporation and the agency.
532 (e) Coordinate activities for the program with the agency,
533 the department, and the corporation.
534 (4) Florida Health Choices, Inc., shall do all of the
535 following:
536 (a) Begin the development of FHIX during Phase One.
537 (b) Implement and administer Phase Two and Phase Three of
538 the FHIX marketplace and the ongoing operations of the program.
539 (c) Offer health benefits coverage packages on the FHIX
540 marketplace, including plans compliant with the Affordable Care
541 Act.
542 (d) Offer FHIX enrollees a choice of at least two plans per
543 county at each benefit level which meet the requirements under
544 the Affordable Care Act.
545 (e) Provide an opportunity for participation in Medicaid
546 managed care plans if those plans meet the requirements of the
547 FHIX marketplace.
548 (f) Offer enhanced or customized benefits to FHIX
549 marketplace enrollees.

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550 (g) Provide sufficient staff and resources to meet the
551 program needs of enrollees.
552 (h) Provide an opportunity for plans contracted with or
553 previously contracted with the Florida Healthy Kids Corporation
554 under s. 624.91 to participate with FHIX if those plans meet the
555 requirements of the program.
556 (i) Encourage insurance agents licensed under chapter 626
557 to identify and assist enrollees. This act does not prohibit
558 these agents from receiving usual and customary commissions from
559 insurers and health maintenance organizations that offer plans
560 in the FHIX marketplace.
561 Section 11. Section 409.729, Florida Statutes, is created
562 to read:
563 409.729 Long-term reorganization.—The FHIX Workgroup is
564 created to facilitate the implementation of FHIX and to plan for
565 a multiyear reorganization of the state’s insurance
566 affordability programs. The FHIX Workgroup consists of two
567 representatives each from the agency, the department, the
568 Florida Healthy Kids Corporation, and the corporation. An
569 additional representative of the agency serves as chair. The
570 FHIX Workgroup must hold its organizational meeting no later
571 than 30 days after the effective date of this act and must meet
572 at least bimonthly. The role of the FHIX Workgroup is to make
573 recommendations to the agency. The responsibilities of the
574 workgroup include, but are not limited to:
575 (1) Recommend a Phase Two implementation plan no later than
576 October 1, 2015.
577 (2) Review network and access standards for plans and
578 products.

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579 (3) Assess readiness and recommend actions needed to
580 reorganize the state's insurance affordability programs for each
581 phase or region. If a phase or region receives a nonreadiness
582 recommendation, the agency must notify the Legislature of that
583 recommendation, the reasons for such a recommendation, and
584 proposed plans for achieving readiness.
585 (4) Recommend any proposed change to the Title XIX-funded
586 or Title XXI-funded programs based on the continued availability
587 and reauthorization of the Title XXI program and its federal
588 funding.
589 (5) Identify duplication of services among the corporation,
590 the agency, and the Florida Healthy Kids Corporation currently
591 and under FHIX's proposed Phase Three program.
592 (6) Evaluate any fiscal impacts based on the proposed
593 transition plan under Phase Three.
594 (7) Compile a schedule of impacted contracts, leases, and
595 other assets.
596 (8) Determine staff requirements for Phase Three.
597 (9) Develop and present a final transition plan that
598 incorporates all elements under this section no later than
599 December 1, 2015, in a report to the Governor, the President of
600 the Senate, and the Speaker of the House of Representatives.
601 Section 12. Section 409.730, Florida Statutes, is created
602 to read:
603 409.730 Federal participation.—The agency may seek federal
604 approval to implement FHIX.
605 Section 13. Section 409.731, Florida Statutes, is created
606 to read:
607 409.731 Program expiration.—The Florida Health Insurance

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608 Affordability Exchange Program expires at the end of Phase One
609 if the state does not receive federal approval for Phase Two or
610 at the end of the state fiscal year in which any of these
611 conditions occurs:
612 (1) The federal match contribution falls below 90 percent.
613 (2) The federal match contribution falls below the
614 increased Federal Medical Assistance Percentage for medical
615 assistance for newly eligible mandatory individuals as specified
616 in the Affordable Care Act.
617 (3) The federal match for the FHIX program and the Medicaid
618 program are blended under federal law or regulation in such a
619 manner that causes the overall federal contribution to diminish
620 when compared to separate, nonblended federal contributions.
621 Section 14. Section 408.70, Florida Statutes, is repealed.
622 Section 15. Section 408.910, Florida Statutes, is amended
623 to read:
624 408.910 Florida Health Choices Program.—
625 (1) LEGISLATIVE INTENT.—The Legislature finds that a
626 significant number of the residents of this state do not have
627 adequate access to affordable, quality health care. The
628 Legislature further finds that increasing access to affordable,
629 quality health care can be best accomplished by establishing a
630 competitive market for purchasing health insurance and health
631 services. It is therefore the intent of the Legislature to
632 create and expand the Florida Health Choices Program to:
633 (a) Expand opportunities for Floridians to purchase
634 affordable health insurance and health services.
635 (b) Preserve the benefits of employment-sponsored insurance
636 while easing the administrative burden for employers who offer

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637 these benefits.
638 (c) Enable individual choice in both the manner and amount
639 of health care purchased.
640 (d) Provide for the purchase of individual, portable health
641 care coverage.
642 (e) Disseminate information to consumers on the price and
643 quality of health services.
644 (f) Sponsor a competitive market that stimulates product
645 innovation, quality improvement, and efficiency in the
646 production and delivery of health services.
647 (2) DEFINITIONS.—As used in this section, the term:
648 (a) "Corporation" means the Florida Health Choices, Inc.,
649 established under this section.
650 (b) "Corporation's marketplace" means the single,
651 centralized market established by the program that facilitates
652 the purchase of products made available in the marketplace.
653 (c) "Florida Health Insurance Affordability Exchange
654 Program" or "FHIX" is the program created under ss. 409.720-
655 409.731 for low-income, uninsured residents of this state.
656 (d) ~~(c)~~ "Health insurance agent" means an agent licensed
657 under part IV of chapter 626.
658 (e) ~~(d)~~ "Insurer" means an entity licensed under chapter 624
659 which offers an individual health insurance policy or a group
660 health insurance policy, a preferred provider organization as
661 defined in s. 627.6471, an exclusive provider organization as
662 defined in s. 627.6472, ~~or~~ a health maintenance organization
663 licensed under part I of chapter 641, ~~or~~ a prepaid limited
664 health service organization or discount medical plan
665 organization licensed under chapter 636, or a managed care plan

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666 contracted with the Agency for Health Care Administration under
667 the managed medical assistance program under part IV of chapter
668 409.
669 (f) “Patient Protection and Affordable Care Act” or
670 “Affordable Care Act” means Pub. L. No. 111-148, as further
671 amended by the Health Care and Education Reconciliation Act of
672 2010, Pub. L. No. 111-152, and any amendments to or regulations
673 or guidance under those acts.
674 (g) ~~(e)~~ “Program” means the Florida Health Choices Program
675 established by this section.
676 (3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health
677 Choices Program is created as a single, centralized market for
678 the sale and purchase of various products that enable
679 individuals to pay for health care. These products include, but
680 are not limited to, health insurance plans, health maintenance
681 organization plans, prepaid services, service contracts, and
682 flexible spending accounts. The components of the program
683 include:
684 (a) Enrollment of employers.
685 (b) Administrative services for participating employers,
686 including:
687 1. Assistance in seeking federal approval of cafeteria
688 plans.
689 2. Collection of premiums and other payments.
690 3. Management of individual benefit accounts.
691 4. Distribution of premiums to insurers and payments to
692 other eligible vendors.
693 5. Assistance for participants in complying with reporting
694 requirements.

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

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724 those employers that meet criteria established by the
725 corporation and elect to make their employees eligible through
726 the program.
727 (b) Individuals eligible to participate in the program
728 include:
729 1. Individual employees of enrolled employers.
730 2. Other individuals that meet criteria established by the
731 corporation.
732 (c) Employers who choose to participate in the program may
733 enroll by complying with the procedures established by the
734 corporation. The procedures must include, but are not limited
735 to:
736 1. Submission of required information.
737 2. Compliance with federal tax requirements for the
738 establishment of a cafeteria plan, pursuant to s. 125 of the
739 Internal Revenue Code, including designation of the employer’s
740 plan as a premium payment plan, a salary reduction plan that has
741 flexible spending arrangements, or a salary reduction plan that
742 has a premium payment and flexible spending arrangements.
743 3. Determination of the employer’s contribution, if any,
744 per employee, provided that such contribution is equal for each
745 eligible employee.
746 4. Establishment of payroll deduction procedures, subject
747 to the agreement of each individual employee who voluntarily
748 participates in the program.
749 5. Designation of the corporation as the third-party
750 administrator for the employer’s health benefit plan.
751 6. Identification of eligible employees.
752 7. Arrangement for periodic payments.

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753 8. Employer notification to employees of the intent to
754 transfer from an existing employee health plan to the program at
755 least 90 days before the transition.
756 (d) All eligible vendors who choose to participate and the
757 products and services that the vendors are permitted to sell are
758 as follows:
759 1. Insurers licensed under chapter 624 may sell health
760 insurance policies, limited benefit policies, other risk-bearing
761 coverage, and other products or services.
762 2. Health maintenance organizations licensed under part I
763 of chapter 641 may sell health maintenance contracts, limited
764 benefit policies, other risk-bearing products, and other
765 products or services.
766 3. Prepaid limited health service organizations may sell
767 products and services as authorized under part I of chapter 636,
768 and discount medical plan organizations may sell products and
769 services as authorized under part II of chapter 636.
770 4. Prepaid health clinic service providers licensed under
771 part II of chapter 641 may sell prepaid service contracts and
772 other arrangements for a specified amount and type of health
773 services or treatments.
774 5. Health care providers, including hospitals and other
775 licensed health facilities, health care clinics, licensed health
776 professionals, pharmacies, and other licensed health care
777 providers, may sell service contracts and arrangements for a
778 specified amount and type of health services or treatments.
779 6. Provider organizations, including service networks,
780 group practices, professional associations, and other
781 incorporated organizations of providers, may sell service

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782 contracts and arrangements for a specified amount and type of
783 health services or treatments.
784 7. Corporate entities providing specific health services in
785 accordance with applicable state law may sell service contracts
786 and arrangements for a specified amount and type of health
787 services or treatments.
788
789 A vendor described in subparagraphs 3.-7. may not sell products
790 that provide risk-bearing coverage unless that vendor is
791 authorized under a certificate of authority issued by the Office
792 of Insurance Regulation and is authorized to provide coverage in
793 the relevant geographic area. Otherwise eligible vendors may be
794 excluded from participating in the program for deceptive or
795 predatory practices, financial insolvency, or failure to comply
796 with the terms of the participation agreement or other standards
797 set by the corporation.
798 (e) Eligible individuals may participate in the program
799 voluntarily. Individuals who join the program may participate by
800 complying with the procedures established by the corporation.
801 These procedures must include, but are not limited to:
802 1. Submission of required information.
803 2. Authorization for payroll deduction, if applicable.
804 3. Compliance with federal tax requirements.
805 4. Arrangements for payment.
806 5. Selection of products and services.
807 (f) Vendors who choose to participate in the program may
808 enroll by complying with the procedures established by the
809 corporation. These procedures may include, but are not limited
810 to:

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811 1. Submission of required information, including a complete
812 description of the coverage, services, provider network, payment
813 restrictions, and other requirements of each product offered
814 through the program.
815 2. Execution of an agreement to comply with requirements
816 established by the corporation.
817 3. Execution of an agreement that prohibits refusal to sell
818 any offered product or service to a participant who elects to
819 buy it.
820 4. Establishment of product prices based on applicable
821 criteria.
822 5. Arrangements for receiving payment for enrolled
823 participants.
824 6. Participation in ongoing reporting processes established
825 by the corporation.
826 7. Compliance with grievance procedures established by the
827 corporation.
828 (g) Health insurance agents licensed under part IV of
829 chapter 626 are eligible to voluntarily participate as buyers’
830 representatives. A buyer’s representative acts on behalf of an
831 individual purchasing health insurance and health services
832 through the program by providing information about products and
833 services available through the program and assisting the
834 individual with both the decision and the procedure of selecting
835 specific products. Serving as a buyer’s representative does not
836 constitute a conflict of interest with continuing
837 responsibilities as a health insurance agent if the relationship
838 between each agent and any participating vendor is disclosed
839 before advising an individual participant about the products and

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840 services available through the program. In order to participate,
841 a health insurance agent shall comply with the procedures
842 established by the corporation, including:
843 1. Completion of training requirements.
844 2. Execution of a participation agreement specifying the
845 terms and conditions of participation.
846 3. Disclosure of any appointments to solicit insurance or
847 procure applications for vendors participating in the program.
848 4. Arrangements to receive payment from the corporation for
849 services as a buyer’s representative.
850 (5) PRODUCTS.—
851 (a) The products that may be made available for purchase
852 through the program include, but are not limited to:
853 1. Health insurance policies.
854 2. Health maintenance contracts.
855 3. Limited benefit plans.
856 4. Prepaid clinic services.
857 5. Service contracts.
858 6. Arrangements for purchase of specific amounts and types
859 of health services and treatments.
860 7. Flexible spending accounts.
861 (b) Health insurance policies, health maintenance
862 contracts, limited benefit plans, prepaid service contracts, and
863 other contracts for services must ensure the availability of
864 covered services.
865 (c) Products may be offered for multiyear periods provided
866 the price of the product is specified for the entire period or
867 for each separately priced segment of the policy or contract.
868 (d) The corporation shall provide a disclosure form for

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869 consumers to acknowledge their understanding of the nature of,
870 and any limitations to, the benefits provided by the products
871 and services being purchased by the consumer.
872 (e) The corporation must determine that making the plan
873 available through the program is in the interest of eligible
874 individuals and eligible employers in the state.
875 (6) PRICING.—Prices for the products and services sold
876 through the program must be transparent to participants and
877 established by the vendors. The corporation may ~~shall~~ annually
878 assess a surcharge for each premium or price set by a
879 participating vendor. Any ~~The~~ surcharge may not be more than 2.5
880 percent of the price and shall be used to generate funding for
881 administrative services provided by the corporation and payments
882 to buyers' representatives; however, a surcharge may not be
883 assessed for products and services sold in the FHIX marketplace.
884 (7) THE MARKETPLACE PROCESS.—The program shall provide a
885 single, centralized market for purchase of health insurance,
886 health maintenance contracts, and other health products and
887 services. Purchases may be made by participating individuals
888 over the Internet or through the services of a participating
889 health insurance agent. Information about each product and
890 service available through the program shall be made available
891 through printed material and an interactive Internet website.
892 (a) Marketplace purchasing.—A participant needing personal
893 assistance to select products and services shall be referred to
894 a participating agent in his or her area.
895 1.~~(a)~~ Participation in the program may begin at any time
896 during a year after the employer completes enrollment and meets
897 the requirements specified by the corporation pursuant to

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898 paragraph (4)(c).
899 2.~~(b)~~ Initial selection of products and services must be
900 made by an individual participant within the applicable open
901 enrollment period.
902 3.~~(c)~~ Initial enrollment periods for each product selected
903 by an individual participant must last at least 12 months,
904 unless the individual participant specifically agrees to a
905 different enrollment period.
906 4.~~(d)~~ If an individual has selected one or more products
907 and enrolled in those products for at least 12 months or any
908 other period specifically agreed to by the individual
909 participant, changes in selected products and services may only
910 be made during the annual enrollment period established by the
911 corporation.
912 5.~~(e)~~ The limits established in subparagraphs 2., 3., and
913 4. ~~paragraphs (b)-(d)~~ apply to any risk-bearing product that
914 promises future payment or coverage for a variable amount of
915 benefits or services. The limits do not apply to initiation of
916 flexible spending plans if those plans are not associated with
917 specific high-deductible insurance policies or the use of
918 spending accounts for any products offering individual
919 participants specific amounts and types of health services and
920 treatments at a contracted price.
921 (b) FHIX marketplace purchasing.—
922 1. Participation in the FHIX marketplace may begin at any
923 time during the year.
924 2. Initial enrollment periods for certain products selected
925 by an individual enrollee which are noncompliant with the
926 Affordable Care Act may be required to last at least 12 months,

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927 unless the individual participant specifically agrees to a
928 different enrollment period.
929 (8) CONSUMER INFORMATION.—The corporation shall:
930 (a) Establish a secure website to facilitate the purchase
931 of products and services by participating individuals. The
932 website must provide information about each product or service
933 available through the program.
934 (b) Inform individuals about other public health care
935 programs.
936 (9) RISK POOLING.—The program may use methods for pooling
937 the risk of individual participants and preventing selection
938 bias. These methods may include, but are not limited to, a
939 postenrollment risk adjustment of the premium payments to the
940 vendors. The corporation may establish a methodology for
941 assessing the risk of enrolled individual participants based on
942 data reported annually by the vendors about their enrollees.
943 Distribution of payments to the vendors may be adjusted based on
944 the assessed relative risk profile of the enrollees in each
945 risk-bearing product for the most recent period for which data
946 is available.
947 (10) EXEMPTIONS.—
948 (a) Products, other than the products set forth in
949 subparagraphs (4)(d)1.-4., sold as part of the program are not
950 subject to the licensing requirements of the Florida Insurance
951 Code, as defined in s. 624.01 or the mandated offerings or
952 coverages established in part VI of chapter 627 and chapter 641.
953 (b) The corporation may act as an administrator as defined
954 in s. 626.88 but is not required to be certified pursuant to
955 part VII of chapter 626. However, a third party administrator

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956 used by the corporation must be certified under part VII of
957 chapter 626.
958 (c) Any standard forms, website design, or marketing
959 communication developed by the corporation and used by the
960 corporation, or any vendor that meets the requirements of
961 paragraph (4)(f) is not subject to the Florida Insurance Code,
962 as established in s. 624.01.
963 (11) CORPORATION.—There is created the Florida Health
964 Choices, Inc., which shall be registered, incorporated,
965 organized, and operated in compliance with part III of chapter
966 112 and chapters 119, 286, and 617. The purpose of the
967 corporation is to administer the program created in this section
968 and to conduct such other business as may further the
969 administration of the program.
970 (a) The corporation shall be governed by a 15-member board
971 of directors consisting of:
972 1. Three ex officio, nonvoting members to include:
973 a. The Secretary of Health Care Administration or a
974 designee with expertise in health care services.
975 b. The Secretary of Management Services or a designee with
976 expertise in state employee benefits.
977 c. The commissioner of the Office of Insurance Regulation
978 or a designee with expertise in insurance regulation.
979 2. Four members appointed by and serving at the pleasure of
980 the Governor.
981 3. Four members appointed by and serving at the pleasure of
982 the President of the Senate.
983 4. Four members appointed by and serving at the pleasure of
984 the Speaker of the House of Representatives.

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985 5. Board members may not include insurers, health insurance
986 agents or brokers, health care providers, health maintenance
987 organizations, prepaid service providers, or any other entity,
988 affiliate, or subsidiary of eligible vendors.
989 (b) Members shall be appointed for terms of up to 3 years.
990 Any member is eligible for reappointment. A vacancy on the board
991 shall be filled for the unexpired portion of the term in the
992 same manner as the original appointment.
993 (c) The board shall select a chief executive officer for
994 the corporation who shall be responsible for the selection of
995 such other staff as may be authorized by the corporation's
996 operating budget as adopted by the board.
997 (d) Board members are entitled to receive, from funds of
998 the corporation, reimbursement for per diem and travel expenses
999 as provided by s. 112.061. No other compensation is authorized.
1000 (e) There is no liability on the part of, and no cause of
1001 action shall arise against, any member of the board or its
1002 employees or agents for any action taken by them in the
1003 performance of their powers and duties under this section.
1004 (f) The board shall develop and adopt bylaws and other
1005 corporate procedures as necessary for the operation of the
1006 corporation and carrying out the purposes of this section. The
1007 bylaws shall:
1008 1. Specify procedures for selection of officers and
1009 qualifications for reappointment, provided that no board member
1010 shall serve more than 9 consecutive years.
1011 2. Require an annual membership meeting that provides an
1012 opportunity for input and interaction with individual
1013 participants in the program.

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1014 3. Specify policies and procedures regarding conflicts of
1015 interest, including the provisions of part III of chapter 112,
1016 which prohibit a member from participating in any decision that
1017 would inure to the benefit of the member or the organization
1018 that employs the member. The policies and procedures shall also
1019 require public disclosure of the interest that prevents the
1020 member from participating in a decision on a particular matter.
1021 (g) The corporation may exercise all powers granted to it
1022 under chapter 617 necessary to carry out the purposes of this
1023 section, including, but not limited to, the power to receive and
1024 accept grants, loans, or advances of funds from any public or
1025 private agency and to receive and accept from any source
1026 contributions of money, property, labor, or any other thing of
1027 value to be held, used, and applied for the purposes of this
1028 section.
1029 (h) The corporation may establish technical advisory panels
1030 consisting of interested parties, including consumers, health
1031 care providers, individuals with expertise in insurance
1032 regulation, and insurers.
1033 (i) The corporation shall:
1034 1. Determine eligibility of employers, vendors,
1035 individuals, and agents in accordance with subsection (4).
1036 2. Establish procedures necessary for the operation of the
1037 program, including, but not limited to, procedures for
1038 application, enrollment, risk assessment, risk adjustment, plan
1039 administration, performance monitoring, and consumer education.
1040 3. Arrange for collection of contributions from
1041 participating employers, third parties, governmental entities,
1042 and individuals.

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1043 4. Arrange for payment of premiums and other appropriate
1044 disbursements based on the selections of products and services
1045 by the individual participants.
1046 5. Establish criteria for disenrollment of participating
1047 individuals based on failure to pay the individual's share of
1048 any contribution required to maintain enrollment in selected
1049 products.
1050 6. Establish criteria for exclusion of vendors pursuant to
1051 paragraph (4)(d).
1052 7. Develop and implement a plan for promoting public
1053 awareness of and participation in the program.
1054 8. Secure staff and consultant services necessary to the
1055 operation of the program.
1056 9. Establish policies and procedures regarding
1057 participation in the program for individuals, vendors, health
1058 insurance agents, and employers.
1059 10. Provide for the operation of a toll-free hotline to
1060 respond to requests for assistance.
1061 11. Provide for initial, open, and special enrollment
1062 periods.
1063 12. Evaluate options for employer participation which may
1064 conform to ~~with~~ common insurance practices.
1065 13. Administer the Florida Health Insurance Affordability
1066 Exchange Program in accordance with ss. 409.720-409.731.
1067 14. Coordinate with the Agency for Health Care
1068 Administration, the Department of Children and Families, and the
1069 Florida Healthy Kids Corporation on the transition plan for FHIX
1070 and any subsequent transition activities.
1071 (12) REPORT.—The board of the corporation shall ~~Beginning~~

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1072 ~~in the 2009-2010 fiscal year,~~ submit by February 1 an annual
1073 report to the Governor, the President of the Senate, and the
1074 Speaker of the House of Representatives documenting the
1075 corporation's activities in compliance with the duties
1076 delineated in this section.
1077 (13) PROGRAM INTEGRITY.—To ensure program integrity and to
1078 safeguard the financial transactions made under the auspices of
1079 the program, the corporation is authorized to establish
1080 qualifying criteria and certification procedures for vendors,
1081 require performance bonds or other guarantees of ability to
1082 complete contractual obligations, monitor the performance of
1083 vendors, and enforce the agreements of the program through
1084 financial penalty or disqualification from the program.
1085 (14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—
1086 (a) *Definitions.*—For purposes of this subsection, the term:
1087 1. "Buyer's representative" means a participating insurance
1088 agent as described in paragraph (4)(g).
1089 2. "Enrollee" means an employer who is eligible to enroll
1090 in the program pursuant to paragraph (4)(a).
1091 3. "Participant" means an individual who is eligible to
1092 participate in the program pursuant to paragraph (4)(b).
1093 4. "Proprietary confidential business information" means
1094 information, regardless of form or characteristics, that is
1095 owned or controlled by a vendor requesting confidentiality under
1096 this section; that is intended to be and is treated by the
1097 vendor as private in that the disclosure of the information
1098 would cause harm to the business operations of the vendor; that
1099 has not been disclosed unless disclosed pursuant to a statutory
1100 provision, an order of a court or administrative body, or a

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1101 private agreement providing that the information may be released
1102 to the public; and that is information concerning:
1103 a. Business plans.
1104 b. Internal auditing controls and reports of internal
1105 auditors.
1106 c. Reports of external auditors for privately held
1107 companies.
1108 d. Client and customer lists.
1109 e. Potentially patentable material.
1110 f. A trade secret as defined in s. 688.002.
1111 5. “Vendor” means a participating insurer or other provider
1112 of services as described in paragraph (4)(d).
1113 (b) *Public record exemptions.*—
1114 1. Personal identifying information of an enrollee or
1115 participant who has applied for or participates in the Florida
1116 Health Choices Program is confidential and exempt from s.
1117 119.07(1) and s. 24(a), Art. I of the State Constitution.
1118 2. Client and customer lists of a buyer’s representative
1119 held by the corporation are confidential and exempt from s.
1120 119.07(1) and s. 24(a), Art. I of the State Constitution.
1121 3. Proprietary confidential business information held by
1122 the corporation is confidential and exempt from s. 119.07(1) and
1123 s. 24(a), Art. I of the State Constitution.
1124 (c) *Retroactive application.*—The public record exemptions
1125 provided for in paragraph (b) apply to information held by the
1126 corporation before, on, or after the effective date of this
1127 exemption.
1128 (d) *Authorized release.*—
1129 1. Upon request, information made confidential and exempt

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1130 pursuant to this subsection shall be disclosed to:
1131 a. Another governmental entity in the performance of its
1132 official duties and responsibilities.
1133 b. Any person who has the written consent of the program
1134 applicant.
1135 c. The Florida Kidcare program for the purpose of
1136 administering the program authorized in ss. 409.810-409.821.
1137 2. Paragraph (b) does not prohibit a participant's legal
1138 guardian from obtaining confirmation of coverage, dates of
1139 coverage, the name of the participant's health plan, and the
1140 amount of premium being paid.
1141 (e) *Penalty.*—A person who knowingly and willfully violates
1142 this subsection commits a misdemeanor of the second degree,
1143 punishable as provided in s. 775.082 or s. 775.083.
1144 (f) *Review and repeal.*—This subsection is subject to the
1145 Open Government Sunset Review Act in accordance with s. 119.15,
1146 and shall stand repealed on October 2, 2016, unless reviewed and
1147 saved from repeal through reenactment by the Legislature.
1148 Section 16. Subsection (2) of section 409.904, Florida
1149 Statutes, is amended to read:
1150 409.904 Optional payments for eligible persons.—The agency
1151 may make payments for medical assistance and related services on
1152 behalf of the following persons who are determined to be
1153 eligible subject to the income, assets, and categorical
1154 eligibility tests set forth in federal and state law. Payment on
1155 behalf of these Medicaid eligible persons is subject to the
1156 availability of moneys and any limitations established by the
1157 General Appropriations Act or chapter 216.
1158 (2) A family, a pregnant woman, a child under age 21, a

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1159 person age 65 or over, or a blind or disabled person, who would
1160 be eligible under any group listed in s. 409.903(1), (2), or
1161 (3), except that the income or assets of such family or person
1162 exceed established limitations. For a family or person in one of
1163 these coverage groups, medical expenses are deductible from
1164 income in accordance with federal requirements in order to make
1165 a determination of eligibility. A family or person eligible
1166 under the coverage known as the "medically needy," is eligible
1167 to receive the same services as other Medicaid recipients, with
1168 the exception of services in skilled nursing facilities and
1169 intermediate care facilities for the developmentally disabled.
1170
1171 Effective October 1, 2015, no new enrollees over the age of 20
1172 may be enrolled under this subsection. This subsection expires
1173 September 30, 2019.
1174 Section 17. Section 624.91, Florida Statutes, is amended to
1175 read:
1176 624.91 The Florida Healthy Kids Corporation Act.—
1177 (1) SHORT TITLE.—This section may be cited as the "William
1178 G. 'Doc' Myers Healthy Kids Corporation Act."
1179 (2) LEGISLATIVE INTENT.—
1180 (a) The Legislature finds that increased access to health
1181 care services could improve children's health and reduce the
1182 incidence and costs of childhood illness and disabilities among
1183 children in this state. Many children do not have comprehensive,
1184 affordable health care services available. It is the intent of
1185 the Legislature that the Florida Healthy Kids Corporation
1186 provide comprehensive health insurance coverage to such
1187 children. The corporation is encouraged to cooperate with any

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1188 existing health service programs funded by the public or the
1189 private sector.
1190 (b) It is the intent of the Legislature that the Florida
1191 Healthy Kids Corporation serve as one of several providers of
1192 services to children eligible for medical assistance under Title
1193 XXI of the Social Security Act. Although the corporation may
1194 serve other children, the Legislature intends the primary
1195 recipients of services provided through the corporation be
1196 school-age children with a family income below 200 percent of
1197 the federal poverty level, who do not qualify for Medicaid. It
1198 is also the intent of the Legislature that state and local
1199 government Florida Healthy Kids funds be used to continue
1200 coverage, subject to specific appropriations in the General
1201 Appropriations Act, to children not eligible for federal
1202 matching funds under Title XXI.
1203 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only residents
1204 of this state are eligible ~~the following individuals are~~
1205 ~~eligible~~ for state-funded assistance in paying Florida Healthy
1206 Kids premiums pursuant to s. 409.814.~~:~~
1207 ~~(a) Residents of this state who are eligible for the~~
1208 ~~Florida Kidcare program pursuant to s. 409.814.~~
1209 ~~(b) Notwithstanding s. 409.814, legal aliens who are~~
1210 ~~enrolled in the Florida Healthy Kids program as of January 31,~~
1211 ~~2004, who do not qualify for Title XXI federal funds because~~
1212 ~~they are not qualified aliens as defined in s. 409.811.~~
1213 (4) NONENTITLEMENT.—Nothing in this section shall be
1214 construed as providing an individual with an entitlement to
1215 health care services. No cause of action shall arise against the
1216 state, the Florida Healthy Kids Corporation, or a unit of local

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1217 government for failure to make health services available under
1218 this section.
1219 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—
1220 (a) There is created the Florida Healthy Kids Corporation,
1221 a not-for-profit corporation.
1222 (b) The Florida Healthy Kids Corporation shall:
1223 1. Arrange for the collection of any individual, family,
1224 ~~local contributions,~~ or employer payment or premium, in an
1225 amount to be determined by the board of directors, to provide
1226 for payment of premiums for comprehensive insurance coverage and
1227 for the actual or estimated administrative expenses.
1228 2. Arrange for the collection of any voluntary
1229 contributions to provide for payment of Florida Kidcare program
1230 or Florida Health Insurance Affordability Exchange Program
1231 premiums ~~for children who are not eligible for medical~~
1232 ~~assistance under Title XIX or Title XXI of the Social Security~~
1233 ~~Act~~.
1234 3. ~~Subject to the provisions of s. 409.8134, accept~~
1235 ~~voluntary supplemental local match contributions that comply~~
1236 ~~with the requirements of Title XXI of the Social Security Act~~
1237 ~~for the purpose of providing additional Florida Kidcare coverage~~
1238 ~~in contributing counties under Title XXI.~~
1239 ~~4.~~ Establish the administrative and accounting procedures
1240 for the operation of the corporation.
1241 4.~~5.~~ Establish, with consultation from appropriate
1242 professional organizations, standards for preventive health
1243 services and providers and comprehensive insurance benefits
1244 appropriate to children, provided that such standards for rural
1245 areas shall not limit primary care providers to board-certified

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pediatricians.

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

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

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

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

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

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

b. The maximum administrative cost for a Florida Healthy

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1275 Kids Corporation contract shall be 15 percent. For health and
1276 dental care contracts, the minimum medical loss ratio for a
1277 Florida Healthy Kids Corporation contract shall be 85 percent.
1278 The calculations must use uniform financial data collected from
1279 all plans in a format established by the corporation and shall
1280 be computed for each plan on a statewide basis. Funds shall be
1281 classified in a manner consistent with 45 C.F.R. part 158 ~~For~~
1282 ~~dental contracts, the remaining compensation to be paid to the~~
1283 ~~authorized insurer or provider under a Florida Healthy Kids~~
1284 ~~Corporation contract shall be no less than an amount which is 85~~
1285 ~~percent of premium; to the extent any contract provision does~~
1286 ~~not provide for this minimum compensation, this section shall~~
1287 ~~prevail~~.
1288 c. The health plan selection criteria and scoring system,
1289 and the scoring results, shall be available upon request for
1290 inspection after the bids have been awarded.
1291 d. Effective July 1, 2016, health and dental services
1292 contracts of the corporation must transition to the FHIX
1293 marketplace under s. 409.722. Qualifying plans may enroll as
1294 vendors with the FHIX marketplace to maintain continuity of care
1295 for participants.
1296 10.~~11.~~ Establish disenrollment criteria in the event ~~local~~
1297 ~~matching~~ funds are insufficient to cover enrollments.
1298 11.~~12.~~ Develop and implement a plan to publicize the
1299 Florida Kidcare program, the eligibility requirements of the
1300 program, and the procedures for enrollment in the program and to
1301 maintain public awareness of the corporation and the program.
1302 12.~~13.~~ Secure staff necessary to properly administer the
1303 corporation. Staff costs shall be funded from state ~~and local~~

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1304 ~~matching funds~~ and such other private or public funds as become
1305 available. The board of directors shall determine the number of
1306 staff members necessary to administer the corporation.
1307 13.~~14.~~ In consultation with the partner agencies, provide a
1308 report on the Florida Kidcare program annually to the Governor,
1309 the Chief Financial Officer, the Commissioner of Education, the
1310 President of the Senate, the Speaker of the House of
1311 Representatives, and the Minority Leaders of the Senate and the
1312 House of Representatives.
1313 14.~~15.~~ Provide information on a quarterly basis online to
1314 the Legislature and the Governor which compares the costs and
1315 utilization of the full-pay enrolled population and the Title
1316 XXI-subsidized enrolled population in the Florida Kidcare
1317 program. The information, at a minimum, must include:
1318 a. The monthly enrollment and expenditure for full-pay
1319 enrollees in the Medikids and Florida Healthy Kids programs
1320 compared to the Title XXI-subsidized enrolled population; and
1321 b. The costs and utilization by service of the full-pay
1322 enrollees in the Medikids and Florida Healthy Kids programs and
1323 the Title XXI-subsidized enrolled population.
1324 15.~~16.~~ Establish benefit packages that conform to the
1325 provisions of the Florida Kidcare program, as created in ss.
1326 409.810-409.821.
1327 16. Contract with other insurance affordability programs
1328 and FHIX to provide customer service or other enrollment-focused
1329 services.
1330 17. Annually develop performance metrics for the following
1331 focus areas:
1332 a. Administrative functions.

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1333 b. Contracting with vendors.
1334 c. Customer service.
1335 d. Enrollee education.
1336 e. Financial services.
1337 f. Program integrity.
1338 (c) Coverage under the corporation’s program is secondary
1339 to any other available private coverage held by, or applicable
1340 to, the participant child or family member. Insurers under
1341 contract with the corporation are the payors of last resort and
1342 must coordinate benefits with any other third-party payor that
1343 may be liable for the participant’s medical care.
1344 (d) The Florida Healthy Kids Corporation shall be a private
1345 corporation not for profit, organized pursuant to chapter 617,
1346 and shall have all powers necessary to carry out the purposes of
1347 this act, including, but not limited to, the power to receive
1348 and accept grants, loans, or advances of funds from any public
1349 or private agency and to receive and accept from any source
1350 contributions of money, property, labor, or any other thing of
1351 value, to be held, used, and applied for the purposes of this
1352 act.
1353 (6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—
1354 (a) The Florida Healthy Kids Corporation shall operate
1355 subject to the supervision and approval of a board of directors.
1356 The board chair shall be an appointee designated by the
1357 Governor, and the board shall be ~~chaired by the~~ ~~Chief Financial~~
1358 ~~Officer or her or his designee, and~~ composed of 12 other
1359 members. The Senate shall confirm the designated chair and other
1360 board appointees. The board members shall be appointed ~~selected~~
1361 for 3-year terms. ~~of office as follows:~~

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1362 ~~1. The Secretary of Health Care Administration, or his or~~
1363 ~~her designee.~~
1364 ~~2. One member appointed by the Commissioner of Education~~
1365 ~~from the Office of School Health Programs of the Florida~~
1366 ~~Department of Education.~~
1367 ~~3. One member appointed by the Chief Financial Officer from~~
1368 ~~among three members nominated by the Florida Pediatric Society.~~
1369 ~~4. One member, appointed by the Governor, who represents~~
1370 ~~the Children's Medical Services Program.~~
1371 ~~5. One member appointed by the Chief Financial Officer from~~
1372 ~~among three members nominated by the Florida Hospital~~
1373 ~~Association.~~
1374 ~~6. One member, appointed by the Governor, who is an expert~~
1375 ~~on child health policy.~~
1376 ~~7. One member, appointed by the Chief Financial Officer,~~
1377 ~~from among three members nominated by the Florida Academy of~~
1378 ~~Family Physicians.~~
1379 ~~8. One member, appointed by the Governor, who represents~~
1380 ~~the state Medicaid program.~~
1381 ~~9. One member, appointed by the Chief Financial Officer,~~
1382 ~~from among three members nominated by the Florida Association of~~
1383 ~~Counties.~~
1384 ~~10. The State Health Officer or her or his designee.~~
1385 ~~11. The Secretary of Children and Families, or his or her~~
1386 ~~designee.~~
1387 ~~12. One member, appointed by the Governor, from among three~~
1388 ~~members nominated by the Florida Dental Association.~~
1389 (b) A member of the board of directors serves at the
1390 pleasure of the Governor ~~may be removed by the official who~~

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1391 ~~appointed that member~~. The board shall appoint an executive
1392 director, who is responsible for other staff authorized by the
1393 board.
1394 (c) Board members are entitled to receive, from funds of
1395 the corporation, reimbursement for per diem and travel expenses
1396 as provided by s. 112.061.
1397 (d) There shall be no liability on the part of, and no
1398 cause of action shall arise against, any member of the board of
1399 directors, or its employees or agents, for any action they take
1400 in the performance of their powers and duties under this act.
1401 (e) Board members who are serving as of the effective date
1402 of this act may remain on the board until January 1, 2016.
1403 (7) LICENSING NOT REQUIRED; FISCAL OPERATION.—
1404 (a) The corporation shall not be deemed an insurer. The
1405 officers, directors, and employees of the corporation shall not
1406 be deemed to be agents of an insurer. Neither the corporation
1407 nor any officer, director, or employee of the corporation is
1408 subject to the licensing requirements of the insurance code or
1409 the rules of the Department of Financial Services. However, any
1410 marketing representative utilized and compensated by the
1411 corporation must be appointed as a representative of the
1412 insurers or health services providers with which the corporation
1413 contracts.
1414 (b) The board has complete fiscal control over the
1415 corporation and is responsible for all corporate operations.
1416 (c) The Department of Financial Services shall supervise
1417 any liquidation or dissolution of the corporation and shall
1418 have, with respect to such liquidation or dissolution, all power
1419 granted to it pursuant to the insurance code.

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1420 (8) TRANSITION PLANS.—The corporation shall confer with the
1421 Agency for Health Care Administration, the Department of
1422 Children and Families, and Florida Health Choices, Inc., to
1423 develop transition plans for the Florida Health Insurance
1424 Affordability Exchange Program as created under ss. 409.720-
1425 409.731.
1426 Section 18. Section 624.915, Florida Statutes, is repealed.
1427 Section 19. The Division of Law Revision and Information is
1428 directed to replace the phrase "the effective date of this act"
1429 wherever it occurs in this act with the date the act becomes a
1430 law.
1431 Section 20. This act shall take effect upon becoming a law.