

By the Committee on Health Policy

588-02139-15

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

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30 Health Choices Program and the pricing of services
31 under the program; providing requirements for
32 operation of the marketplace; providing additional
33 duties for the corporation to perform; requiring an
34 annual report to the Governor and the Legislature;
35 amending s. 409.904, F.S.; removing certain Medicaid-
36 eligible persons from those for whom the agency may
37 make payments for medical assistance and related
38 services; 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
57 as the "Florida Health Insurance Affordability Exchange Program"
58 or "FHIX."

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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
86 term:

87 (1) "Agency" means the Agency for Health Care

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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
115 through the FHIX marketplace who lost coverage through the
116 marketplace for non-payment, but maintains access to his or her

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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 FHI.

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 FHI, an
 143 individual must be a resident and must meet the following
 144 requirements, as applicable:

145 (a) Qualify as a newly eligible enrollee, who must be an

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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 FHIIX, 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 FHIIX 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
173 participant's economic circumstances change.

174 (c) Retention of applicable unspent credits in the

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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, which includes proof of
187 employment, on-the-job training or placement activities, or
188 pursuit of educational opportunities at the following hourly
189 levels:

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

192 2. For a childless adult, a minimum of 30 hours weekly. A
193 disabled adult or caregiver of a disabled child or adult may
194 submit a request for an exception to these requirements to the
195 corporation. A participant shall annually submit to the
196 department such a request for an exception to the hourly level
197 requirements.

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

201 (c) Execute a contract with the department to acknowledge
202 that:

203 1. FHIX is not an entitlement and state and federal funding

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204 may end at any time;

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

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

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

210 (e) Comply with all program rules and the prohibitions
211 against fraud, as described in s. 414.39.

212 (f) Make monthly premium and any other cost-sharing
213 payments by the deadline.

214 (g) Meet minimum coverage requirements by selecting a high-
215 deductible health plan combined with a health savings or health
216 reimbursement account if not selecting a plan with more
217 extensive coverage.

218 (5) COST SHARING.-

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

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

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

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

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

229 5. Greater than 100 percent of the federal poverty level:
230 \$25.

231 (b) Depending on the products and services selected by the
232 enrollee, the enrollee may also incur additional cost-sharing,

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233 such as copayments, deductibles, or other out-of-pocket costs.

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

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

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

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

250 409.724 Available assistance.—

251 (1) PREMIUM CREDITS.—

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

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

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

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262 unexpended funds from the monthly premium credit must be
263 deposited into each enrollee's individual account in a timely
264 manner. Enrollees may also be rewarded for healthy behaviors,
265 adherence to wellness programs, and other activities established
266 by the corporation which demonstrate compliance with prevention
267 or disease management guidelines. Funds deposited into these
268 accounts may be used to pay cost-sharing obligations or to
269 purchase other health-related items to the extent permitted
270 under federal law.

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

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

281 (2) CHOICE COUNSELING.—The agency and the corporation shall
282 work together to develop a choice counseling program for FHIx.
283 The choice counseling program must ensure that participants have
284 information about the FHIx marketplace program, products, and
285 services and that participants know where and whom to call for
286 questions or to make their plan selections. The choice
287 counseling program must provide culturally sensitive materials
288 and must take into consideration the demographics of the
289 projected population.

290 (3) EDUCATION CAMPAIGN.—The agency, the corporation, and

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291 the Florida Healthy Kids Corporation must coordinate an ongoing
292 enrollee education campaign beginning in Phase One, as provided
293 in s. 409.27, informing participants, at a minimum:

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

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

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

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

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

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

307 (4) CUSTOMER SUPPORT.—Beginning in Phase Two, the Florida
308 Healthy Kids Corporation shall provide customer support for
309 FHIIX, shall address general program information, financial
310 information, and customer service issues, and shall provide
311 status updates on bill payments. Customer support must also
312 provide a toll-free number and maintain a website that is
313 available in multiple languages and that meets the needs of the
314 enrollee population.

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

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

322 409.725 Available products and services.—The FHIX
323 marketplace shall offer the following products and services:

324 (1) Authorized products and services pursuant to s.
325 408.910.

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

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

330 (4) Employer-sponsored plans.

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

333 409.726 Program accountability.—

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

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

346 (3) The department shall develop accountability measures
347 and performance standards to be applied to applications and
348 renewal applications for FHIX which are submitted online, by

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349 mail, by fax, or through referrals from a third party. The
350 minimum performance standards are:

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

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

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

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

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

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

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

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

374 (5) The agency, the department, and the Florida Healthy
375 Kids Corporation must conduct an annual satisfaction survey to
376 address all measures that require participant input specific to
377 the FHIIX marketplace program. The parties may elect to

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378 incorporate these elements into the annual report required under
379 subsection (7).

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

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

387 (a) Enrollment and application trends and issues.

388 (b) Utilization and cost data.

389 (c) Customer satisfaction.

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

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

394 (f) Types of products and plans purchased.

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

397 (h) Recommendations for program improvement.

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

400 409.727 Implementation schedule.—The agency, the
401 corporation, the department, and the Florida Healthy Kids
402 Corporation shall begin implementation of FHIIX by the effective
403 date of this act, with statewide implementation in all regions,
404 as described in s. 409.966(2), by January 1, 2016.

405 (1) READINESS REVIEW.—Before implementation of any phase
406 under this section, the agency shall conduct a readiness review

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407 in consultation with the FHI Workgroup described in s. 409.729.
408 The agency must determine, at a minimum, the following readiness
409 milestones:

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

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

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

415 (d) Availability of customer support.

416 (e) Other factors critical to the success of FHI.

417 (2) PHASE ONE.—

418 (a) Phase One begins on July 1, 2015. The agency, the
419 corporation, the department, and the Florida Healthy Kids
420 Corporation shall coordinate activities to ensure that
421 enrollment begins by July 1, 2015.

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

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

428 (d) An enrollee shall have a choice of at least two managed
429 care plans in each region.

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

432 (3) PHASE TWO.—

433 (a) Beginning no later than January 1, 2016, and contingent
434 upon federal approval, participants may enroll or transition to
435 health benefits coverage under the FHI marketplace.

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

438 (c) An enrollee may select any benefit, service, or product
439 available.

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

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

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

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

453 (4) PHASE THREE.—

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

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

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

461 (d) A Florida Healthy Kids enrollee who selects a FHIIX
462 marketplace plan must be provided a premium credit equivalent to
463 the average capitation rate paid in his or her county of
464 residence under Florida Healthy Kids as of June 30, 2016. The

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465 enrollee is responsible for any difference in costs and may use
466 any remaining funds for supplemental benefits on the FHI
467 marketplace.

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

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

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

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

477 409.728 Program operation and management.—In order to
478 implement ss. 409.720-409.731:

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

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

486 (b) Administer Phase One of FHI.

487 (c) Provide administrative support to the FHI Workgroup
488 under s. 409.729.

489 (d) Transition the FHI enrollees to the FHI marketplace
490 beginning January 1, 2016, in accordance with the transition
491 workplan. Stakeholders that serve low-income individuals and
492 families must be consulted during the implementation and
493 transition process through a public input process. All regions

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494 must complete the transition no later than April 1, 2016.

495 (e) Timely transmit enrollee information to the
496 corporation.

497 (f) Beginning with Phase Two, determine annually the risk-
498 adjusted rate to be paid per month based on historical
499 utilization and spending data for the medical and behavioral
500 health of this population, projected forward, and adjusted to
501 reflect the eligibility category, medical and dental trends,
502 geographic areas, and the clinical risk profile of the
503 enrollees.

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

506 (h) Encourage Medicaid managed care plans to apply as
507 vendors to the marketplace to facilitate continuity of care and
508 family care coordination.

509 (2) The Department of Children and Families shall, in
510 coordination with the corporation, the agency, and the Florida
511 Healthy Kids Corporation, determine eligibility of applications
512 and application renewals for FHIIX in accordance with s. 409.902
513 and shall transmit eligibility determination information on a
514 timely basis to the agency and corporation.

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

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

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

521 (c) Transfer funds and provide financial support to the
522 FHIIX marketplace, including the collection of monthly cost

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523 sharing.

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

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

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

530 (a) Begin the development of FHIX during Phase One.

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

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

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

539 (e) Provide an opportunity for participation in Medicaid
540 managed care plans if those plans meet the requirements of the
541 FHIX marketplace.

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

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

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

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

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552 409.729 Long-term reorganization.—The FHIX Workgroup is
553 created to facilitate the implementation of FHIX and to plan for
554 a multiyear reorganization of the state’s insurance
555 affordability programs. The FHIX Workgroup consists of two
556 representatives each from the agency, the department, the
557 Florida Healthy Kids Corporation, and the corporation. An
558 additional representative of the agency serves as chair. The
559 FHIX Workgroup must hold its organizational meeting no later
560 than 30 days after the effective date of this act and must meet
561 at least bimonthly. The role of the FHIX Workgroup is to make
562 recommendations to the agency. The responsibilities of the
563 workgroup include, but are not limited to:

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

566 (2) Review network and access standards for plans and
567 products.

568 (3) Assess readiness and recommend actions needed to
569 reorganize the state’s insurance affordability programs for each
570 phase or region. If a phase or region receives a nonreadiness
571 recommendation, the agency must notify the Legislature of that
572 recommendation, the reasons for such a recommendation, and
573 proposed plans for achieving readiness.

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

578 (5) Identify duplication of services among the corporation,
579 the agency, and the Florida Healthy Kids Corporation currently
580 and under FHIX’s proposed Phase Three program.

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

583 (7) Compile a schedule of impacted contracts, leases, and
584 other assets.

585 (8) Determine staff requirements for Phase Three.

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

590 Section 12. Section 409.730, Florida Statutes, is created
591 to read:

592 409.730 Federal participation.—The agency may seek federal
593 approval to implement FHI.

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

596 409.731 Program expiration.—The Florida Health Insurance
597 Affordability Exchange Program expires at the end of Phase One
598 if the state does not receive federal approval for Phase Two or
599 at the end of the state fiscal year in which any of these
600 conditions occurs:

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

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

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

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

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

613 408.910 Florida Health Choices Program.—

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

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

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

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

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

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

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

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

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

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

642 (c) "Florida Health Insurance Affordability Exchange
643 Program" or "FHIX" is the program created under ss. 409.720-
644 409.731 for low-income, uninsured residents of this state.

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

647 (e)~~(d)~~ "Insurer" means an entity licensed under chapter 624
648 which offers an individual health insurance policy or a group
649 health insurance policy, a preferred provider organization as
650 defined in s. 627.6471, an exclusive provider organization as
651 defined in s. 627.6472, ~~or~~ a health maintenance organization
652 licensed under part I of chapter 641, ~~or~~ a prepaid limited
653 health service organization or discount medical plan
654 organization licensed under chapter 636, or a managed care plan
655 contracted with the Agency for Health Care Administration under
656 the managed medical assistance program under part IV of chapter
657 409.

658 (f) "Patient Protection and Affordable Care Act" or
659 "Affordable Care Act" means Pub. L. No. 111-148, as further
660 amended by the Health Care and Education Reconciliation Act of
661 2010, Pub. L. No. 111-152, and any amendments to or regulations
662 or guidance under those acts.

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

665 (3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health
666 Choices Program is created as a single, centralized market for
667 the sale and purchase of various products that enable

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

673 (a) Enrollment of employers.

674 (b) Administrative services for participating employers,
675 including:

676 1. Assistance in seeking federal approval of cafeteria
677 plans.

678 2. Collection of premiums and other payments.

679 3. Management of individual benefit accounts.

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

682 5. Assistance for participants in complying with reporting
683 requirements.

684 (c) Services to individual participants, including:

685 1. Information about available products and participating
686 vendors.

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

691 3. Account information to assist individual participants
692 with managing available resources.

693 4. Services that promote healthy behaviors.

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

696 6. Consumer assistance and enrollment services for the

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697 Florida Health Insurance Affordability Exchange Program, or
698 FHIX.

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

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

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

706 (g) Information services for individuals and employers.

707 (h) Program evaluation.

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

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

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

718 1. Individual employees of enrolled employers.

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

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

725 1. Submission of required information.

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

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

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

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

740 6. Identification of eligible employees.

741 7. Arrangement for periodic payments.

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

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

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

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

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

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

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

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

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

777
778 A vendor described in subparagraphs 3.-7. may not sell products
779 that provide risk-bearing coverage unless that vendor is
780 authorized under a certificate of authority issued by the Office
781 of Insurance Regulation and is authorized to provide coverage in
782 the relevant geographic area. Otherwise eligible vendors may be
783 excluded from participating in the program for deceptive or

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784 predatory practices, financial insolvency, or failure to comply
785 with the terms of the participation agreement or other standards
786 set by the corporation.

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

- 791 1. Submission of required information.
- 792 2. Authorization for payroll deduction, if applicable.
- 793 3. Compliance with federal tax requirements.
- 794 4. Arrangements for payment.
- 795 5. Selection of products and services.

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

- 800 1. Submission of required information, including a complete
801 description of the coverage, services, provider network, payment
802 restrictions, and other requirements of each product offered
803 through the program.
- 804 2. Execution of an agreement to comply with requirements
805 established by the corporation.
- 806 3. Execution of an agreement that prohibits refusal to sell
807 any offered product or service to a participant who elects to
808 buy it.
- 809 4. Establishment of product prices based on applicable
810 criteria.
- 811 5. Arrangements for receiving payment for enrolled
812 participants.

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813 6. Participation in ongoing reporting processes established
814 by the corporation.

815 7. Compliance with grievance procedures established by the
816 corporation.

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

832 1. Completion of training requirements.

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

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

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

839 (5) PRODUCTS.—

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

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- 842 1. Health insurance policies.
- 843 2. Health maintenance contracts.
- 844 3. Limited benefit plans.
- 845 4. Prepaid clinic services.
- 846 5. Service contracts.
- 847 6. Arrangements for purchase of specific amounts and types
- 848 of health services and treatments.
- 849 7. Flexible spending accounts.
- 850 (b) Health insurance policies, health maintenance
- 851 contracts, limited benefit plans, prepaid service contracts, and
- 852 other contracts for services must ensure the availability of
- 853 covered services.
- 854 (c) Products may be offered for multiyear periods provided
- 855 the price of the product is specified for the entire period or
- 856 for each separately priced segment of the policy or contract.
- 857 (d) The corporation shall provide a disclosure form for
- 858 consumers to acknowledge their understanding of the nature of,
- 859 and any limitations to, the benefits provided by the products
- 860 and services being purchased by the consumer.
- 861 (e) The corporation must determine that making the plan
- 862 available through the program is in the interest of eligible
- 863 individuals and eligible employers in the state.
- 864 (6) PRICING.—Prices for the products and services sold
- 865 through the program must be transparent to participants and
- 866 established by the vendors. The corporation may ~~shall~~ annually
- 867 assess a surcharge for each premium or price set by a
- 868 participating vendor. Any ~~The~~ surcharge may not be more than 2.5
- 869 percent of the price and shall be used to generate funding for
- 870 administrative services provided by the corporation and payments

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871 to buyers' representatives; however, a surcharge may not be
872 assessed for products and services sold in the FHI marketplace.

873 (7) THE MARKETPLACE PROCESS.—The program shall provide a
874 single, centralized market for purchase of health insurance,
875 health maintenance contracts, and other health products and
876 services. Purchases may be made by participating individuals
877 over the Internet or through the services of a participating
878 health insurance agent. Information about each product and
879 service available through the program shall be made available
880 through printed material and an interactive Internet website.

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

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

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

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

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

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900 corporation.

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

910 (b) FHIR marketplace purchasing.-

911 1. Participation in the FHIR marketplace may begin at any
912 time during the year.

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

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

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

923 (b) Inform individuals about other public health care
924 programs.

925 (9) RISK POOLING.—The program may use methods for pooling
926 the risk of individual participants and preventing selection
927 bias. These methods may include, but are not limited to, a
928 postenrollment risk adjustment of the premium payments to the

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929 vendors. The corporation may establish a methodology for
930 assessing the risk of enrolled individual participants based on
931 data reported annually by the vendors about their enrollees.
932 Distribution of payments to the vendors may be adjusted based on
933 the assessed relative risk profile of the enrollees in each
934 risk-bearing product for the most recent period for which data
935 is available.

936 (10) EXEMPTIONS.—

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

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

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

952 (11) CORPORATION.—There is created the Florida Health
953 Choices, Inc., which shall be registered, incorporated,
954 organized, and operated in compliance with part III of chapter
955 112 and chapters 119, 286, and 617. The purpose of the
956 corporation is to administer the program created in this section
957 and to conduct such other business as may further the

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958 administration of the program.

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

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

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

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

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

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

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

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

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

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

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

986 (d) Board members are entitled to receive, from funds of

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987 the corporation, reimbursement for per diem and travel expenses
988 as provided by s. 112.061. No other compensation is authorized.

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

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

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

1000 2. Require an annual membership meeting that provides an
1001 opportunity for input and interaction with individual
1002 participants in the program.

1003 3. Specify policies and procedures regarding conflicts of
1004 interest, including the provisions of part III of chapter 112,
1005 which prohibit a member from participating in any decision that
1006 would inure to the benefit of the member or the organization
1007 that employs the member. The policies and procedures shall also
1008 require public disclosure of the interest that prevents the
1009 member from participating in a decision on a particular matter.

1010 (g) The corporation may exercise all powers granted to it
1011 under chapter 617 necessary to carry out the purposes of this
1012 section, including, but not limited to, the power to receive and
1013 accept grants, loans, or advances of funds from any public or
1014 private agency and to receive and accept from any source
1015 contributions of money, property, labor, or any other thing of

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1016 value to be held, used, and applied for the purposes of this
1017 section.

1018 (h) The corporation may establish technical advisory panels
1019 consisting of interested parties, including consumers, health
1020 care providers, individuals with expertise in insurance
1021 regulation, and insurers.

1022 (i) The corporation shall:

1023 1. Determine eligibility of employers, vendors,
1024 individuals, and agents in accordance with subsection (4).

1025 2. Establish procedures necessary for the operation of the
1026 program, including, but not limited to, procedures for
1027 application, enrollment, risk assessment, risk adjustment, plan
1028 administration, performance monitoring, and consumer education.

1029 3. Arrange for collection of contributions from
1030 participating employers, third parties, governmental entities,
1031 and individuals.

1032 4. Arrange for payment of premiums and other appropriate
1033 disbursements based on the selections of products and services
1034 by the individual participants.

1035 5. Establish criteria for disenrollment of participating
1036 individuals based on failure to pay the individual's share of
1037 any contribution required to maintain enrollment in selected
1038 products.

1039 6. Establish criteria for exclusion of vendors pursuant to
1040 paragraph (4) (d).

1041 7. Develop and implement a plan for promoting public
1042 awareness of and participation in the program.

1043 8. Secure staff and consultant services necessary to the
1044 operation of the program.

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1045 9. Establish policies and procedures regarding
1046 participation in the program for individuals, vendors, health
1047 insurance agents, and employers.

1048 10. Provide for the operation of a toll-free hotline to
1049 respond to requests for assistance.

1050 11. Provide for initial, open, and special enrollment
1051 periods.

1052 12. Evaluate options for employer participation which may
1053 conform to ~~with~~ common insurance practices.

1054 13. Administer the Florida Health Insurance Affordability
1055 Exchange Program in accordance with ss. 409.720-409.731.

1056 14. Coordinate with the Agency for Health Care
1057 Administration, the Department of Children and Families, and the
1058 Florida Healthy Kids Corporation on the transition plan for FHIX
1059 and any subsequent transition activities.

1060 (12) REPORT.—The board of the corporation shall ~~Beginning~~
1061 ~~in the 2009-2010 fiscal year,~~ submit by February 1 an annual
1062 report to the Governor, the President of the Senate, and the
1063 Speaker of the House of Representatives documenting the
1064 corporation's activities in compliance with the duties
1065 delineated in this section.

1066 (13) PROGRAM INTEGRITY.—To ensure program integrity and to
1067 safeguard the financial transactions made under the auspices of
1068 the program, the corporation is authorized to establish
1069 qualifying criteria and certification procedures for vendors,
1070 require performance bonds or other guarantees of ability to
1071 complete contractual obligations, monitor the performance of
1072 vendors, and enforce the agreements of the program through
1073 financial penalty or disqualification from the program.

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1074 (14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—

1075 (a) *Definitions.*—For purposes of this subsection, the term:

1076 1. "Buyer's representative" means a participating insurance
1077 agent as described in paragraph (4) (g).

1078 2. "Enrollee" means an employer who is eligible to enroll
1079 in the program pursuant to paragraph (4) (a).

1080 3. "Participant" means an individual who is eligible to
1081 participate in the program pursuant to paragraph (4) (b).

1082 4. "Proprietary confidential business information" means
1083 information, regardless of form or characteristics, that is
1084 owned or controlled by a vendor requesting confidentiality under
1085 this section; that is intended to be and is treated by the
1086 vendor as private in that the disclosure of the information
1087 would cause harm to the business operations of the vendor; that
1088 has not been disclosed unless disclosed pursuant to a statutory
1089 provision, an order of a court or administrative body, or a
1090 private agreement providing that the information may be released
1091 to the public; and that is information concerning:

1092 a. Business plans.

1093 b. Internal auditing controls and reports of internal
1094 auditors.

1095 c. Reports of external auditors for privately held
1096 companies.

1097 d. Client and customer lists.

1098 e. Potentially patentable material.

1099 f. A trade secret as defined in s. 688.002.

1100 5. "Vendor" means a participating insurer or other provider
1101 of services as described in paragraph (4) (d).

1102 (b) *Public record exemptions.*—

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1103 1. Personal identifying information of an enrollee or
 1104 participant who has applied for or participates in the Florida
 1105 Health Choices Program is confidential and exempt from s.
 1106 119.07(1) and s. 24(a), Art. I of the State Constitution.

1107 2. Client and customer lists of a buyer's representative
 1108 held by the corporation are confidential and exempt from s.
 1109 119.07(1) and s. 24(a), Art. I of the State Constitution.

1110 3. Proprietary confidential business information held by
 1111 the corporation is confidential and exempt from s. 119.07(1) and
 1112 s. 24(a), Art. I of the State Constitution.

1113 (c) *Retroactive application.*—The public record exemptions
 1114 provided for in paragraph (b) apply to information held by the
 1115 corporation before, on, or after the effective date of this
 1116 exemption.

1117 (d) *Authorized release.*—

1118 1. Upon request, information made confidential and exempt
 1119 pursuant to this subsection shall be disclosed to:

1120 a. Another governmental entity in the performance of its
 1121 official duties and responsibilities.

1122 b. Any person who has the written consent of the program
 1123 applicant.

1124 c. The Florida Kidcare program for the purpose of
 1125 administering the program authorized in ss. 409.810-409.821.

1126 2. Paragraph (b) does not prohibit a participant's legal
 1127 guardian from obtaining confirmation of coverage, dates of
 1128 coverage, the name of the participant's health plan, and the
 1129 amount of premium being paid.

1130 (e) *Penalty.*—A person who knowingly and willfully violates
 1131 this subsection commits a misdemeanor of the second degree,

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1132 punishable as provided in s. 775.082 or s. 775.083.

1133 (f) *Review and repeal.*—This subsection is subject to the
1134 Open Government Sunset Review Act in accordance with s. 119.15,
1135 and shall stand repealed on October 2, 2016, unless reviewed and
1136 saved from repeal through reenactment by the Legislature.

1137 Section 16. Subsection (2) of section 409.904, Florida
1138 Statutes, is amended to read:

1139 409.904 Optional payments for eligible persons.—The agency
1140 may make payments for medical assistance and related services on
1141 behalf of the following persons who are determined to be
1142 eligible subject to the income, assets, and categorical
1143 eligibility tests set forth in federal and state law. Payment on
1144 behalf of these Medicaid eligible persons is subject to the
1145 availability of moneys and any limitations established by the
1146 General Appropriations Act or chapter 216.

1147 ~~(2) A family, a pregnant woman, a child under age 21, a~~
1148 ~~person age 65 or over, or a blind or disabled person, who would~~
1149 ~~be eligible under any group listed in s. 409.903(1), (2), or~~
1150 ~~(3), except that the income or assets of such family or person~~
1151 ~~exceed established limitations. For a family or person in one of~~
1152 ~~these coverage groups, medical expenses are deductible from~~
1153 ~~income in accordance with federal requirements in order to make~~
1154 ~~a determination of eligibility. A family or person eligible~~
1155 ~~under the coverage known as the "medically needy," is eligible~~
1156 ~~to receive the same services as other Medicaid recipients, with~~
1157 ~~the exception of services in skilled nursing facilities and~~
1158 ~~intermediate care facilities for the developmentally disabled.~~

1159 Section 17. Section 624.91, Florida Statutes, is amended to
1160 read:

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1161 624.91 The Florida Healthy Kids Corporation Act.—

1162 (1) SHORT TITLE.—This section may be cited as the “William

1163 G. ‘Doc’ Myers Healthy Kids Corporation Act.”

1164 (2) LEGISLATIVE INTENT.—

1165 (a) The Legislature finds that increased access to health

1166 care services could improve children’s health and reduce the

1167 incidence and costs of childhood illness and disabilities among

1168 children in this state. Many children do not have comprehensive,

1169 affordable health care services available. It is the intent of

1170 the Legislature that the Florida Healthy Kids Corporation

1171 provide comprehensive health insurance coverage to such

1172 children. The corporation is encouraged to cooperate with any

1173 existing health service programs funded by the public or the

1174 private sector.

1175 (b) It is the intent of the Legislature that the Florida

1176 Healthy Kids Corporation serve as one of several providers of

1177 services to children eligible for medical assistance under Title

1178 XXI of the Social Security Act. Although the corporation may

1179 serve other children, the Legislature intends the primary

1180 recipients of services provided through the corporation be

1181 school-age children with a family income below 200 percent of

1182 the federal poverty level, who do not qualify for Medicaid. It

1183 is also the intent of the Legislature that state and local

1184 government Florida Healthy Kids funds be used to continue

1185 coverage, subject to specific appropriations in the General

1186 Appropriations Act, to children not eligible for federal

1187 matching funds under Title XXI.

1188 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only residents

1189 of this state are eligible ~~the following individuals are~~

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1190 eligible for state-funded assistance in paying Florida Healthy
1191 Kids premiums pursuant to s. 409.814.~~+~~

1192 ~~(a) Residents of this state who are eligible for the~~
1193 ~~Florida Kidcare program pursuant to s. 409.814.~~

1194 ~~(b) Notwithstanding s. 409.814, legal aliens who are~~
1195 ~~enrolled in the Florida Healthy Kids program as of January 31,~~
1196 ~~2004, who do not qualify for Title XXI federal funds because~~
1197 ~~they are not qualified aliens as defined in s. 409.811.~~

1198 (4) NONENTITLEMENT.—Nothing in this section shall be
1199 construed as providing an individual with an entitlement to
1200 health care services. No cause of action shall arise against the
1201 state, the Florida Healthy Kids Corporation, or a unit of local
1202 government for failure to make health services available under
1203 this section.

1204 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

1205 (a) There is created the Florida Healthy Kids Corporation,
1206 a not-for-profit corporation.

1207 (b) The Florida Healthy Kids Corporation shall:

1208 1. Arrange for the collection of any individual, family,
1209 ~~local contributions,~~ or employer payment or premium, in an
1210 amount to be determined by the board of directors, to provide
1211 for payment of premiums for comprehensive insurance coverage and
1212 for the actual or estimated administrative expenses.

1213 2. Arrange for the collection of any voluntary
1214 contributions to provide for payment of Florida Kidcare program
1215 or Florida Health Insurance Affordability Exchange Program
1216 ~~premiums for children who are not eligible for medical~~
1217 ~~assistance under Title XIX or Title XXI of the Social Security~~
1218 ~~Act.~~

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1219 3. ~~Subject to the provisions of s. 409.8134, accept~~
1220 ~~voluntary supplemental local match contributions that comply~~
1221 ~~with the requirements of Title XXI of the Social Security Act~~
1222 ~~for the purpose of providing additional Florida Kidcare coverage~~
1223 ~~in contributing counties under Title XXI.~~

1224 4. Establish the administrative and accounting procedures
1225 for the operation of the corporation.

1226 4.5. Establish, with consultation from appropriate
1227 professional organizations, standards for preventive health
1228 services and providers and comprehensive insurance benefits
1229 appropriate to children, provided that such standards for rural
1230 areas shall not limit primary care providers to board-certified
1231 pediatricians.

1232 5.6. Determine eligibility for children seeking to
1233 participate in the Title XXI-funded components of the Florida
1234 Kidcare program consistent with the requirements specified in s.
1235 409.814, ~~as well as the non-Title XXI-eligible children as~~
1236 ~~provided in subsection (3).~~

1237 6.7. Establish procedures under which ~~providers of local~~
1238 ~~match to,~~ applicants to and participants in the program may have
1239 grievances reviewed by an impartial body and reported to the
1240 board of directors of the corporation.

1241 7.8. Establish participation criteria and, if appropriate,
1242 contract with an authorized insurer, health maintenance
1243 organization, or third-party administrator to provide
1244 administrative services to the corporation.

1245 8.9. Establish enrollment criteria that include penalties
1246 or waiting periods of 30 days for reinstatement of coverage upon
1247 voluntary cancellation for nonpayment of family or individual

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1248 premiums.

1249 ~~9.10.~~ Contract with authorized insurers or any provider of
1250 health care services, meeting standards established by the
1251 corporation, for the provision of comprehensive insurance
1252 coverage to participants. Such standards shall include criteria
1253 under which the corporation may contract with more than one
1254 provider of health care services in program sites.

1255 a. Health plans shall be selected through a competitive bid
1256 process. The Florida Healthy Kids Corporation shall purchase
1257 goods and services in the most cost-effective manner consistent
1258 with the delivery of quality medical care.

1259 b. The maximum administrative cost for a Florida Healthy
1260 Kids Corporation contract shall be 15 percent. For health and
1261 dental care contracts, the minimum medical loss ratio for a
1262 Florida Healthy Kids Corporation contract shall be 85 percent.
1263 The calculations must use uniform financial data collected from
1264 all plans in a format established by the corporation and shall
1265 be computed for each plan on a statewide basis. Funds shall be
1266 classified in a manner consistent with 45 C.F.R. part 158 ~~For~~
1267 ~~dental contracts, the remaining compensation to be paid to the~~
1268 ~~authorized insurer or provider under a Florida Healthy Kids~~
1269 ~~Corporation contract shall be no less than an amount which is 85~~
1270 ~~percent of premium; to the extent any contract provision does~~
1271 ~~not provide for this minimum compensation, this section shall~~
1272 ~~prevail.~~

1273 c. The health plan selection criteria and scoring system,
1274 and the scoring results, shall be available upon request for
1275 inspection after the bids have been awarded.

1276 d. Effective July 1, 2016, health and dental services

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1277 contracts of the corporation must transition to the FHIX
1278 marketplace under s. 409.722. Qualifying plans may enroll as
1279 vendors with the FHIX marketplace to maintain continuity of care
1280 for participants.

1281 ~~10.11.~~ Establish disenrollment criteria in the event ~~local~~
1282 ~~matching~~ funds are insufficient to cover enrollments.

1283 ~~11.12.~~ Develop and implement a plan to publicize the
1284 Florida Kidcare program, the eligibility requirements of the
1285 program, and the procedures for enrollment in the program and to
1286 maintain public awareness of the corporation and the program.

1287 ~~12.13.~~ Secure staff necessary to properly administer the
1288 corporation. Staff costs shall be funded from state ~~and local~~
1289 ~~matching funds~~ and such other private or public funds as become
1290 available. The board of directors shall determine the number of
1291 staff members necessary to administer the corporation.

1292 ~~13.14.~~ In consultation with the partner agencies, provide a
1293 report on the Florida Kidcare program annually to the Governor,
1294 the Chief Financial Officer, the Commissioner of Education, the
1295 President of the Senate, the Speaker of the House of
1296 Representatives, and the Minority Leaders of the Senate and the
1297 House of Representatives.

1298 ~~14.15.~~ Provide information on a quarterly basis online to
1299 the Legislature and the Governor which compares the costs and
1300 utilization of the full-pay enrolled population and the Title
1301 XXI-subsidized enrolled population in the Florida Kidcare
1302 program. The information, at a minimum, must include:

1303 a. The monthly enrollment and expenditure for full-pay
1304 enrollees in the Medikids and Florida Healthy Kids programs
1305 compared to the Title XXI-subsidized enrolled population; and

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1306 b. The costs and utilization by service of the full-pay
1307 enrollees in the Medikids and Florida Healthy Kids programs and
1308 the Title XXI-subsidized enrolled population.

1309 ~~15.16.~~ Establish benefit packages that conform to the
1310 provisions of the Florida Kidcare program, as created in ss.
1311 409.810-409.821.

1312 16. Contract with other insurance affordability programs
1313 and FHIX to provide customer service or other enrollment-focused
1314 services.

1315 17. Annually develop performance metrics for the following
1316 focus areas:

1317 a. Administrative functions.

1318 b. Contracting with vendors.

1319 c. Customer service.

1320 d. Enrollee education.

1321 e. Financial services.

1322 f. Program integrity.

1323 (c) Coverage under the corporation's program is secondary
1324 to any other available private coverage held by, or applicable
1325 to, the participant child or family member. Insurers under
1326 contract with the corporation are the payors of last resort and
1327 must coordinate benefits with any other third-party payor that
1328 may be liable for the participant's medical care.

1329 (d) The Florida Healthy Kids Corporation shall be a private
1330 corporation not for profit, organized pursuant to chapter 617,
1331 and shall have all powers necessary to carry out the purposes of
1332 this act, including, but not limited to, the power to receive
1333 and accept grants, loans, or advances of funds from any public
1334 or private agency and to receive and accept from any source

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1335 contributions of money, property, labor, or any other thing of
 1336 value, to be held, used, and applied for the purposes of this
 1337 act.

1338 (6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

1339 (a) The Florida Healthy Kids Corporation shall operate
 1340 subject to the supervision and approval of a board of directors.
 1341 The board chair shall be an appointee designated by the
 1342 Governor, and the board shall be chaired by the Chief Financial
 1343 Officer or her or his designee, and composed of 12 other
 1344 members. The Senate shall confirm the designated chair and other
 1345 board appointees. The board members shall be appointed ~~selected~~
 1346 for 3-year terms. ~~of office as follows:~~

1347 ~~1. The Secretary of Health Care Administration, or his or~~
 1348 ~~her designee.~~

1349 ~~2. One member appointed by the Commissioner of Education~~
 1350 ~~from the Office of School Health Programs of the Florida~~
 1351 ~~Department of Education.~~

1352 ~~3. One member appointed by the Chief Financial Officer from~~
 1353 ~~among three members nominated by the Florida Pediatric Society.~~

1354 ~~4. One member, appointed by the Governor, who represents~~
 1355 ~~the Children's Medical Services Program.~~

1356 ~~5. One member appointed by the Chief Financial Officer from~~
 1357 ~~among three members nominated by the Florida Hospital~~
 1358 ~~Association.~~

1359 ~~6. One member, appointed by the Governor, who is an expert~~
 1360 ~~on child health policy.~~

1361 ~~7. One member, appointed by the Chief Financial Officer,~~
 1362 ~~from among three members nominated by the Florida Academy of~~
 1363 ~~Family Physicians.~~

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1364 ~~8. One member, appointed by the Governor, who represents~~
1365 ~~the state Medicaid program.~~

1366 ~~9. One member, appointed by the Chief Financial Officer,~~
1367 ~~from among three members nominated by the Florida Association of~~
1368 ~~Counties.~~

1369 ~~10. The State Health Officer or her or his designee.~~

1370 ~~11. The Secretary of Children and Families, or his or her~~
1371 ~~designee.~~

1372 ~~12. One member, appointed by the Governor, from among three~~
1373 ~~members nominated by the Florida Dental Association.~~

1374 (b) A member of the board of directors serves at the
1375 pleasure of the Governor ~~may be removed by the official who~~
1376 ~~appointed that member.~~ The board shall appoint an executive
1377 director, who is responsible for other staff authorized by the
1378 board.

1379 (c) Board members are entitled to receive, from funds of
1380 the corporation, reimbursement for per diem and travel expenses
1381 as provided by s. 112.061.

1382 (d) There shall be no liability on the part of, and no
1383 cause of action shall arise against, any member of the board of
1384 directors, or its employees or agents, for any action they take
1385 in the performance of their powers and duties under this act.

1386 (e) Board members who are serving as of the effective date
1387 of this act may remain on the board until January 1, 2016.

1388 (7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

1389 (a) The corporation shall not be deemed an insurer. The
1390 officers, directors, and employees of the corporation shall not
1391 be deemed to be agents of an insurer. Neither the corporation
1392 nor any officer, director, or employee of the corporation is

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1393 subject to the licensing requirements of the insurance code or
1394 the rules of the Department of Financial Services. However, any
1395 marketing representative utilized and compensated by the
1396 corporation must be appointed as a representative of the
1397 insurers or health services providers with which the corporation
1398 contracts.

1399 (b) The board has complete fiscal control over the
1400 corporation and is responsible for all corporate operations.

1401 (c) The Department of Financial Services shall supervise
1402 any liquidation or dissolution of the corporation and shall
1403 have, with respect to such liquidation or dissolution, all power
1404 granted to it pursuant to the insurance code.

1405 (8) TRANSITION PLANS.—The corporation shall confer with the
1406 Agency for Health Care Administration, the Department of
1407 Children and Families, and Florida Health Choices, Inc., to
1408 develop transition plans for the Florida Health Insurance
1409 Affordability Exchange Program as created under ss. 409.720-
1410 409.731.

1411 Section 18. Section 624.915, Florida Statutes, is repealed.

1412 Section 19. The Division of Law Revision and Information is
1413 directed to replace the phrase "the effective date of this act"
1414 wherever it occurs in this act with the date the act becomes a
1415 law.

1416 Section 20. This act shall take effect upon becoming a law.