The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Tuesday, March 10, 2015
TIME: 1:30 —3:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Braynon, Flores, Gaetz, Galvano, Garcia, Grimsley, and Joyner

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SPB 7044**	Health Insurance Affordability Exchange; Creating the Florida Health Insurance Affordability Exchange Program or FHIX in the Agency for Health Care Administration; providing patient rights and responsibilities; providing for the development of a long-term reorganization plan and the formation of the FHIX Workgroup; removing certain Medicaid-eligible persons from those for whom the agency may make payments for medical assistance and related services, etc.	Submitted as Committee Bill Yeas 9 Nays 0
2	**SB 1146** Simmons (Identical H 965)	Agency Relationships with Governmental Health Care Contractors; Extending sovereign immunity to employees or agents of a health care provider that executes a contract with a governmental contractor; authorizing such health care provider to collect from a patient, or the parent or guardian of a patient, a nominal fee for administrative costs under certain circumstances, etc. HP 03/10/2015 Fav/CS JU RC	Fav/CS Yeas 9 Nays 0
3	**SB 640** Detert (Similar CS/H 243)	Vital Statistics; Authorizing the Department of Health to produce and maintain paper death certificates and fetal death certificates and issue burial-transit permits; requiring electronic filing of death and fetal death certificates with the department or local registrar on a prescribed form; authorizing the department, rather than the local registrar, to grant an extension of time for providing certain information regarding a death or a fetal death; requiring the department to electronically notify the United States Social Security Administration of deaths in the state, etc. HP 03/10/2015 Fav/CS AHS FP	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 950** Hukill (Similar CS/H 697)	Public Health Emergencies; Requiring certain state and local officers to assist in enforcing rules and orders issued by the Department of Health under ch. 381, F.S.; authorizing the State Health Officer to issue orders to isolate individuals; specifying that any order the department issues is immediately enforceable by a law enforcement officer; providing a penalty for violating an isolation order, etc. HP 03/10/2015 Fav/CS AHS FP	Fav/CS Yeas 9 Nays 0
5	**SB 996** Richter (Identical H 1305)	Home Medical Equipment; Exempting allopathic, osteopathic, and chiropractic physicians who sell or rent electrostimulation medical equipment and supplies to their patients in the course of their practice from licensure as home medical equipment providers, etc. HP 03/10/2015 Favorable AHS FP	Favorable Yeas 9 Nays 0
6	**SB 792** Bean (Similar H 279)	Pharmacy; Authorizing a registered intern under the supervision of a pharmacist to administer specified vaccines to an adult; revising which vaccines may be administered by a pharmacist or a registered intern under the supervision of a pharmacist, etc. HP 03/10/2015 Fav/CS AHS FP	Fav/CS Yeas 9 Nays 0
7	**SB 482** Braynon (Similar H 285)	Community Health Worker Certification; Requiring the Department of Health to approve qualified third-party credentialing entities to administer voluntary community health worker certification programs; establishing criteria for the approval of a third-party credentialing entity; requiring a third-party credentialing entity to issue a certification to certain qualified individuals who meet the grandfathering standards established by the entity; establishing a maximum fee for such certification, etc. HP 03/10/2015 Favorable AHS AP	Favorable Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 768** Gaetz (Similar H 309, S 820)	Patient Observation Status Notification; Requiring licensed facilities to notify patients if they place them in observation status rather than admitted status; requiring facilities to provide certain notice, etc. HP 03/10/2015 Fav/CS CF FP	Fav/CS Yeas 9 Nays 0

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 7044
INTRODUCER:	Health Policy Committee
SUBJECT:	Health Insurance Affordability Exchange
DATE:	March 11, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall		**HP Submitted as Committee Bill**

I. Summary:

SB 7044 creates the "Florida Health Insurance Affordability Exchange Program" or FHIX under ss. 409.710 - 409.731, F.S., as a multi-phased, consumer-driven approach to providing access to high-quality, affordable health care coverage to low-income, uninsured Floridians. Implementation of the program will begin upon the effective date of the act.

The bill extends health care coverage to an estimated 800,000 uninsured, low-income Floridians who are individuals earning less than 138 percent of the federal poverty level (FPL) and who are not currently eligible under the current Medicaid program, s. 409.902, F.S. To be eligible, an individual must be a U.S. citizen and a Florida resident.

Under FHIX, enrollees may access all Florida Health Choices products and services, Medicaid managed care plans, products offered by the Florida Healthy Kids Corporation, and employer sponsored plans.

Every enrollee must be provided with a health reimbursement or health savings account. The bill provides for how funds may roll-over into the account, who may contribute to the account, and how the enrollee may earn additional credits. An enrollee may only withdraw a refund from the account those funds that he or she has contributed to the account.

The bill outlines participant rights and responsibilities under the program to delineate the roles that both the participant and the state agencies and organizations have under FHIX.

FHIX participants may begin accessing coverage through the Medicaid managed care delivery system in Phase One beginning July 1, 2015, with statewide implementation completed by January 1, 2016. Applicants will use the Medicaid eligibility determination process through the Department of Children and Families (department) and the choice counseling and consumer support services of the Agency for Health Care Administration (AHCA) during this phase. The Florida Health Choices, Inc., (corporation) and the Florida Healthy Kids Corporation (FHKC) will coordinate the implementation of FHIX and other program phases as Phase One is started.

Phase Two's implementation is contingent upon the approval of the federal Centers for Medicare and Medicaid Services. Beginning with Phase Two on January 1, 2016, participants are required to provide proof at application and renewal of employment, on-the-job training or placement activities, or pursuit of educational opportunities at minimal weekly hourly levels based on their classification as either a parent with children (20 hours) or childless adult (30 hours). An exception process is established through the Medicaid Fair Hearing Process and for those who are disabled or are a parent or caregiver of a disabled child.

Under Phase Two enrollees are also required to make monthly premium payments to remain in active status. Premiums range from $3 to $25. After a 30-day grace period, individuals who have not made a payment will not be disenrolled, but will be moved to inactive status and retain access to funds in their health reimbursement or health savings accounts. Accounts may not be reinstated to active status for 6 months.

Delivery of services and benefits under Phase Two will occur through the FHIX marketplace administered by the corporation. Phase One enrollees will be required to transition coverage to FHIX by April 1, 2016 and may be able to keep their Medicaid managed care plan if that plan participates in the FHIX. Enrollees will receive a premium credit based on a risk adjusted rate amount to shop for plans, services, and products on the FHIX marketplace.

Phase Three of the program folds the enrollees of the Healthy Kids program into the FHIX marketplace starting July 1, 2016.

Enrollees may be charged for inappropriate use of the emergency room. For the first visit, an $8 copayment may be assessed and subsequent visits may be $25, depending on the plan selected by the enrollee.

A Transition Workgroup will oversee the process and make recommendations to the agency regarding implementation. The agency, as the single state agency for Medicaid, will make the final decision on whether to move forward on each region or phase of the program.

SB 7044 provides the agency, department, corporation, and FHKC with specific administrative duties and functions for the implementation of the FHIX program. The agency has the administrative lead for Phase One of the program and the corporation for Phases Two and Three. The department shall continue its function of determining Medicaid eligibility. The FHKC retains its functions and responsibilities until Phase Three when its enrollees are transitioned to FHIX.

The bill provides the agency with authority to seek federal approval to implement the FHIX program. Triggers for ending the program are also included should the Phase Two not be approved or if the federal match rate falls below certain thresholds.

The Florida Health Choices Program statute, s. 409.910, F.S., is modified to recognize the FHIX marketplace and to authorize the corporation to administer FHIX.

The Florida Healthy Kids Corporation, s. 624.91, F.S., is modified to remove obsolete provisions, recognize the FHIX program and changes made in this act, and to reconfigure its board of directors.

The bill also repeals two statutes: the FHKC Operating Fund statute, s. 624.915, F.S., and the Medically Needy program, s. 409.904, F.S., under Medicaid.

The bill is effective upon becoming a law.

II. Present Situation:

In 2013, the American Community Survey (ACS) of the federal Census Bureau, estimated that 4 million Floridians were uninsured.[1] Of that number, 594,000 had been projected to be children.[2] Approximately 900,000 adults in Florida were estimated to have incomes under 100 percent of the FPL, according to statistics for 2013.[3]

Beginning January 1, 2014, health insurance coverage in Florida became available through the federal Marketplace[4] to persons with incomes above 100 percent of the FPL. Also, on January 1, 2014, Florida Medicaid coverage to children up to age 18 was extended to 133 percent of the FPL.

The Census Bureau's March 2014 Supplement to the Current Population Survey showed that Florida's overall uninsured number had dropped to 3.6 million and the children's number to 504,900.[5,6] The survey had been conducted from January through April 2014.[7]

Florida Medicaid

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

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[1] Office of Economic and Demographic Research, Florida Legislature, *Economic Analysis of PPACA and Medicaid Expansion*, Presentation to Senate Select Committee on Patient Protection and Affordable Care Act (Mar. 4, 2013), http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2071.pdf (last visited Mar. 8, 2015).
[2] Ibid.
[3] Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of the Non-Elderly (0-64) with Income Below 100% Federal Poverty Level (FPL)* *http://kff.org/other/state-indicator/nonelderly-up-to-139-fpl/* (Mar. 7, 2015).
[4] President Obama signed the Affordable Care Act into law on March 23, 2010. The first open enrollment was held starting on October 1, 2013 and a second one was held from November 15, 2014 through February 15, 2015. Florida does not operate its own exchange, so Floridians purchase coverage through the federal marketplace on www.healthcare.gov.
[5] Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of the Total Population (2013),* *http://kff.org/other/state-indicator/total-population/* (last visited Mar. 7, 2015).
[6] Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of Children 0-18,* *http://kff.org/other/state-indicator/children-0-18/* (last visited Mar. 7, 2015).
[7] More current, reliable estimates of the number of uninsured Floridians is not available at this time.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds. The Department of Children and Families (DCF) determines eligibility for the Medicaid program and transmits that information to the AHCA. The AHCA is designated as the single state Medicaid agency and has the lead responsibility for the overall program.[8]

Over 3.7 million Floridians are currently enrolled in Medicaid[9] and the program's estimated expenditures for the 2014-2015 fiscal year are 23.4 billion.[10] The current traditional federal share is 60.51 percent with the state paying 39.49 percent for Medicaid enrollees.[11] Florida has the fourth largest Medicaid program in the country.[12]

Medicaid currently covers:
- 20% of Florida's population;
- 27% of Florida's children;
- 62.2% of Florida's births;
- 69% of Florida's nursing homes days.[13]

The structure for each state's Medicaid program is different and what states pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law and regulation sets the minimum amount, scope, and duration of services offered in the program among other requirements. Eligibility for the Medicaid program is based on a number of factors, including age, household or individual income, and assets. State Medicaid benefits are provided in statute under s. 409.903, F.S. (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.[14] Applicants must also agree to cooperate with Child Support Enforcement during the application process and then be completed after the eligibility process.[15]

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[8] *See* s. 409.963, F.S.
[9] Agency for Health Care Administration, *Report of Medicaid Eligibles - January 31, 2015,* http://ahca.myflorida.com/medicaid/about/pdf/age_assistance_category_2015-01-31.pdf (last visited Mar. 9, 2015).
[10] Office of Economic and Demographic Research, *Social Services Estimating Conference Medicaid Expenditures* (December 12, 2014) http://edr.state.fl.us/Content/conferences/medicaid/medhistory.pdf (last visited Mar. 6, 2015).
[11] Office of Economic and Demographic Research, *Social Services Estimating Conference - Official FMAP Estimate (November 2014),* http://edr.state.fl.us/Content/conferences/medicaid/fmap.pdf (last viewed Mar. 8, 2015). The SSEC has also created a "real time" FMAP blend" for the Statewide Medicaid Managed Care Program which is 60.43% for SFY 2015-16.
[12] Agency for Health Care Administration, Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - An Overview (Jan. 22, 2015),* Slide 9, http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2759.pdf (last visited: Mar. 6, 2015).
[13] Id at 10.
[14] Florida Department of Children and Families, *Family-Related Medicaid Programs Fact Sheet, (January 2015),* p.3, http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last visited: Mar. 8, 2015).
[15] Id.

Florida's Current Medicaid and CHIP Eligibility Levels in Florida[16] (With Income Disregards and Modified Adjusted Gross Income)						
Children's Medicaid			**CHIP (Kidcare)**	**Pregnant Women**	**Parents**	**Childless Adults**
Age 0-1	Age 1-5	Age 6-18	Ages 0-18	Medicaid		
206% FPL	140% FPL	133% FPL	210% FPL	191% FPL	30% FPL	0% FPL

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

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

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.[18] States can add benefits, with federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.[19] For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services which are those health care and diagnostic services and treatment and measures that may be needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services consistent with federal law.[20]

Medicaid Managed Care

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) Program as part IV of ch. 409, F.S.[21] The SMMC has two components: the Long Term Care Managed Care (LTC) program and the Managed Medical Assistance (MMA) program. The SMMC is an integrated managed care program for Medicaid enrollees that incorporates all of the covered services, for the delivery of primary and acute care in 11 regions.

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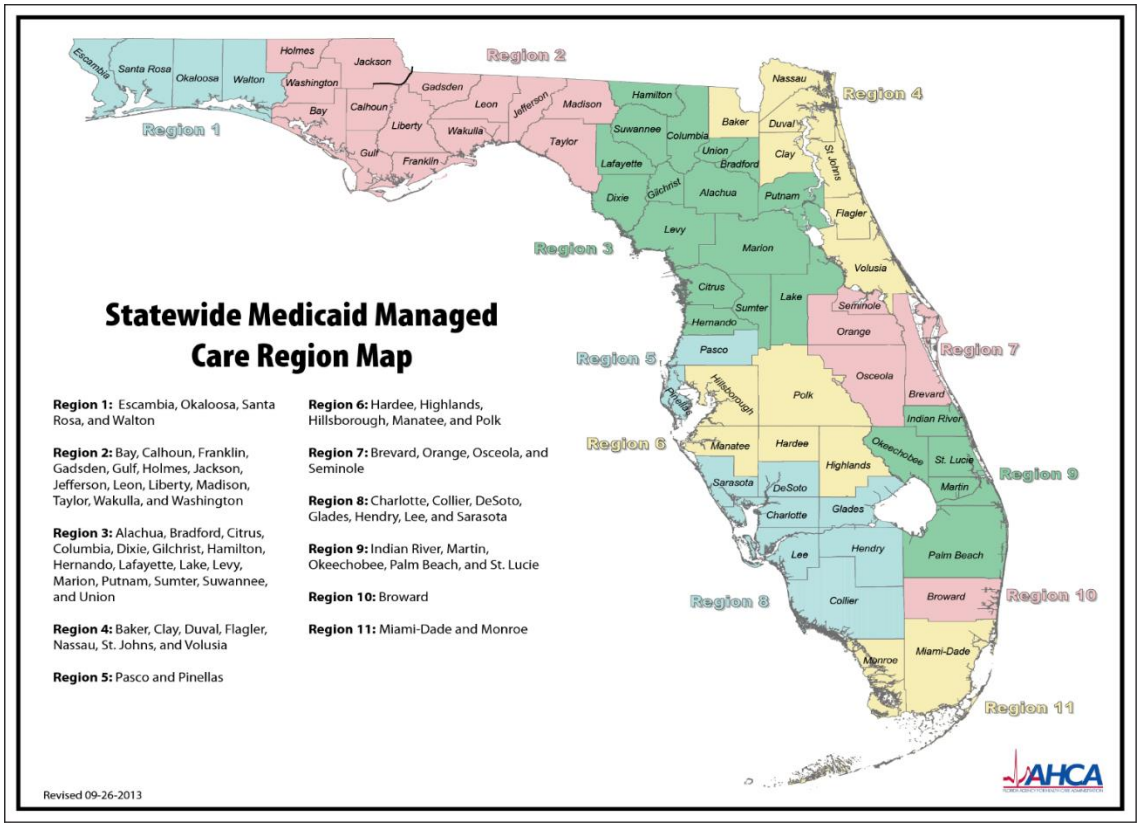
[16] U.S. Centers for Medicare and Medicaid Services, Medicaid.gov, *Florida*, *http://www.medicaid.gov/medicaid-chip-program-information/by-state/florida.html* (last visited Mar. 7, 2015).
[17] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid and CHIP Program Information - 2015 Federal Poverty Level Charts* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf (last visited Mar. 7, 2015.
[18] Section 409.905, F.S.
[19] Section 409.906, F.S.
[20] *See* Section 1905 9(r) of the Social Security Act.
[21] *See* Chapter Laws, 2011-134 and 2011-135.



To implement the two components and receive federal Medicaid funding, the AHCA received federal authorization through two different Medicaid waivers from the CMS. The first component authorized was the LTC's 1915(b) and (c) waivers on February 1, 2013. These two waivers for the LTC program are effective July 1, 2013 through June 30, 2015 and operate concurrently.[22]

Long Term Care Managed Care Program (LTC)

For the LTC program, individuals must meet these eligibility requirements or participate in one of these existing waivers to enroll in the program:

- Age 65 years or older and need nursing facility level of care;
- Age 18 years of age or older and are eligible for Medicaid by reason of a disability and need nursing facility level of care;
- Aged and Disabled Adult (A/DA) waiver;
- Consumer Directed Care Plus for individuals in the A/DA waiver;
- Assisted Living waiver;
- Nursing Home Diversion waiver;
- Frail Elder Option; or

[22] Department of Health and Human Services, Disabled & Elderly Health Programs Group, *Approval Letter to Agency for Health Care Administration*, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (last visited: Mar. 6, 2015).

- Channeling Services waiver.[23]

Individuals who are enrolled in these programs may enroll in the LTC, but are not required to:
- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Injury waiver;
- Project AIDS Care waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver; or
- Model waiver.[24]

The AHCA engaged in a competitive procurement to select providers in each of the 11 regions. Contracts were awarded to health maintenance organizations and provider service networks. Seven non-specialty plans are currently contracted, including one provider service network that is available in all eleven regions and one health maintenance organization that is in 10 regions.[25]

Choice counselors are available via a toll-free number or the internet to assist Medicaid recipients with plan selection. An in-person visit may also be requested.

Enrollment into the LTC Managed Care program began in August 1, 2013, and finished March 1, 2014. As of December 1, 2014, 85,169 were enrolled in the LTC program.[26]

Managed Medical Assistance Program (MMA)

For the MMA component, health care services were also bid competitively using the same 11 regions. Thirteen non-specialty managed care plans contract with AHCA across the different regions. Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure or cardiovascular disease may also select from specialized plans.

Most plans supplemented the required benefits and offered enhanced options, such as adult dental, hearing and vision coverage, outpatient hospital coverage and physician services. The minimum and maximum number of plans selected by region is prescribed under s. 409.974, F.S.

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[23] Agency for Health Care Administration, *A Snapshot of the Florida Medicaid Long-term Care Program*, *http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf* (last visited Mar. 6, 2015).
[24] Id.
[25] Id.
[26] Agency for Health Care Administration, Presentation to Senate Health and Human Services Appropriations Committee, *Implementation and Status of Statewide Medicaid Managed Care (Jan. 7, 2015)*, Slide 4, http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2729.pdf (last visited Mar. 6, 2015).

Eligible Number of Non-Specialty Managed Care Plans[27]			
Region	**Minimum**	**Maximum**	**Current MMA**
1	2	NA	2
2	2	NA	2
3	3	5	4
4	3	5	4
5	2	4	4
6	4	7	7
7	3	6	6
8	2	4	4
9	2	4	4
10	2	4	4
11	5	10	10

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

Statewide implementation of SMMC started May 1, 2014 and was completed by August 1, 2014. Similar to the LTC component, enrollees receive choice counseling service via a toll-free number or online. In-person visits are available for those enrollees with special needs.

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

- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities under s. 394.455(32), F.S.;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.[28]

Other Medicaid enrollees are exempt from the MMA program and are served in the Medicaid fee-for-service program. Exempt enrollees are:

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

The MMA program is authorized by a section 1115 demonstration waiver by federal CMS. It was approved in 2005 and is currently operating as an expansion of the managed care pilot

[27] Agency for Health Care Administration, *A Snapshot of the Florida Medicaid Medical Assistance Program*, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_MMA_Snapshot.pdf (last visited Mar. 6, 2015).
[28] Section 409.972, F.S.

program and renewed for an second additional 3-year period on July 31, 2014 through June 30, 2017.[29]

A part of the original waiver approval included the Low Income Pool supplemental payment authority (LIP). The LIP program was extended through June 30, 2015.[30] LIP funds are used to assist safety net providers in providing health care services to Medicaid, underinsured, and uninsured populations. The total computable funds under LIP for the 2014-2015 fiscal year are not to exceed $2.1 billion under the extension.[31] Additionally, the state was directed by federal CMS to develop a plan to reform Medicaid provider payments and funding mechanisms with the goal of identifying a mechanism that that would ensure the delivery of quality medical services to Medicaid recipients without reliance on LIP funds.[32]

Florida Kidcare Program

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

The Program includes four operating components:
- Medicaid administered by AHCA with eligibility determined by the Department of Children and Families;
- Medikids administered by AHCA;
- Children's Medical Services Network administered by the Department of Health; and
- Healthy Kids administered by the Florida Healthy Kids Corporation.[33]

A fifth component under the statute, the employer sponsored group health insurance plan, has never been implemented. The AHCA submitted State Plan Amendment #7 in December 1998 for implementation of that component; however, the plan amendment withdrawn from further consideration.[34]

The Title XXI-funded or CHIP-funded components of Florida Kidcare serve distinct populations under the program:

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[29] Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid 1115 Demonstration Fact Sheet* (July 31, 2014), *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf* (last visited Mar. 8, 2015).
[30] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Approval Letter to the Agency for Health Care Administration* (July 31, 2014), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/July312014ApprovalLetter.pdf (last visited Mar. 5, 2015).
[31] Id at 3.
[32] Id at 3.
[33] Section 409.813, F.S.
[34] *See* U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services, Florida State Plan Amendment #22, Plan Amendment History, p.8, http://www.medicaid.gov/CHIP/Downloads/FL/FL-CSPA-22-FINAL.pdf (last visited Mar. 8, 2015).

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

The Program is funded by Medicaid funds under Title XIX of the Social Security Act, state funds from General Revenue and the Tobacco Settlement Trust Fund, and family contributions.[35] CHIP has an enhanced federal matching rate that is more favorable than Medicaid. For the period of October 2014 through June 2015, the federal match rate is 71.80 percent.[36]

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

CHIP was re-authorized by Congress in 2009 until federal Fiscal Year 2019, but federal funding was only re-authorized until September 30, 2015. Re-authorization bills are pending in Congress, including a bipartisan discussion draft led by the House Energy and Commerce Chair Fred Upton, House Health Subcommittee Chair Joe Pitts and the Senate Finance Committee Chair and original CHIP bill sponsor, Orrin Hatch.[37] The discussion draft does not provide an extension period but extends funding for at least 1 year while seeking stakeholder feedback.

Another proposal, *Protecting & Retaining Our Children's Health Insurance Program Act of 2015 (PRO-CHIP)* has also been introduced and would extend CHIP funding through 2019 and the other components of the program. The proposal, Senate Bill 522, is sponsored by Senator

[35] Florida Kidcare Coordinating Council, *2014 Annual Report and Recommendations,* p. 14, http://www.floridakidcare.org/council/wp-content/uploads/2014/08/2014_Annual_Report.pdf (last reviewed Mar. 8, 2015).
[36] Office of Economic and Demographic Research, *Social Services Estimating Conference - Kidcare Program (November 21, 2014 Conference Results)* http://edr.state.fl.us/Content/conferences/kidcare/kidcaredetail.pdf (last viewed Mar. 8, 2015).
[37] U.S. House Energy and Commerce Committee, *Extending Funding for the State's Children Health Insurance Program*, (Feb. 24, 2015), http://energycommerce.house.gov/fact-sheet/extending-funding-state-children%E2%80%99s-health-insurance-program (last visited: Mar. 5, 2015).

Sherrod Brown with Senators Stabenow, Wyden, Casey and Minority Leader Reid and more than 40 other Senators. [38,39]

Florida Healthy Kids Corporation

The Florida Healthy Kids Program is authorized under s. 624.91, F.S., which is also known as the "William G. 'Doc' Myers Healthy Kids Corporation Act." The FHKC was created as a private, not-for-profit corporation by the 1990 Florida Legislature in an effort to increase access to health insurance for school-aged children.[40]

Eligibility for the state-funded assistance is prescribed under s. 624.91(3), F.S., and provides cross references to the Florida Kidcare Act. The Healthy Kids program is also identified as a non-entitlement program.[41]

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

- Collect contributions from families, local sources or employer based premiums;
- Establish administrative and accounting procedures;
- Establish preventive health standards for children that do not limit participation to pediatricians in rural areas with consultation from appropriate experts;
- Determine eligibility for children seeking enrollment in Title XXI funded and non-Title XXI components;
- Establish grievance processes;
- Establish participation criteria for administrative services for the FHKC;
- Establish enrollment criteria that include penalties or waiting periods for non-payment of premiums of 30 days;
- Contract with authorized insurers and other health care providers meeting standards established by the FHKC for the delivery of services and select health plans through a competitive bid process;
- Purchase goods and services in a cost effective manner with a minimum medical loss ratio of 85 percent for health plan contracts;
- Establish disenrollment criteria for insufficient funding levels;
- Develop a plan to publicize the program;
- Secure staff and the necessary funds to administer the program;
- Provide an annual Kidcare report, in consultation with partner agencies, to the governor, chief financial officer, commissioner of education, President of the Senate, Speaker of the House of Representatives, and minority leaders of the Senate and House of Representatives;

[38] U.S. Senate Committee on Finance, *Wyden Joins Sens. Brown, Casey and Stabenow on Legislation to Extend the Children's Health Insurance Program*, (February 12, 2015) http://www.finance.senate.gov/newsroom/ranking/release/?id=20c6ac77-77af-424f-bb3e-dc84a92af22d (last visited: Mar. 5, 2015).
[39] S. 522, 114th Congress (2015).
[40] Florida Healthy Kids Corporation, *History*, https://www.healthykids.org/healthykids/history/ (last visited Mar. 7, 2015).
[41] A non-entitlement program means that funding may be limited. If more applicants or enrollees apply or enroll for the program than funding allows, an enrollee is not entitled to enrollment, even if eligible.

- Provide quarterly enrollment information on the full pay population; and
- Establish benefit packages that conform to the Florida Kidcare benchmark benefit.

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

Enrollees also have copayments for non-preventive services that range from $5 per prescription to $10 for an inappropriate use of the emergency room visit. There are no copayments for visits related to well-child, preventive health, or dental care.[42]

Benefits for the program must also meet the benchmark benefit plan under the Kidcare Act.[43] FHKC is under discussions with CMS regarding its benefits package for its non-subsidized enrollees. CMS had notified FHKC that the benefit package for these enrollees must be compliant with the Affordable Care Act minimum benefit requirements and have identified a few benefits that do not meet those standards: removal of annual or lifetime limits on benefits, addition of applied behavioral analysis benefits, and removal of an overall lifetime limit.[44]

The FHKC is governed by a 13-member board of directors, chaired by Florida's chief financial officer or his or her designee.[45] The 12 other board members are:

- Secretary of the AHCA;
- One member appointed by the commissioner of education from the Office of School Health Programs from the Department of Education;
- One member, appointed by the chief financial officer from among three members nominated by the Florida Pediatric Society;
- One member, appointed by the governor, who represents the Children's Medical Services Program;
- One member appointed by the chief financial officer from among three members nominated by the Florida Hospital Association;
- One member, appointed by the governor, who is an expert on child health policy;
- One member, appointed by the chief financial officer, from among three members nominated by the Florida Academy of Family Physicians;
- One member, appointed by the governor, who represents the state Medicaid program;

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

[43] A benchmark benefit plan under Kidcare, excluding Medicaid and Medikids coverage, must include the minimum benefits listed under s. 409.815(2), F.S. The plan includes preventive health services, inpatient hospital services, emergency services, maternity services, organ transplantation services, outpatient services, behavioral health services, durable medical equipment, health practitioner services, home health services, hospice services, laboratory and x-ray services, nursing facility services, prescribed drugs, therapy services, transportation services, dental services, and a lifetime maximum.

[44] E-Mail Correspondence from Fred Knapp, Interim Executive Director, Florida Healthy Kids Corporation (Sept. 2, 2014) (on file in the Senate Health Policy Committee).

[45] *See* s. 624.91(6), F.S.

- One member, appointed by the chief financial officer, from among three members nominated by the Florida Association of Counties;
- The state health officer or his or her designee;
- The secretary of the DCF, or his or her designee; and
- One member, appointed by the governor, from among three members nominated by the Florida Dental Association.

Board members do not receive compensation for their service but may receive reimbursement for per diem and travel expenses in accordance with s. 112.061, F.S.[46]

The FHKC is not an insurer and is not subject to the licensing requirements of the Department of Financial Services. In addition, the FHKC board is also granted complete fiscal control over the FHKC and responsibility for all fiscal operations. Any liquidation of the FHKC would be supervised by the Department of Financial Services.[47]

Cover Florida and Florida Health Choices

In 2008, the Florida Legislature created two programs simultaneously to address the issue of Florida's uninsured: the Cover Florida Health Access Program and the Florida Health Choices Program.[48] The two programs offered two unique methods of addressing Florida's uninsured population.

Cover Florida Health Access Program

Cover Florida is designed to provide affordable health care options for uninsured residents between the ages of 19 and 64 and who met other criteria under s. 408.9091, F.S. The AHCA and the Office of Insurance Regulation (OIR) have joint responsibility for the program and were directed to issue an Invitation to Negotiate (ITN) to secure plans for the delivery of services by July 1 2008. An ITN was released July 2, 2008, and as a result of that ITN, 2-year contracts were executed with two statewide plans and four regional plans.[49]

The Cover Florida plans were not subject to the Florida Insurance Code and ch. 641, F.S., relating to HMOs. Two plan options were required for development: plans with catastrophic coverage and plans without catastrophic coverage. Plans without catastrophic coverage are required to include other benefit options such as:[50]

- Incentives for routine preventive care;
- Office visits for diagnosis and treatment of illness or injury;
- Behavioral health services;
- Durable medical equipment and prosthetics; and
- Diabetic supplies.

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[46] *See* s. 624.91(5), F.S.
[47] *See* s. 624.91(7), F.S.
[48] *See* Chapter Law 2008-32.
[49] Agency for Health Care Administration, *Cover Florida Health Care Access Program Annual Report*, p. 1 (March 2013), *http://ahca.myflorida.com/MCHQ/Managed_Health_Care/CHMO/docs/CoverFLReport-Mar2013.pdf* (last visited Mar. 22, 2013).
[50] *See* s. 409.9091(4)(6)(a).

Plans that did include catastrophic coverage were required to include all of the benefits above, plus have options for these additional benefits:[51]

- Inpatient hospital stays;
- Hospital emergency care services;
- Urgent care services; and,
- Outpatient facility services, outpatient surgery, and outpatient diagnostic services.

All plans are guaranteed-issue policies[52] and are required to include prescription drug benefits. Plans can also place limits on services and cap benefits and copayments.

To be eligible, the enrollee must be:

- A resident of Florida;
- Between 19 and 64 years old;
- Not covered by private insurance or eligible for public insurance, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements; and
- Uninsured for at least the prior 6 months, with exceptions for persons who lose coverage within the past 6 months under certain conditions.

No insurers or HMOs currently offer any new policies under Cover Florida due to lack of participation by both applicants and other insurers.[53] Only one insurer has enrollment and that carrier has 633 enrollees as of December 31, 2014.[54]

Florida Health Choices Corporation, Inc. (Corporation)

The corporation is a private, non-profit, corporation under s. 408.910, F.S., and operates in compliance with part III of chapter 112 (Public Officers and Employees) and chapter 119 (Public Records), 286 (Public Business), and 617 (Corporations Not for Profit).

The corporation is led by a 15-member board of directors and three ex-officio, non-voting board members for 3-year terms to include:

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

[51] *See* s. 409.9091(4)(a)(7).
[52] Guaranteed issue policies means a policy where the health plan must permit an individual to enroll regardless of health status, age, gender, or other factors that might predict the use of health services.
[53] Florida Office of Insurance Regulation, *Cover Florida Health Care Access Program Annual Report (March 2015)*, (last visited Mar. 7, 2015).
[54] Id.

- Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

No board members may include insurers, health insurance agents or brokers, health care providers, health maintenance organizations (HMOs), prepaid service providers, or any other entity or affiliate or subsidiary of eligible vendors. Board members may not serve for more than 9 years and members must disclose any conflicts of interest that would prohibit him or her from participating in any decision that would inure to the member's benefit or the member's organization. The board selects a chief executive officer for the corporation who is responsible for the selection of other staff, as authorized by an operating budget.

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

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

The corporation is authorized to collect premiums and other payments from employers. The law further specifies who may participate as either an employer or an individual. Employers eligible to enroll include employers that meet criteria established by the corporation and their individual employees and other individuals meeting criteria established by the corporation.[55]

The corporation is required to:

- Determine eligibility of employers, vendors, individuals and agents;
- Establish procedures for the operation of the program;
- Arrange for the collection of contributions from employers and participants;
- Establish criteria for disenrollment for failure to pay the individual's share of any contribution required to maintain enrollment in any product;
- Establish criteria for exclusion of vendors;
- Develop and implement a plan for public awareness and program promotion;
- Secure staff and consultant services, as necessary;

[55] *See* s. 408.910(4)(a), F.S.

- Establish policies and procedures as necessary;
- Operate a toll-free hotline to respond to requests for assistance;
- Provide for initial, open and special enrollment periods; and
- Evaluate options for employer participation which may conform with common insurance practices.

Florida Health Choices' marketplace currently includes individual health plans, discount plans, and limited benefit plans. The marketplace offers options that are PPACA-compliant[56] across the different metal ranges, dental-only plans, vision and hearing plans, telemedicine plans, discount plans, and prescription drug plans.[57] Additional marketplace platforms for group health plans for small employers and associations are planned.

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

During its most recent open enrollment, January 5, 2015 through February 15, 2015, FHCC reported 51 total individual product enrollments covering 56 adults and children with 66 applications started. Of those that purchased coverage, 85 percent purchased individual coverage and 15 percent purchased spouse or family coverage.[58] Florida's Health Insurance Marketplace recorded 4,800 visits during their January open enrollment.[59]

The corporation offers a minimum of 20 plans per county from two different companies with a maximum of 46 plans in a county from six different companies as of March 2015.[60]

The Patient Protection and Affordable Care Act of 2010

In March 2010, the Congress passed and the President signed two pieces of legislation: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 that are together called PPACA.[61] Under PPACA, one of the key components required the states to expand Medicaid to a minimum national eligibility threshold of 133 percent of the FPL, or, as it is sometimes expressed, 138 percent of the FPL with application of an

[56] To be compliant with PPACA, plans must eliminate any pre-existing condition exclusions, annual or lifetime dollar limits on the essential benefits, prohibit recissions, provide preventive services without cost sharing, include emergency services without prior authorization, establish an appeals process, provide access to pediatricians and OB\GYNs, extend dependent coverage to age 26 and provide the essential health benefits. For a checklist, see Nat'l Assn. of Insurance Commissioners Compliance Summary: http://www.naic.org/documents/index_health_reform_ppaca_uniform_compliance_summary.pdf (last visited: Mar. 9, 2015).
[57] Florida Office of Insurance Regulation, *Cover Florida Health Care Access Program Annual Report (March 2015)*, (last visited Mar. 7, 2015).
[58] Florida Health Choices Corporation, *Florida Health Choices Reports Zero Glitches with New Online Marketplace Launched in January* (February 20, 2015) http://www.myfloridachoices.org/florida-health-choices-reports-zero-glitches-with-new-online-marketplace-launched-in-january/ (last visited Mar. 7, 2015).
[59] Id.
[60] Conversation with Rose Naff, CEO, Florida Health Choices, Inc.,(Mar. 9, 2015).
[61] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010) and (Pub. Law No. 111-152, 111th Cong. (Mar. 30, 2010).

automatic 5 percent income disregard, effective January 1, 2014.[62] While the funding for the newly eligible under this expansion would be initially funded at 100 percent federal funds for the first three calendar years (2014, 2015, and 2016), the states would gradually be required to pay a share of the costs, starting at 5 percent in calendar year 2017 before leveling off at 10 percent in 2020.[63] As enacted, PPACA provided that states refusing to expand to the new national eligibility threshold faced the loss of *all* of their federal Medicaid funding.[64]

Enhanced Medicaid Match Rate for Newly Eligibles Only: CY 2014 and Beyond[65]							
CY	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020+**
FMAP	100%	100%	100%	95%	94%	93%	90%

Florida, along with 25 other states challenged the constitutionality of the law. In *NFIB v. Sebelius*, the Supreme Court found the enforcement provisions of the Medicaid expansion unconstitutional.[66] As a result, states can voluntarily expand their Medicaid eligibility thresholds to PPACA standards and receive the enhanced federal match for the expansion population, but states cannot be penalized for not doing so.[67]

Since the decision in *NFIB v. Sebelius*, federal guidance has emphasized state flexibility in how states expand coverage to those defined as the newly eligible population. In a letter to the National Governors Association January 14, 2013, then-Health and Human Services Secretary Kathleen Sebelius reminded states of their ability to design flexible benefit packages without the need for waivers and the alternative benefit plans that are available.[68] This letter was preceded by the Frequently Asked Questions document on Exchange, Market Reforms and Medicaid, issued on December 10, 2012, that discussed promotion of personal responsibility, wellness benefits, and state flexibility to design benefits.[69]

Individual and Employer Mandates

A state Medicaid director letter on November 20, 2012 (ACA #21) further addressed state options for the adult Medicaid expansion group and the alternative benefit plans available under Section 1937 of the Social Security Act.[70] Under Section 1937, state Medicaid programs have the

[62] 42 U.S.C. s. 1396a(1).
[63] 42 U.S.C. s. 1396d(y)(1).
[64] 42 U.S.C. s. 1396c
[65] *Supra* at Note 63.
[66] *National Federal of Independent Business (NFIB) v. Sebelius, Secretary of Health and Human Services*, 648 F. 3d 1235, affirmed in part, reversed in part.

[67] Department of Health and Human Services, *Secretary Sebelius Letter to Governors*, (July 10, 2012), http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf (last visited Mar. 7, 2015).
[68] *Letter to National Governor's Association from Secretary Sebelius*, January 14, 2013 (copy on file with Senate Health Policy Committee).
[69] Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, pp. 15-16, (December 10, 2012), http://cciio.cms.gov/resources/factsheets/index.html, (last visited Mar. 17, 2013).
[70] Centers for Medicare and Medicaid Services, *State Medicaid Director Letter: Essential Health Benefits in the Medicaid Program* (November 20, 2012), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf (last visited Mar. 17, 2013).

option of providing certain groups with benchmark or benchmark equivalent coverage based on four products: (1) the standard Blue Cross/Blue Shield Preferred Provider option offered to federal employees; (2) state employee coverage that is generally offered to all state employees; (3) the commercial HMO with the largest insured, non-Medicaid enrollment in the state or (4) Secretary-approved coverage.[71] For children under the age of 21, the coverage must include the Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT). Other aspects of the essential health benefit requirements of PPACA, as discussed further below, may also be applicable, depending on the benefit package utilized.

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

Under the provisions, employers with more than 50 full-time employees that do not offer coverage meeting the essential benefits coverage standard and who does not offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and at least one employee receive a premium tax credit through the federal Marketplace, the employer will be assessed a fee of $2,000 per full time employee, with the first 30 employees, including those who have minimum essential coverage.[72] Or, if an employer does offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and at least one employee receives a premium tax credit through the federal marketplace because the employer's coverage was not affordable, did not provide minimum value, or because the employee was not one of the 95 percent of the employees offered coverage, the employer is assessed the lesser of $3,000 per employee receiving the credit.[73] The large employer can only be assessed under one of the scenarios, not both.

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

- Information reporting requirements applicable to insurers, self-insuring employers and certain other providers of minimum essential coverage;
- Information reporting requirements applicable to large employers; and
- Employer shared responsibilities.[74]

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[71] Id.

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

[73] Id.

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

The notice indicates the delay is intended to give additional time to provide input by employers and other reporting entities and to allow all parties to adapt their reporting systems. The transition relief states that it has no impact on other PPACA provisions.[75]

Individuals may be exempt from the purchase of minimum essential coverage if the minimum amount the individual must pay for that coverage is more than 8 percent of their household income or they may qualify to receive a hardship exemption.[76] Some of the reasons that may qualify an individual for a hardship exemption include, but are not limited to:

- Being ineligible for Medicaid because the individual lives in a state that decided not to expand Medicaid under the PPACA;
- Spending less than three consecutive months without minimum essential health coverage;
- Buying coverage would pose a hardship or go against religious beliefs;
- Having gross income below the applicable return filing threshold;
- Finding no affordable coverage on the Marketplace that meets the minimum value standard; and
- Being eligible for services through Indian Health Care Services.[77]

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

- One percent of your household income that is above the tax return filing threshold for your filing status, or
- Your family's flat dollar amount, which is $95 per adult and $47.50 per adult, limited to a family maximum of $285.[78]

The amount is calculated based on the national average for a premium payment for a bronze level health plan in the marketplace for 2014. For 2014, the annual national average premium for a bronze level health plan was $2,448 per individual, but $12,240 for a family with five or more members.[79]

Exchanges

A health insurance exchange is intended to create an organized and competitive market for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the health care options available to them.[80] To facilitate coverage, PPACA authorized the state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP)

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[75] Id.
[76] Internal Revenue Service, *Individual Shared Responsibility Provision*, *http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision* (last visited Mar. 7, 2015).
[77] Internal Revenue Service, *Shared Responsibility Provision*, http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision (last visited Mar. 7, 2015).
[78] Internal Revenue Service, *Individual Shared Responsibility Provision - Reporting and Calculating the Payment*, http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment (last visited Mar. 7, 2015).
[79] Id.
[80] Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Exchanges* (April 2010) https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7908-02.pdf (last visited Mar. 7, 2015).

Exchanges. These exchanges can be administered by governmental agencies or non-profit organizations. The exchanges, at a minimum, must:[81]

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

On November 16, 2012, Florida Governor Rick Scott notified then-HHS Secretary Sebelius that Florida had too many unanswered questions to commit to a state-based exchange under PPACA for the first enrollment period on January 1, 2014.[82] Florida has since opted to use the federal marketplace.

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

Exchange Benefits

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

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

Qualified Health Plans

In order to receive a health care tax credit, an individual must be enrolled in a qualified health plan.[83] Qualified health plans are certified by the marketplace and meet specific requirements:

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[81]Centers for Medicare and Medicaid Services, *Initial Guidance to States on Exchanges*, (November 18, 2010), http://www.cms.gov/CCIIO/Resources/Files/guidance_to_states_on_exchanges.html (last visited Mar. 7, 2015).
[82] *Letter from Governor Rick Scott to Health and Human Services Secretary Kathleen Sebelius,* (November 16, 2012) http://www.flgov.com/2012/11/16/letter-from-governor-rick-scott-to-u-s-secretary-of-health-and-human-services-kathleen-sebelius/ (last visited Mar. 6, 2015).
[83] Internal Revenue Service, *Health Care Tax Credits: Qualified Health Plan Requirements*, http://www.irs.gov/Individuals/HCTC:-Qualified-Health-Plan-Requirements (last viewed Mar. 8, 2015).

- Provide essential health benefits;
- Follow the established limits on cost sharing; and
- Meet all other requirements.[84]

These plans are available on the federal marketplace or may also be available directly from an insurance company or one of the state's qualified health plans.[85]

Each plan sold must also be one of the following actuarial values[86] or "metal levels:"
- Bronze: 60 percent actuarial value;
- Silver: 70 percent actuarial value;
- Gold: 80 percent actuarial value; and
- Platinum: 90 percent actuarial value.

Premium Tax Credits and Cost Sharing Subsidies

Premium credits and other cost sharing subsidies are available to United States citizens and legal immigrants within certain income limits for coverage purchased through the exchanges. Legal immigrants with incomes at or below 100 percent of the FPL who are not eligible for Medicaid during their first 5 years are eligible for premium credits.[87] Premium credits are set on a sliding scale based on the percent of FPL for the household and reduce the out-of-pocket costs incurred by individuals and families.

The amount for premium tax credits, as a percentage of income, are set in section 36B of the Internal Revenue Code follows:[88]

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

In addition to subsidies for the costs of health insurance premiums, individuals may also qualify to offset other out of pocket costs through cost sharing credits. Subsidies for cost sharing are

[84] U.S. Department of Health and Human Services, Healthcare.gov, *Qualified Health Plan*, *https://www.healthcare.gov/glossary/qualified-health-plan/* (last viewed Mar. 8, 2015).
[85] Id.
[86] Actuarial value is calculated by computing the ratio of total expected payments by the plan for essential health benefits and costing sharing rules with the total costs of the essential health benefits the standard population is expected to incur. For example, a health plan with an actuarial value of 70 percent would be expected to pay an average of 70 percent of the standard population's expected medical expenses for the essential health benefits. Individuals covered by the plan would then be expected to pay the remaining 30 percent, on average through cost sharing such as deductibles, co-pays and co-insurance.
[87] 26 U.S.C. s. 36B(c).
[88] 26 U.S.C. s. 36B(b).

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

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

Cost Sharing Subsidies[89]	
FPL Level	**Cost Sharing Subsidy**
100% - 150%	94%
150% - 200%	87%
200% - 250%	73%
250% - 400%	70%

Cost sharing limitations are based on the limits placed on Health Savings Accounts under the Internal Revenue Code.[90] The maximum out of pocket costs for any federal Marketplace plan in 2015 are $6,600 for an individual and $13,200 for a family plan, even with a catastrophic plan.[91]

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

Supreme Court Action - King v. Burwell

On March 4, 2015, the U.S. Supreme Court heard oral arguments in *King v. Burwell*, a collection of cases that challenge the availability of federal premium tax subsidies for individuals who purchase health insurance coverage on the federal marketplace.[92] The argument centers on Section 1311(b)(1) of the PPACA and the direction that each state shall establish an exchange. Thirty-six states have since declined to develop their own state exchanges and their residents rely on the federal marketplace. If those residents would no longer be eligible for subsidies on the federal marketplace, it is estimated that the uninsured would increase by 8.2 million and that $28.8 billion in tax credits would be eliminated.[93] For Florida, over 1.1 million individuals would

[89] 42 U.S.C. s. 18071(c)(1)(B)
[90] CFR 45 §126.130; *See also* Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended for self only coverage for 2014; or for other than self-only coverage, the annual dollar amount in section 223(c)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended, for non-self only coverage that is in effect for 2014.
[91] U.S. Department of Health and Human Services, healthcare.gov, *Out of pocket costs*, *https://www.healthcare.gov/choose-a-plan/out-of-pocket-costs/* (last visit Mar. 7, 2015).
[92] King v. Burwell, ___F.2d ___ (Fed. Cir. 2014). 2014 U.S. App. LEXIS 13902.
[93] Linda J. Blumberg et al., *The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums*, ROBERT WOOD JOHNSON FOUNDATION AND URBAN INSTITUTE (Jan. 2015) http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf (last visited Mar. 7, 2015).

lose tax credits resulting in over 1 million people becoming uninsured and a loss of $3.8 billion in tax credits and cost sharing reductions,[94]

High Deductible Plans

High-deductible plans are paired with health savings accounts.[95] To qualify as a high deductible plan, the annual deductible must be at least $1,250 for single plans and $2,500 for family coverage. The employer and the employee make annual contributions[96] to a limit of $3,250 for single coverage and $6,250 for family coverage. For 2014, total out of pocket spending is capped at $6,350 for individual and $12,700 for family.[97] Both the employer and the employee contributions are not subject to federal income tax on the employee's income. Unused funds roll over automatically every year. A health savings account is owned by the employee and is portable.

Alternative Medicaid Expansion in Other States

Arkansas

Arkansas received approval for a Medicaid Section 1115 demonstration waiver to implement its Medicaid expansion in September 2013. Under its waiver, Arkansas uses Medicaid funds as premium assistance to purchase coverage in the federal Marketplace for its newly eligible adults up to 138 percent FPL. All newly eligible adults will primarily purchase coverage and enroll in a plan through the federal Marketplace to receive their coverage. Any services not covered through their plan are provided through the state's fee-for-service Medicaid delivery system.[98]

Individuals excluded from enrolling in the federal Marketplace include the medically frail, who may opt out and receive services directly through the state, and American Indians or Alaskan Natives. For all other enrollees affected by the demonstration, enrollment in a QHP is a condition of receiving benefits.[99]

Arkansas' Approved Monthly Premiums - Medicaid Expansion Waiver[100]		
Less than 50%	**50% - 100%**	**100 - 138% FPL**
None	$5 to IA	$10-$25 to IA

[94] Id at 5.
[95] Internal Revenue Code, 26 U.S.C. sec. 223.
[96] The IRS annually sets the contribution limit as adjusted by inflation.
[97] Internal Revenue Services, *Health Savings Accounts and Other Tax-Favored Health Plans (Pub. 969)(2013)* *http://www.irs.gov/publications/p969/index.html* (last visited Mar. 7, 2015).
[98] Centers for Medicare and Medicaid Services, *Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration Fact Sheet*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-fs.pdf (last visited Mar. 7, 2015).
[99] Centers for Medicare and Medicaid Services, Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration, pp.14-15, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (last visited Mar. 7, 2015).
[100] Centers for Medicare and Medicaid Services, Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration, pp.7 & 21, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (last visited Mar. 7, 2015).

All beneficiaries with incomes between 50 percent and 133 percent of the FPL will be assigned an Independence Account (IA). The individual will receive a credit or debit card to access the amounts in that account to cover copayments and coinsurance. Both the state and the participant are required to make contributions to this account.[101]

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

Enrollees under 50 percent of the FPL have no additional cost sharing. Those enrollees above 50 percent of the FPL have cost sharing consistent with Medicaid requirements and does exceed more than 5 percent of family monthly or quarterly income.[102]

Iowa

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

- Expands Medicaid for those at or below 100 percent FPL through Medicaid managed care; and
- Expands Medicaid for those from 101 percent FPL - 138 percent FPL by purchasing silver-level qualified health plan coverage in the marketplace.

Premiums were not imposed during the first year of the program but will be in the second year of the demonstration for enrollees above 50 percent of the FPL. Enrollees have the opportunity to have these waived if they complete healthy behaviors and can continue to be waived in subsequent years for meeting those incentives. At the state's option, the non-payment of a premium can result in a collectible debt, but not a loss of coverage.[103]

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

Individuals in the Wellness Plan (Medicaid Managed Care) receive a Medicaid alternative benefits plan that is at least equivalent to the state employee benefit plan, except for an enhanced dental plan with access to additional dental benefits with prior authorization.[104] While those in the Marketplace plan, receive an essential health benefit plan that is at least equivalent to those

[101] Centers for Medicare and Medicaid Services, Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration, p.7, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (last visited Mar. 7, 2015).
[102] Id at 16.
[103] Centers for Medicare and Medicaid Services, Special Terms and Conditions with Iowa Department of Human Services - Iowa Wellness Plan (11-W-00289/5) http://dhs.iowa.gov/sites/default/files/WellnessSTCsTechnicalCorrections_020215.pdf (last visited Mar. 7, 2015).
[104] Iowa Department of Human Services, Medicaid 1115 Waiver Application, Iowa Wellness Plan, p.5, http://dhs.iowa.gov/sites/default/files/IAWellnessPlan1115_Final.pdf (last visited Mar. 7, 2015).

provided on the commercial essential health benefits benchmark.[105] Wrap-around services are provided by the Medicaid agency for family planning services at non-network providers and for EPSDT services for 19 and 20 year old enrollees. Iowa is not required to provide non-emergency transportation. The waiver was initially granted in year one of the demonstration and continued through July 31, 2015.[106]

Indiana

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

- HIP Basic - an ABP for individuals that includes all of the essential health benefits and does not require a premium payment;
- HIP Plus - a comprehensive ABP for individuals who contribute to a POWER account with additional benefits not available in HIP Basic; and
- HIP Link Program - a voluntary premium assistance program for individuals above age 21 with access to cost effective employer sponsored insurance that meets qualification criteria.[107]

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

In addition to health benefits coverage, individuals who contribute to a Personal Wellness and Responsibility (POWER) account access additional benefits, contributions to a POWER account are a condition of eligibility for those with incomes above 100 percent of the FPL.[108] Funds in the POWER accounts are used to pay for some of beneficiaries' health care expenses. With the exception of inappropriate use of the emergency room fee, no other cost sharing is charged under the HIP Plus component.

Those enrolled in HIP Basic are subject to copayments. These copayments are consistent with the Medicaid cost sharing rule and must include the automated tracking of the 5 percent monthly or quarterly aggregate cap. Indiana had the following co-payments approved:

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

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

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

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

Indiana HIP Basic Co-Pay Schedule[109]	
Service	**Per Visit\Service**
Preventive Care Services (including family planning and maternity services)	$0
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-Preferred Drugs	$8
Non-Emergent ER Use (HIP Basic and HIP Plus)	$8 - 1st visit $25 - Recurrent

Enrollees above 100 percent of the FPL who do not make contributions or who cease transition to the HIP Basic program after a 60 day grace period are disqualified from the HIP Plus program for 6 months.[110] There are exceptions to the lock-out period for the medically frail and other special circumstances.

Indiana Maximum Monthly POWER Contributions[111]					
<5% FPL	**<22%**	**22% - 50%**	**51% -75%**	**76%-100%**	**101%-138%**
$1	$4.32	$9.82	$14.72	$19.62	$27.39
- Represents approximately 2% of enrollee's income; - When enrollee leaves the program, the member amount is refunded to the member; and - When enrollee remains in the program, the member portion rolls over at the end of the year; can double if member completes required preventive services.					

The POWER accounts function like a health savings account and hold both beneficiary and state contributions. The POWER account funds pay for the first $2,500 in claims; claims beyond that amount are covered through capitation or other payments made by the state.[112] The funds are not for copayments under the HIP Plus accounts. For HIP Link enrollees, the POWER account funds are used to pay premium and cost sharing amounts.[113]

Employers and other third parties are also permitted to contribute to POWER accounts. It is the managed care organization's responsibility to issue the POWER card to each enrollee upon enrollment and to track all of the contributions.[114]

Outside of this demonstration, Indiana will offer a separate work search and job training program to encourage employment called Gateway to Work for those enrollees who choose to participate. Health coverage under Medicaid will not be affected.[115]

[109] Id at 35 and 36.
[110] Id.
[111] Healthy Indiana Plan 2.0, Presentation to Senate Health Policy Committee (March 4, 2015), slides 16 & 17 (on file with the Senate Committee on Health Policy).
[112] *Supra* Note 108, at 26.
[113] Id.
[114] *Supra* Note 108, at 30.
[115] *Supra* Note 108, at 3.

III. Effect of Proposed Changes:

Florida Health Insurance Affordability Exchange Program (Sections 1-14)

SB 7044 directs the Division of Law Revision and Information to rename part II of chapter 409, Florida Statutes as the "Insurance Affordability Programs" which is currently named "Kidcare," to incorporate the newly created sections of ss. 409.720-409.731, F.S., under this part. The "Florida Health Insurance Affordability Exchange Program" or "FHIX" is established under sections 409.720 through 409.731, Florida Statutes, a new program under part II of ch. 409F.S.

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

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

Definitions specific for the FHIX program are:

- "Agency" means the Agency for Health Care Administration;
- "Applicant" means an individual who applies for determination of eligibility for health benefits coverage under this part;
- "Corporation" means Florida Health Choices, Inc.;
- "Enrollee" means an individual who has been determined eligible for and is receiving health benefits coverage under this part;
- "Florida Health Insurance Affordability Exchange" or "FHIX" means the program created under ss. 409.720-409.731, F.S.;
- "Florida Healthy Kids Corporation" means the entity created under s. 624.91, F.S.;
- "Florida Kidcare Program" or "Kidcare" means the program created under ss. 409,810-409.821, F.S.;
- "Health benefits coverage" means the payment of benefits for covered health care services or the availability, directly or through arrangements with other persons, of covered health care services on prepaid or per capita basis or a prepaid aggregate fixed sum basis;
- "Inactive status" means the enrollment status of a participant previously enrolled in health benefits coverage in the FHIX marketplace, who lost coverage through non-payment, but maintains access to his or her balance in a health savings account or health reimbursement account;
- "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and part III and IV of ch. 409, F.S., as administered by the agency;
- "Modified adjusted gross income" means the individual's or household's adjusted gross income as defined in s. 36B(d)(2) of the Internal Revenue Code of 1986 and which is used to determine eligibility for FHIX;

- "Patient Protection and Affordable Care Act" or "Affordable Care Act" means Public Law No. 111-148, as further amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and amendments to, and regulations or guidance under, those acts;
- "Premium credit" means the monthly amount paid by the agency per enrollee in the FHIX toward health benefits coverage;
- "Qualified alien" means an alien as defined in 8 U.S.C. s. 1641(b) or (c);[116] and
- "Resident" means a United States citizen or qualified alien who is domiciled in this state.

Eligibility

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

- Qualify as a newly eligible enrollee as described in s. 1902(a)(10)(A)(i)(VIII) of the Social Security Act or s. 2001 of the Affordable Care Act and as may be further defined by federal regulation;
- Meet and maintain the responsibilities under participant responsibilities; and
- Qualify as a participant in the Florida Healthy Kids program under s. 624.91, F.S., subject to the implementation of Phase Three under s. 409.727, F.S.

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

Enrollment

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

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

Participant Rights

A participant has certain rights under FHIX:

- Access to the FHIX marketplace to select the scope, amount, and type of health care coverage and services to purchase;

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

- Continuity and portability of coverage to avoid disruption of coverage and other health care services when the participant's economic circumstances change;
- Retention of unspent credits in the participant's health savings or health reimbursement account following a change in the participant's eligibility status. Credits are maintained for an inactive status participant for up to 5 years after the participant enters inactive status;
- Ability to select more than one product or plan on the FHIX marketplace; and
- Choice of at least two health benefits products that meet the requirements of the Affordable Care Act.

Participant Responsibilities

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

- Complete an initial application for health benefits coverage and annual renewal process which includes proof of employment, on-the-job training or placement activities, or pursuit of educational opportunities at certain hourly levels based on status;
- Learn and remain informed about the choices available on the FHIX marketplace and the uses of credit in the individual accounts;
- Execute a contract with the department that acknowledges that FHIX is not an entitlement, state and federal funding may end at any time, failure to pay cost sharing may result in a transition to inactive status, and noncompliance with other requirements may also result in a transition to inactive status;
- Select plans and other products in a timely manner;
- Comply with program rules and prohibitions against fraud;
- Make monthly premium payments and other cost sharing by the deadline; and
- Meet minimum coverage requirements by selecting a high deductible health plan combined with a health savings or health reimbursement account if not selecting a plan with more extensive coverage.

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

Cost Sharing

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

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

Depending on the products and services selected by the enrollee, he or she may incur additional cost sharing, such as copayments, deductibles, or other out of pocket costs. An enrollee may also be charged an inappropriate emergency room fee of $8 for the first visit and up to $25 for any subsequent visit, based on the plan selected by the enrollee. Cumulative annual cost sharing, however, may not exceed 5 percent of the enrollee's annual modified adjusted gross income.

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

Available Assistance

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

In addition to the standard health benefits provided, the corporation must also offer each enrollee access to an individual account that qualifies as a health reimbursement or health savings account. Unexpended funds from the monthly premium credit must be placed in the account as well as credits earned from healthy behaviors, adherence to wellness plans, or compliance with disease management plans. Funds in these accounts may be used to pay cost sharing obligations or to purchase other health-related items, as permitted under federal law. This account may be retained for up to 5 years after a participant moves into inactive status.

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

Choice counseling will be coordinated by the agency and the corporation for the FHIX. The choice counseling program must ensure the enrollees have information about the FHIX marketplace program, the products and services, who to call for questions or to make plan selections. The program will also provide culturally sensitive materials that take into consideration the projected population.

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

- How the transition process to the FHIX marketplace will occur and the timeline for the enrollee's specific transition;
- What plans are available and how to research information about available plans;
- Information about other available insurance affordability programs for the individual and his or her family;
- Information about health benefits coverage, provider networks, and cost sharing for available plans in each region;
- Information on how to complete the required annual renewal process, including renewal dates and deadlines; and

- Information on how to update eligibility if the participant's data have changed since his or her last renewal or application date.

Beginning in Phase Two (January 1, 2016), the Florida Healthy Kids Corporation will provide customer support for the FHIX marketplace. Customer support will include:
- Having a toll-free number;
- Maintaining a web site in multiple languages;
- Providing general program information;
- Handling financial information, including enrollee premiums; and
- Providing customer service and status reports on enrollee premiums;

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

Available Products and Services

Section 409.725, F.S., requires the FHIX marketplace to offer the following products and services:
- Authorized products and services that are offered on the Florida Health Choices, Inc. marketplace (409.910, F.S.);
- Medicaid managed care plans under part IV of this chapter, that qualify to participate;
- Authorized products under the Florida Healthy Kids Corporation; and
- Employer sponsored plans.

Program Accountability

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

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

SB 7044 establishes specific performance standards for the department for the processing of applications, both initial applications and renewals. The agency, department, and the Florida Healthy Kids Corporation must conduct an annual satisfaction survey for the FHIX marketplace which may be incorporated into the annual report. Enrollment reports must be posted online monthly.

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

Implementation Schedule

The implementation schedule for FHIX is based on each phase passing a readiness review and before implementation under s. 409.727, F.S. The agency is identified as the lead agency for FHIX, as the state's designated Medicaid agency. The agency, the corporation, the department, and the Florida Healthy Kids Corporation are directed to begin implementation upon SB 7044 becoming law, with statewide implementation of the FHIX marketplace by January 1, 2016.

Implementation Activities			
Phase	**Start Date**	**Activities**	**Enrollee Requirements**
Readiness	Effective Date - Ongoing Based on Phase\Region	Implementation Activities	None
One	July 1, 2015	-Enroll newly eligible, low-income, uninsured into Medicaid managed care plans -Corporation readies for implementation of FHIX marketplace for Phase Two -Healthy Kids prepares for customer service, financial support and choice counseling in Phase Two and Three	-Complete application -Select MMA plan -Utilize health savings or health reimbursement account
Two	January 1, 2016*	1. Enroll newly eligible, low-income, uninsured into FHIX 2. Transition Phase One enrollees from MMA plans to FHIX by April 1, 2016 3. Renew existing enrollees at annual enrollment date 3. Healthy Kids prepares to transition enrollees to FHIX under Phase Three	-Complete application -Meet work or educational requirements or seek an exemption -Pay required premium or transition to inactive status -Select plans products, or services from FHIX -Execute contract -Comply with program rules -Meet minimum coverage requirements -Utilize health savings or health reimbursement account
Three	July 1, 2016*	1. Enroll newly eligible, low-income, uninsured into FHIX 2. Renew existing enrollees at annual enrollment date 3. Healthy Kids transitions enrollees to FHIX under Phase Three	-Complete application -Meet work or educational requirements or seek an exemption -Pay required premium or transition to inactive status -Select plans products, or services from FHIX -Execute contract -Comply with program rules

Implementation Activities			
Phase	**Start Date**	**Activities**	**Enrollee Requirements**
			-Meet minimum coverage requirements -Utilize health savings or health reimbursement account

**Phase Two implementation is contingent upon federal approval*

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

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

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

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

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

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

Enrollees moving from Phase One coverage must complete the process by April 1, 2016, or they will transition to inactive status. There is no automatic enrollment in the FHIX. Choice

counseling during Phase Two will be provided in coordination by the agency and the corporation with customer support by the Florida Healthy Kids Corporation.

Phase Three begins no later than July 1, 2016 with the transition of Healthy Kids enrollees to the FHIX marketplace. Healthy Kids enrollees must meet the eligibility requirements of Phase Two enrollees and be eligible for the Healthy Kids program under s. 624.91, F.S. A Healthy Kids enrollee who selects a FHIX marketplace plan will be provided a premium credit equal to the average capitation rate paid in his or her county of residence in the Healthy Kids program as of June 30, 2016. The enrollee would be responsible for any difference in costs. Any unexpended funds from the premium credit may be used on the FHIX marketplace for supplemental benefits.

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

Program Operation and Management

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

Specific Program Operations and Management Duties for FHIX			
Agency for Health Care Admin.	**Dept. of Children and Families**	**Florida Health Choices, Inc.**	**Florida Healthy Kids**
Contract with Fla Health Choices for FHIX for implementation, development and administration and release of funds	Coordinate with other agencies and corporations	Begin implementation of FHIX in Phase One	Retain duties in Phase One and Two
Administer Phase One	Determine eligibility and renewals	Implement FHIX for Phase Two and Three	Provide customer service to FHIX
Provide administrative support to FHIX Workgroup	Transmit eligibility determinations to agency and corporation	Offer health benefits coverage compliant with PPACA	Collect and transfer family funds to FHIX
Transition Phase One Enrollees to FHIX no later than April 1, 2016		Offer at least 2 plans at each metal level	Conduct financial reporting
Transmit enrollee information to FHIX		Provide opportunity for MMA plans to participate on FHIX in Phase Three	Coordinate activities with partner agencies

Specific Program Operations and Management Duties for FHIX			
Agency for Health Care Admin.	**Dept. of Children and Families**	**Florida Health Choices, Inc.**	**Florida Healthy Kids**
With Phase Two, determine risk adjusted rates annually based on specific statutory criteria		Offer enhanced or customized benefits	
Transfer funds to FHIX for premium credits		Provide sufficient staff and resources	
Encourage Medicaid Managed Assistance (MMA) plans to participate on FHIX		Provide opportunity for Healthy Kids plans to participate at FHIX	

Long Term Re-Organization

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

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

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

Federal Authorities

Section 12 creates under s. 409.730, F.S., to authorize the agency to seek federal approval to implement FHIX. Obtaining federal approval may be a multi-step process.

Section 13 creates s. 409.731, F.S., and establishes triggers for expiration of the FHIX program under certain conditions. FHIX expires at the end of Phase One if the state does not receive federal approval for Phase Two or at the end of the state fiscal year in which any of these conditions occur:

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

Florida Health Choices Program

Section 15 revises s. 408.910, F.S., to recognize the role the corporation will play in the FHIX marketplace. The bill makes the necessary changes to authorize the corporation to offer the products and services to the newly eligible population under the FHIX.

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

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

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

SB 7044 includes a modification that recognizes that not all enrollees may have the option of payroll deduction.

The bill clarifies that surcharges may not be assessed on products or services sold on the FHIX marketplace. A separate reference to the FHIX marketplace has been created within the statute from the existing marketplace to distinguish the process, enrollment periods, and differing limits.

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

Florida Healthy Kids Corporation (Sections 17 and 18)

Section 17 revises s. 624.91, F.S., the "William G. 'Doc' Myers Healthy Kids Corporation Act." Obsolete language referring to local and state subsidized non-Title XXI enrollees who have attritioned out of the program is deleted throughout the act. References to local match or local funds which are no longer collected are also deleted.

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

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

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

Quarterly full-pay enrollment and utilization comparison information is required to be provided online. The current statute is not specific as to how the information may be provided.

The board of directors is re-configured with the chair being an appointee designated by the Governor and composed of 12 other members appointed by the Governor and confirmed by the Senate for 3-year terms. The board members serve at the pleasure of the Governor. Those members who are serving as of the effective date of this act may remain on the board until January 1, 2016.

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

Under section 18, s. 624.915, F.S., the Operating Fund of the Florida Healthy Kids Corporation is repealed effective upon the bill becoming law. The Operating Fund of Healthy Kids has never been separately funded.

Other Provisions (Sections 14, 19)

Section 408.70, F.S., which authorizes the Medically Needy program under Medicaid is repealed under section 14 of this bill. The action would be effective upon the bill becoming law.

Section 19 directs the Division of Law Revision and Information to replace the phrase "the effective date of this act" wherever it occurs with the date the act becomes law.

Effective Date (Section 20)

The act shall take effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 7044 may provide cost saving to Floridians and stimulate economic growth. The following two organizations have published estimates:

- The Florida Chamber estimates that Florida's families and business pay $1.4 billion in hidden health care taxes to cover the costs of the uninsured.[117] As an example, the Chamber has estimated that every insured Floridian pays about $2,000 for every hospital stay to cover the cost of the uninsured.[118]
- The Florida Hospital Association (FHA) has also conducted research on the impact of extending health insurance coverage to this population. By covering 1 million or more Floridians, the FHA has projected 121,000 new jobs, savings of more than $2.5 billion in state general revenue, and $541 million a year in local government revenue.[119]

The Affordable Care Act imposes an employer mandate effective in 2015 for businesses that employ 100 or more people. Those employers must provide affordable health insurance coverage or face penalties of $2,000 or $3,000 per person. This may also have an impact on Florida's economy if additional options are not available and more individuals are not covered.[120]

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[117] Florida Chamber of Commerce, *Smarter Healthcare Coverage in Florida*, p.3, http://www.flchamber.com/wp-content/uploads/FL-Chamber-Plan-for-Smarter-Healthcare-Coverage.pdf (last visited Mar. 8, 2015).
[118] Id.
[119] Florida Hospital Association, *A Healthy Florida Works, http://ahealthyfloridaworks.com/v6/wp-content/uploads/2014/10/AHealthyFloridaIGv10.pdf* (last visited Mar. 8, 2015).
[120] Id.

C. Government Sector Impact:

Additional jobs that lead to 1 million additional insured individuals in the state may have an impact on other government services, state and local.

Medically Needy Program
Repeal of the Medically Needy program and a shift of those individuals into a more comprehensive medical insurance program at a higher federal match rate may generate savings in General Revenue or Tobacco Settlement funds that could be utilized to offset costs in the program in the long-term. For the 2014-2015 state fiscal year, the latest estimates are from February 2015 Social Services Estimating Conference:

TOTAL COST	**$671,322,121**
GENERAL REVENUE	$152,671,797
MEDICAL CARE TRUST FUND	$314,710,200
REFUGEE ASSISTANCE TRUST FUND	$0
PUBLIC MEDICAL ASSIST TRUST FUND	$35,000,000
OTHER STATE FUNDS	$2,249
GRANTS AND DONATIONS TRUST FUND	$138,937,874
HEALTH CARE TRUST FUND	$0
TOBACCO SETTLEMENT TRUST FUND	$30,000,000

The partner agencies and the two state-created non-profit corporations have provided preliminary fiscal analyses of the recurring and non-recurring costs of development, implementation and maintenance of the FHIX marketplace.

Agency for Health Care Administration
The agency has not finalized any specific fiscal estimates for the bill. The agency will incur the medical care costs for the enrollees in the first fiscal year and have identified two areas for additional resource needs:

- Actuarial Services; and
- Choice Counseling under Phase One.

Department of Children and Families
The department projects that an additional 120 eligibility or case management staff would be necessary to process and maintain an estimated 487,996 applicants during the first year of FHIX based on 60 percent of its current 813,327 food assistance households are projected to qualify as newly eligible for coverage.[121]

Of the non-recurring expenses, the department includes costs for furniture and equipment for the additional FTEs and a one-time mass-mailing to the affected individuals.[122]

[121] Florida Department of Children and Families, *2015 Agency Bill Analysis - SPB 7044* (Mar. 9, 2015) p.5, (on file with the Senate Committee on Health Policy).
[122] Id.

The department also estimates a need for additional budget authority for information technology enhancements; however, the final estimate for this enhancement is not yet known. Information technology costs also include creating an interface with Florida Health Choices, new FLORIDA system notices to inform enrollees of case actions and new eligibility rules for a new Medicaid group.

Federal match for Medicaid eligibility staff costs is reimbursable at 75 percent and information system development costs at 90 percent.[123]

FHIX Estimated Costs - Year One 2015-2016	
Entity	**Totals**
AHCA	
No specific estimates have been received	
Department of Children & Families[124]	
Salaries and Benefits *(120 FTEs)*	$4,455,355
Expenses (Recurring)	$1,335,499
Expenses (Non-Recurring)	$707,030
Human Resources Charge	$41,280
Computer Related Expenses (pending final)	$1,000,000
Recurring 2015-16	$5,832,134
Non-Recurring 2015-16	$1,707,030
TOTAL - DCF	**$7,539,164**
Florida Health Choices[125]	
Software License	$300,000
Technical Implementation	$200,000
Plan Solicitation and Mgmt	$90,000
Provider Network Monitoring	$90,000
Transition Medicaid Enrollees	$25,000
Enrollment Management (200,000/3mos)	$1,200,000
TOTAL- FHC	$2,605,000

[123] Id at 6.
[124] Department of Children and Families, *Supplemental Fiscal Analysis*, Email on file with Senate Health Policy Committee (March 10, 2015).
[125] Florida Health Choices, Inc., Email from Rose Naff, CEO, Florida Health Choices (Mar. 9, 2015), on file with Senate Health Policy Committee).

FHIX Estimated Costs - Year One 2015-2016	
Entity	**Totals**
Florida Healthy Kids Corporation	
No specific estimates have been received	

Second year costs for the department are based on a workload impact created by the remaining 40 percent of food assistance eligible individuals seeking benefits. The department seeks an additional 78 FTEs to handle the increased caseload.

Florida Health Choices

For Florida Health Choices, second year costs reflect the transition of enrollees from Phase One to Phase Two and increased management responsibilities.

Florida Healthy Kids Corporation

The Florida Healthy Kids Corporation will incur costs for its responsibilities under the bill relating to customer service, financial services and IT infrastructure. Cost estimates are not available at this time.

FHIX Estimated Costs - Year Two 2016-2017	
Entity	**Totals**
AHCA	
No specific estimates have been received.	
Department of Children & Families	
Salaries and Benefits *(78 FTEs)*	$2,896,690
Expenses (Recurring)	$878,740
Expenses (Non-Recurring)	$301,068
Human Resources Charge	$26,832
Recurring 2016-17	$3,802,262
Non-Recurring 2016-17	$301,068
TOTAL_DCF	**$4,873,224**
Florida Health Choices	
Enrollment Management (400,000/9mos)	$7,200,000
Enrollment Management (200,000/3mos)	$3,600,000
Plan Solicitation & Mgmt	$90,000
Provider Network Monitoring	$150,000

FHIX Estimated Costs - Year Two 2016-2017	
Entity	**Totals**
Transition FHKC Enrollees	$25,000
TOTAL - FHC	$11,765,000
Florida Healthy Kids Corporation	
No specific estimates have been received.	

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 408.910, 409.904, and 624.91.
This bill creates the following sections of the Florida Statutes: 409.720 - 409.731.
This bill repeals the following sections of the Florida Statutes: 408.70 and 624.915.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: UNFAV	.	
03/10/2015	.	
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	.	

The Committee on Health Policy (Sobel) recommended the following:

Senate Amendment

Delete lines 92 - 549
and insert:
(3) "Corporation" means the Florida Healthy Kids Corporation, as established under s. 624.91.
(4) "Enrollee" means an individual who has been determined eligible for and is receiving health benefits coverage under this part.
(5) "FHIX marketplace" or "marketplace" means the single,

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centralized market established under s. 408.910 which facilitates health benefits coverage.

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

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

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

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

(10) "Inactive status" means the enrollment status of a participant previously enrolled in health benefits coverage through the FIX marketplace who lost coverage through the marketplace for non-payment, but maintains access to his or her balance in a health savings account or health reimbursement account.

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

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

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

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

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

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

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

409.723 Participation.—

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

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

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

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

(2) ENROLLMENT.—To enroll in FHIX, an applicant must submit an application to the department for an eligibility

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determination.

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

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

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

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

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

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

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

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

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

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

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

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(a) Complete an initial application for health benefits coverage and an annual renewal process, which includes proof of employment, on-the-job training or placement activities, or pursuit of educational opportunities at the following hourly levels:

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

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

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

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

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

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

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

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

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

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

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

(5) COST SHARING.—

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

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

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

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

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

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

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

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

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

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

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has not been received, the enrollee shall be transitioned from coverage to inactive status and may not reenroll for a minimum of 6 months, unless a hardship exception has been granted. Enrollees may seek a hardship exception under the Medicaid Fair Hearing Process.

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

409.724 Available assistance.—

(1) PREMIUM CREDITS.—

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

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

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

(d) Enrollee contributions.—The enrollee may make deposits

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to his or her account at any time to supplement the premium credit, to purchase additional FHIX products, or to offset other cost-sharing obligations.

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

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

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

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

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

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

(d) Information about health benefits coverage, provider

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networks, and cost sharing for available plans in each region.

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

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

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

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

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

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

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

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

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

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(4) Employer-sponsored plans.

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

409.726 Program accountability.—

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

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

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

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

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

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

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days.

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

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

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

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

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

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

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

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

(a) Enrollment and application trends and issues.

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(b) Utilization and cost data.

(c) Customer satisfaction.

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

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

(f) Types of products and plans purchased.

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

(h) Recommendations for program improvement.

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

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

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

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

(b) Plan availability and presence of plan choice.

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

(d) Availability of customer support.

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

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(2) PHASE ONE.—

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

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

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

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

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

(3) PHASE TWO.—

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

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

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

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

(e) A Phase One enrollee must be transitioned to the FHIX marketplace by April 1, 2016. An enrollee who does not select a plan or service on the FHIX marketplace by that deadline shall

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be moved to inactive status.

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

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

(4) PHASE THREE.—

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

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

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

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

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

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

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

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

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

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

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

(b) Administer Phase One of FHIX.

(c) Provide administrative support to the FHIX Workgroup under s. 409.729.

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

(e) Timely transmit enrollee information to the corporation.

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


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

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

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

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

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

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

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

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

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

(f) Begin the development of FHIX during Phase One.

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

(h) Offer health benefits coverage packages on the FHIX marketplace, including plans compliant with the Affordable Care


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Act.

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

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

(k) Offer enhanced or customized benefits to FHIX marketplace enrollees.

(l) Provide sufficient staff and resources to meet the program needs of enrollees.

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


525078

LEGISLATIVE ACTION

Senate	.	House
Comm: UNFAV	.	
03/10/2015	.	
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	.	

The Committee on Health Policy (Sobel) recommended the following:

Senate Amendment

Between lines 197 and 198
insert:

A participant in compliance with this paragraph whose modified adjusted gross income is below 100 percent of the federal poverty level must be provided assistance with education, transportation, and child care costs.

907122

LEGISLATIVE ACTION

Senate	.	House
Comm: UNFAV	.	
03/10/2015	.	
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The Committee on Health Policy (Sobel) recommended the following:

Senate Amendment

Delete lines 242 - 247
and insert:
(e) For an enrollee whose modified adjusted gross income is at or above 100 percent of the federal poverty line, if, after a 30-day grace period, full premium payment has not been received, the enrollee shall be transitioned from coverage to inactive status and may not reenroll for a minimum of 6 months, unless a hardship exception has been granted. Enrollees may seek a

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hardship exception under the Medicaid fair hearing process.

(f) For an enrollee whose modified adjusted gross income is below 100 percent of the federal poverty line, if, after a 60-day grace period, full premium payment has not been received, the enrollee shall be transitioned from coverage to inactive status and may not reenroll for a minimum of 3 months, unless a hardship exception has been granted. Enrollees may seek a hardship exception under the Medicaid fair hearing process.

789632

LEGISLATIVE ACTION

Senate	.	House
Comm: UNFAV	.	
03/10/2015	.	
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The Committee on Health Policy (Braynon) recommended the following:

Senate Amendment

Delete lines 404 - 474
and insert:
as described in s. 409.966(2), by July 1, 2016.
(1) READINESS REVIEW.—Before implementation of any phase under this section, the agency shall conduct a readiness review in consultation with the FHIX Workgroup described in s. 409.729. The agency must determine that the region has satisfied, at a minimum, the following readiness milestones:

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

(b) Plan availability and presence of plan choice.

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

(d) Availability of customer support.

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

(2) PHASE ONE.—

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

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

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

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

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

(3) PHASE TWO.—

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

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

(c) An enrollee may select any benefit, service, or product

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available.

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

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

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

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

(4) PHASE THREE.—

(a) No later than January 1, 2017, the corporation and the Florida Healthy Kids Corporation must begin the transition of enrollees under s. 624.91 to the FHIX marketplace.

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

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

(d) A Florida Healthy Kids enrollee who selects a FHIX marketplace plan must be provided a premium credit equivalent to the average capitation rate paid in his or her county of residence under Florida Healthy Kids as of December 31, 2016. The enrollee is responsible for any difference in costs and may use any remaining funds for supplemental benefits on the FHIX marketplace.

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

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

(g) Enrollees under s. 624.91 must transition to the FHIX marketplace by March 31, 2017.

478094

LEGISLATIVE ACTION

Senate	.	House
Comm: UNFAV	.	
03/10/2015	.	
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The Committee on Health Policy (Joyner) recommended the following:

Senate Amendment

Delete line 555
and insert:
affordability programs. The FHIX Workgroup consists of four representatives from stakeholder social service or health service organizations, with the Senate President, the Speaker of the House of Representatives, the Senate Minority Leader, and the House Minority Leader each appointing one such member, and two

187042

LEGISLATIVE ACTION

Senate	.	House
Comm: UNFAV	.	
03/10/2015	.	
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The Committee on Health Policy (Joyner) recommended the following:

Senate Amendment (with title amendment)

Delete lines 1137 - 1158.

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

And the title is amended as follows:

Delete lines 35 - 38

and insert:

amending s. 624.91, F.S.; revising

FOR CONSIDERATION By the Committee on Health Policy

588-01827A-15 20157044pb

A bill to be entitled

An act relating to a health insurance affordability exchange; creating s. 409.720, F.S.; providing a short title; creating s. 409.721, F.S.; creating the Florida Health Insurance Affordability Exchange Program or FHIX in the Agency for Health Care Administration; providing program authority and principles; creating s. 409.722, F.S.; defining terms; creating s. 409.723, F.S.; providing eligibility and enrollment criteria; providing patient rights and responsibilities; providing premium levels; creating s. 409.724, F.S.; providing for premium credits and choice counseling; establishing an education campaign; providing for customer support and disenrollment; creating s. 409.725, F.S.; providing for available products and services; creating s. 409.726, F.S.; providing for program accountability; creating s. 409.727, F.S.; providing an implementation schedule; creating s. 409.728, F.S.; providing program operation and management duties; creating s. 409.729, F.S.; providing for the development of a long-term reorganization plan and the formation of the FHIX Workgroup; creating s. 409.730, F.S.; authorizing the agency to seek federal approval; creating s. 409.731, F.S.; providing for program expiration; repealing s. 408.70, F.S., relating to legislative findings regarding access to affordable health care; amending s. 408.910, F.S.; revising legislative intent; redefining terms; revising the scope of the Florida

Health Choices Program and the pricing of services under the program; providing requirements for operation of the marketplace; providing additional duties for the corporation to perform; requiring an annual report to the Governor and the Legislature; amending s. 409.904, F.S.; removing certain Medicaid-eligible persons from those for whom the agency may make payments for medical assistance and related services; amending s. 624.91, F.S.; revising eligibility requirements for state-funded assistance; revising the duties and powers of the Florida Healthy Kids Corporation; revising provisions for the appointment of members of the board of the Florida Healthy Kids Corporation; requiring transition plans; repealing s. 624.915, F.S., relating to the operating fund of the Florida Healthy Kids Corporation; providing an effective date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Administration.

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

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

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

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

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

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

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

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

(10) "Inactive status" means the enrollment status of a participant previously enrolled in health benefits coverage through the FIX marketplace who lost coverage through the marketplace for non-payment, but maintains access to his or her

balance in a health savings account or health reimbursement account.

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

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

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

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

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

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

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

409.723 Participation.—

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Retention of applicable unspent credits in the

participant's health savings or health reimbursement account following a change in the participant's eligibility status. Credits are valid for an inactive status participant for up to 5 years after the participant first enters an inactive status.

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

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

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

(a) Complete an initial application for health benefits coverage and an annual renewal process, which includes proof of employment, on-the-job training or placement activities, or pursuit of educational opportunities at the following hourly levels:

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

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

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

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

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

may end at any time;

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

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

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

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

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

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

(5) COST SHARING.—

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

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

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

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

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

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

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

copayments, deductibles, or other out-of-pocket costs.

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

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

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

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

409.724 Available assistance.—

(1) PREMIUM CREDITS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Employer-sponsored plans.

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

409.726 Program accountability.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Enrollment and application trends and issues.

(b) Utilization and cost data.

(c) Customer satisfaction.

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

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

(f) Types of products and plans purchased.

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

(h) Recommendations for program improvement.

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

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

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

in consultation with the FHIX Workgroup described in s. 409.729. The agency must determine that the region has satisfied, at a minimum, the following readiness milestones:

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

(b) Plan availability and presence of plan choice.

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

(d) Availability of customer support.

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

(2) PHASE ONE.—

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

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

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

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

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

(3) PHASE TWO.—

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

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

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

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

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

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

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

(4) PHASE THREE.—

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

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

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

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

enrollee is responsible for any difference in costs and may use any remaining funds for supplemental benefits on the FHIX marketplace.

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

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

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

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

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

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

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

(b) Administer Phase One of FHIX.

(c) Provide administrative support to the FHIX Workgroup under s. 409.729.

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

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

(e) Timely transmit enrollee information to the corporation.

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

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

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

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

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

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

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

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

sharing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) Determine staff requirements for Phase Three.

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

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

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

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

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

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

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

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

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

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

408.910 Florida Health Choices Program.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

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

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

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

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

4. Services that promote healthy behaviors.

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

6. Consumer assistance and enrollment services for the

Florida Health Insurance Affordability Exchange Program, or FHIX.

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

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

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

(g) Information services for individuals and employers.

(h) Program evaluation.

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

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

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

1. Individual employees of enrolled employers.

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

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

1. Submission of required information.

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

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

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

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

6. Identification of eligible employees.

7. Arrangement for periodic payments.

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

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

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

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

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

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

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

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

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

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

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

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

1. Submission of required information.

2. Authorization for payroll deduction, if applicable.

3. Compliance with federal tax requirements.

4. Arrangements for payment.

5. Selection of products and services.

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

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

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

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

4. Establishment of product prices based on applicable criteria.

5. Arrangements for receiving payment for enrolled participants.

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

7. Compliance with grievance procedures established by the corporation.

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

1. Completion of training requirements.

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

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

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

(5) PRODUCTS.—

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

1. Health insurance policies.

2. Health maintenance contracts.

3. Limited benefit plans.

4. Prepaid clinic services.

5. Service contracts.

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

7. Flexible spending accounts.

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

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

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

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

(6) PRICING.—Prices for the products and services sold through the program must be transparent to participants and established by the vendors. The corporation may ~~shall~~ annually assess a surcharge for each premium or price set by a participating vendor. Any ~~The~~ surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the corporation and payments

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

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

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

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

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

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

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

corporation.

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

(b) *FHIX marketplace purchasing.*—

1. Participation in the FHIX marketplace may begin at any time during the year.

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

(8) CONSUMER INFORMATION.—The corporation shall:

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

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

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

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

(10) EXEMPTIONS.—

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

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

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

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

administration of the program.

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

1. Three ex officio, nonvoting members to include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The corporation shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—

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

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

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

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

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

a. Business plans.

b. Internal auditing controls and reports of internal auditors.

c. Reports of external auditors for privately held companies.

d. Client and customer lists.

e. Potentially patentable material.

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

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

(b) *Public record exemptions.*—

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

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

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

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

(d) *Authorized release.*—

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

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

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

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

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

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

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

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

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

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

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

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

624.91 The Florida Healthy Kids Corporation Act.—

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

(2) LEGISLATIVE INTENT.—

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

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

(3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only residents of this state are eligible ~~the following individuals are~~

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

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

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

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

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

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

(b) The Florida Healthy Kids Corporation shall:

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

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

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

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

4.~~5.~~ Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified 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 Kids Corporation contract shall be 15 percent. For health and dental care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. The calculations must use uniform financial data collected from all plans in a format established by the corporation and shall be computed for each plan on a statewide basis. Funds shall be classified in a manner consistent with 45 C.F.R. part 158 ~~For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail~~.

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

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

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

10.~~11.~~ Establish disenrollment criteria in the event ~~local matching~~ funds are insufficient to cover enrollments.

11.~~12.~~ Develop and implement a plan to publicize the Florida Kidcare program, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.

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

13.~~14.~~ In consultation with the partner agencies, provide a report on the Florida Kidcare program annually to the Governor, the Chief Financial Officer, the Commissioner of Education, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and the House of Representatives.

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

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

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

15.~~16.~~ Establish benefit packages that conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.821.

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

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

a. Administrative functions.

b. Contracting with vendors.

c. Customer service.

d. Enrollee education.

e. Financial services.

f. Program integrity.

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

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

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

(6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

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

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

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

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

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

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

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

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1146
INTRODUCER:	Health Policy Committee and Senator Simmons
SUBJECT:	Agency Relationships with Governmental Health Care Contractors
DATE:	March 10, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	**Fav/CS**
2.			JU	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1146 revises the description of volunteer uncompensated services under the Access to Health Care Act (the Act) that is established in s. 766.1115, F.S. Under the Act, sovereign immunity applies for services provided by a health care provider that has entered into a contractual relationship to provide health care services to low-income recipients as an agent of the governmental contractor.

Specifically, the bill authorizes a free clinic to receive and use appropriations or grants from a governmental entity or nonprofit corporation to support the delivery of the contracted services by volunteer health care providers, which may include employing providers to supplement, coordinate, or support the volunteers. Such monies do not constitute compensation under this Act from the governmental contractor for services provided under the contract.

Also the bill authorizes a free clinic, while acting as an agent of the governmental contractor to allow a patient, or a parent or guardian of the patient, to pay a nominal fee per visit, not to exceed $10, for administrative costs related to the services provided under the contract.

The bill also clarifies that employees and agents of a health care provider fall within the sovereign immunity protections of the contracted health care provider when providing health care services pursuant to the contract. Section 768.28, F.S., is likewise amended to specifically include a health care provider's employees or agents so as to avoid any potential ambiguity between the provisions in that section of law and the Act.

The bill provides for efficiencies in health care delivery under the contract by requiring the patient, or the patient's legal representative, to acknowledge in writing receipt of the notice of agency relationship between the governmental contractor and the health care provider at the initial visit only. Thereafter, the notice requirement is met by posting the notice in a place conspicuous to all persons.

The bill has no fiscal impact on governmental entities.

II. Present Situation:

Access to Health Care Act

Section 766.1115, F.S., is entitled "The Access to Health Care Act" (the Act). The Act was enacted in 1992 to encourage health care providers to provide care to low-income persons.[1] This section of law extends sovereign immunity to health care providers who execute a contract with a governmental contractor and who provide volunteer, uncompensated health care services to low-income individuals as an agent of the state. These health care providers are considered agents of the state under s. 768.28(9), F.S., for purposes of extending sovereign immunity while acting within the scope of duties required under the Act.

The Act is administered by the Department of Health (department) through the Volunteer Health Services Program.[2]

A contract under the Act must pertain to volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services, the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient or any public or private third-party payor for the specific services provided to the low-income recipients covered by the contract.[3]

Health care providers under the Act include:[4]

- A birth center licensed under ch. 383, F.S.[5]
- An ambulatory surgical center licensed under ch. 395, F.S.[6]
- A hospital licensed under ch. 395, F.S.[7]

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[1] Low-income persons are defined in the Act as a person who is Medicaid-eligible, a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, or any eligible client of the Department of Health who voluntarily chooses to participate in a program offered or approved by the department. Section 766.1115(3)(e), F.S. A single individual whose annual income does not exceed $23,540 is at 200 percent of the federal poverty level using Medicaid data. *See 2015 Poverty Guidelines, Annual Guidelines* at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2015-Federal-Poverty-level-charts.pdf (last visited Mar. 7, 2015).

[2] *See* http://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteerism-volunteer-opportunities/index.html, (last visited Mar. 7, 2015) and Rule Chapter 64I-2, F.A.C.

[3] Section 766.1115(3)(a), F.S.

[4] Section 766.1115(3)(d), F.S.

[5] Section 766.1115(3)(d)1., F.S.

[6] Section 766.1115(3)(d)2., F.S.

[7] Section 766.1115(3)(d)3., F.S.

- A physician or physician assistant licensed under ch. 458, F.S.[8]
- An osteopathic physician or osteopathic physician assistant licensed under ch. 459, F.S.[9]
- A chiropractic physician licensed under ch. 460, F.S.[10]
- A podiatric physician licensed under ch. 461, F.S.[11]
- A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of ch. 464, F.S., or any facility that employs nurses licensed or registered under part I of ch. 464, F.S., to supply all or part of the care delivered under the Act.[12]
- A dentist or dental hygienist licensed under ch. 466, F.S.[13]
- A midwife licensed under ch. 467, F.S.[14]
- A health maintenance organization certificated under part I of ch. 641, F.S.[15]
- A health care professional association and its employees or a corporate medical group and its employees.[16]
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.[17]
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.[18]
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as a physician, physician assistant, nurse, or midwife.[19]
- Any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, that delivers health care services provided by the listed licensed professionals, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

A governmental contractor is defined in the Act as the department, a county health department, a special taxing district having health care responsibilities, or a hospital owned and operated by a governmental entity.[20]

The Act further specifies additional contract requirements. The contract must provide that:

- The governmental contractor retains the right of dismissal or termination of any health care provider delivering services under the contract.

[8] Section 766.1115(3)(d)4., F.S.
[9] Section 766.1115(3)(d)5., F.S.
[10] Section 766.1115(3)(d)6., F.S.
[11] Section 766.1115(3)(d)7., F.S.
[12] Section 766.1115(3)(d)8., F.S.
[13] Section 766.1115(3)(d)13., F.S.
[14] Section 766.1115(3)(d)9., F.S.
[15] Section 766.1115(3)(d)10., F.S.
[16] Section 766.1115(3)(d)11., F.S.
[17] Section 766.1115(3)(d)12., F.S.
[18] Section 766.1115(3)(d)14., F.S.
[19] Section 766.1115(3)(d)15., F.S.
[20] Section 766.1115(3)(c), F.S.

- The governmental contractor has access to the patient records of any health care provider delivering services under the contract.
- The health care provider must report adverse incidents and information on treatment outcomes.
- The governmental contractor or the health care provider must make patient selection and initial referrals.
- The health care provider is subject to supervision and regular inspection by the governmental contractor.[21]
- The health care provider must accept all referred patients; however, the contract may specify limits on the number of patients to be referred.[22]

The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is covered under s. 768.28, F.S., for purposes of actions related to medical negligence.[23]

The individual accepting services through this contracted provider cannot have medical or dental care insurance coverage for the illness, injury, or condition for which medical or dental care is sought.[24] Services not covered under the Act include experimental procedures and clinically unproven procedures. The governmental contractor must determine whether a procedure is covered.

The health care provider may not subcontract for the provision of services under this chapter.[25]

In 2014, the Legislature amended the Act to authorize dentists providing services as an agent of the governmental contractor to allow a patient to voluntarily contribute a monetary amount to cover costs of dental laboratory work related to the services provided under the contract to the patient.[26]

According to the department, from July 1, 2012, through June 30, 2013, 13,543 licensed health care volunteers (plus an additional 26,002 clinic staff volunteers) provided 427,731 health care patient visits with a total value of donated goods and services of $294,427,678 under the Act.[27] The Florida Department of Financial Services, Division of Risk Management, reported on February 14, 2014, that 10 claims had been filed against the Volunteer Health Care Provider Program under s. 766.1115, F.S., since February 15, 2000.[28]

[21] Section 766.1115(4), F.S.
[22] Rule 64I-2.003(2), F.A.C.
[23] Section 766.1115(5), F.S.
[24] Rule 64I-2.002(2), F.A.C.
[25] Rule 64I-2.004(2), F.A.C.
[26] Chapter 2014-108, Laws of Fla.
[27] Department of Health, *Volunteer Health Services 2012-2013 Annual Report*, available at: http://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteerism-volunteer-opportunities/vhs1213annualreport2.pdf, (last visited Mar. 7, 2015).
[28] Correspondence from Lewis R. Williams, Chief of State Liability and Property Claims, to Duane A. Ashe, Department of Health (Feb. 14, 2014) (on file with the Senate Committee on Health Policy).

Legislative Appropriation to Free and Charitable Clinics

The Florida Association of Free and Charitable Clinics received a $4.5 million appropriation in the 2014-2015 General Appropriations Act through the department.[29] The department restricted the use of these funds by free and charitable clinics that were health care providers under the Act to clinic capacity building purposes in the contract which distributed this appropriation. The clinic capacity building was limited to products or processes that increase skills, infrastructure and resources of clinics. The department did not authorize these funds to be used to build capacity through the employment of clinical personnel. The department cautiously interpreted the provision in the Act relating to volunteer, uncompensated services, which states that a health care provider must receive no compensation from the governmental contractor for any services provided under the contract, precluded the use of the appropriation for this purpose.

Sovereign Immunity

The term "sovereign immunity" originally referred to the English common law concept that the government may not be sued because "the King can do no wrong." Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, section 13 of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the power to waive such immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. However, personal liability may result from actions in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

Instead, the state steps in as the party litigant and defends against the claim. The recovery by any one person is limited to $200,000 for one incident and the total for all recoveries related to one incident is limited to $300,000.[30] The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps, but the plaintiff cannot recover the excess damages without action by the Legislature.[31]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[32] In *Stoll v. Noel*, the Florida Supreme Court explained that independent contractor physicians may be agents of the state for purposes of sovereign immunity:

> One who contracts on behalf of another and subject to the other's control except with respect to his physical conduct is an agent and also independent contractor.[33]

[29] Chapter 2014-51, Laws of Fla., line item 461.
[30] Section 768.28(5), F.S.
[31] *Id.*
[32] *Stoll v. Noel*, 694 So. 2d 701, 703 (Fla. 1997).
[33] *Id.*

The court examined the employment contract between the physicians and the state to determine whether the state's right to control was sufficient to create an agency relationship and held that it did.[34] The court explained:

> Whether the [Children's Medical Services] CMS physician consultants are agents of the state turns on the degree of control retained or exercised by CMS. This Court has held that the right to control depends upon the terms of the employment contract. . . . CMS requires each consultant, as a condition of participating in the CMS program, to agree to abide by the terms published in its HRS[35] Manual and CMS Consultant's Guide which contain CMS policies and rules governing its relationship with the consultants. The Consultant's Guide states that all services provided to CMS patients must be authorized in advance by the clinic medical director. The language of the HRS Manual ascribes to CMS responsibility to supervise and direct the medical care of all CMS patients and supervisory authority over all personnel. The manual also grants to the CMS medical director absolute authority over payment for treatments proposed by consultants. The HRS Manual and the Consultant's Guide demonstrate that CMS has final authority over all care and treatment provided to CMS patients, and it can refuse to allow a physician consultant's recommended course of treatment of any CMS patient for either medical or budgetary reasons.
>
> Our conclusion is buttressed by HRS's acknowledgement that the manual creates an agency relationship between CMS and its physician consultants, and despite its potential liability in this case, HRS has acknowledged full financial responsibility for the physicians' actions. HRS's interpretation of its manual is entitled to judicial deference and great weight.[36]

III. Effect of Proposed Changes:

The bill authorizes a free clinic[37] to receive and use appropriations or grants from a governmental entity or nonprofit corporation to support the delivery of contracted services by volunteer health care providers under the Access to Health Care Act (the Act) without those funds being deemed compensation which might jeopardize the sovereign immunity protections afforded in the Act. The bill authorizes these appropriations or grants to be used for the employment of health care providers to supplement, coordinate, or support the delivery of services by volunteer health care providers. The bill states that the receipt and use of the appropriation or grant does not constitute the acceptance of compensation for the specific services provided to the low-income recipients covered by the contract.

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[34] *Id.* at 703.
[35] Florida Department of Health and Rehabilitative Services.
[36] *Stoll*, 694 So. 2d at 703 (Fla. 1997) (internal citations omitted).
[37] A free clinic for purposes of this provision is a clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.

The bill also authorizes a free clinic to allow a patient, or a parent or guardian of the patient, to pay a nominal fee for administrative costs related to the services provided to the patient under the contract without jeopardizing the sovereign immunity protections afforded in the Act. The fee may not exceed $10 per visit and is a voluntary payment.

The bill inserts the phrase "employees or agents" in several provisions in the Act to clarify that employees and agents of a health care provider, which typically are paid by a health care provider, fall within the sovereign immunity protections of the contracted health care provider when acting pursuant to the contract. Subsection (5) of the Act currently recognizes employees and agents of a health care provider. This subsection requires the governmental contractor to provide written notice to each patient, or the patient's legal representative, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider *or any employee or agent thereof* acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28, F.S.

Section 768.28, F.S., is likewise amended to specifically include a health care provider's employees or agents so as to avoid any potential ambiguity between the provisions in that section of law and the Act.

The bill provides for efficiencies in health care delivery under the contract by requiring the patient, or the patient's legal representative, to acknowledge in writing receipt of the notice of agency relationship between the government contractor and the health care provider at the initial visit only. Thereafter, the notice requirement is met by posting the notice in a place conspicuous to all persons.

The bill removes obsolete language and makes technical and grammatical changes.

The effective date of the bill is July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Free clinics may receive up to $10 per visit from patients who choose to pay the fee to cover administrative costs. The amount that may be collected is indeterminate. Likewise, some patients or recipients may voluntarily pay up to $10 per visit to cover administrative costs.

Contracted free clinics may receive or continue to receive governmental funding in the form of an appropriation or grant without the concern of restrictions on such funding for certain uses that might be imposed by the Act. The receipt of any such funding is speculative at this point and therefor the amount is indeterminate.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 766.1115 and 768.28.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 10, 2015:
The CS reinstates current law that in order to qualify as volunteer, uncompensated services, the health care provider may not receive compensation from the governmental contractor for any services provided under the contract. It adds authorization for a free clinic to receive and use appropriations or grants from a governmental entity or nonprofit corporation to support the delivery of the contracted services by volunteer health care providers, which may include employing providers to supplement, coordinate, or support the volunteers. Additionally, it limits the administrative fee to free clinics and couches it

in terms of "allowing" the patient to pay as opposed to the clinic "charging" the fee. The administrative fee is authorized per visit.

B. Amendments:

None.

727902

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/10/2015	.	
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	.	
	.	

The Committee on Health Policy (Flores) recommended the following:

Senate Amendment

Delete lines 37 - 43
and insert:
under this section, the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or a public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract, except as provided in

727902

paragraphs (4)(g) and (h). A free clinic as described in subparagraph (3)(d)14. may receive a legislative appropriation, a grant through a legislative appropriation, or a grant from a governmental entity or nonprofit corporation to support the delivery of such contracted services by volunteer health care providers, including the employment of health care providers to supplement, coordinate, or support the delivery of services by volunteer health care providers. Such an appropriation or grant does not constitute compensation under this paragraph from the governmental contractor for services provided under the contract, nor does receipt and use of the appropriation or grant constitute the acceptance of compensation under this paragraph for the specific services provided to the low-income recipients covered by the contract.

345158

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/10/2015	.	
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	.	
	.	

The Committee on Health Policy (Flores) recommended the following:

Senate Amendment

Delete lines 152 - 157
and insert:
(h) A health care provider that is a free clinic under subparagraph (3)(d)14., as an agent of the governmental contractor for purposes of s. 768.28(9), may allow a patient, or a parent or guardian of the patient, to pay a nominal fee for administrative costs related to the services provided to the patient under the contract. For purposes of this paragraph, a

345158

nominal fee may not exceed $10 per visit.

By Senator Simmons

10-00698B-15 20151146__

A bill to be entitled

An act relating to agency relationships with governmental health care contractors; amending s. 766.1115, F.S.; redefining terms; deleting an obsolete date; extending sovereign immunity to employees or agents of a health care provider that executes a contract with a governmental contractor; authorizing such health care provider to collect from a patient, or the parent or guardian of a patient, a nominal fee for administrative costs under certain circumstances; limiting the nominal fee; clarifying that a receipt of specified notice must be acknowledged by a patient or the patient's representative at the initial visit; requiring the posting of notice that a specified health care provider is an agent of a governmental contractor; amending s. 768.28, F.S.; redefining the term "officer, employee, or agent" to include employees or agents of a health care provider; providing an effective date.

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

Section 1. Paragraphs (a) and (d) of subsection (3) and subsections (4) and (5) of section 766.1115, Florida Statutes, are amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

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

(a) "Contract" means an agreement executed in compliance

with this section between a health care provider and a governmental contractor which allows the health care provider, or any employee or agent of the health care provider, to deliver health care services to low-income recipients as an agent of the governmental contractor. The contract must be for volunteer, uncompensated services~~, except as provided in paragraph (4)(g)~~. For services to qualify as volunteer, uncompensated services under this section, the health care provider ~~must receive no compensation from the governmental contractor for any services provided under the contract and~~ must not bill or accept compensation from the recipient, or a public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract, except as provided in paragraphs(4)(g) and (h).

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician or physician assistant licensed under chapter 458.

5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatric physician licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter

464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association ~~and its employees~~ or a corporate medical group ~~and its employees~~.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.

13. A dentist or dental hygienist licensed under chapter 466.

14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients, except as provided in paragraph (4)(h).

15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care

services.

(4) CONTRACT REQUIREMENTS.—A health care provider that executes a contract with a governmental contractor to deliver health care services ~~on or after April 17, 1992,~~ as an agent of the governmental contractor, or any employee or agent of such health care provider, is an agent for purposes of s. 768.28(9), while acting within the scope of duties under the contract, if the contract complies with the requirements of this section and regardless of whether the individual treated is later found to be ineligible. A health care provider, or any employee or agent of the health care provider, shall continue to be an agent for purposes of s. 768.28(9) for 30 days after a determination of ineligibility to allow for treatment until the individual transitions to treatment by another health care provider. A health care provider under contract with the state, or any employee or agent of such health care provider, may not be named as a defendant in any action arising out of medical care or treatment ~~provided on or after April 17, 1992,~~ under contracts entered into under this section. The contract must provide that:

(a) The right of dismissal or termination of any health care provider delivering services under the contract is retained by the governmental contractor.

(b) The governmental contractor has access to the patient records of any health care provider delivering services under the contract.

(c) Adverse incidents and information on treatment outcomes must be reported by any health care provider to the governmental contractor if the incidents and information pertain to a patient treated under the contract. The health care provider shall

submit the reports required by s. 395.0197. If an incident involves a professional licensed by the Department of Health or a facility licensed by the Agency for Health Care Administration, the governmental contractor shall submit such incident reports to the appropriate department or agency, which shall review each incident and determine whether it involves conduct by the licensee that is subject to disciplinary action. All patient medical records and any identifying information contained in adverse incident reports and treatment outcomes which are obtained by governmental entities under this paragraph are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(d) Patient selection and initial referral must be made by the governmental contractor or the provider. Patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395.

(e) If emergency care is required, the patient need not be referred before receiving treatment, but must be referred within 48 hours after treatment is commenced or within 48 hours after the patient has the mental capacity to consent to treatment, whichever occurs later.

(f) The provider is subject to supervision and regular inspection by the governmental contractor.

(g) ~~As an agent of the governmental contractor for purposes of s. 768.28(9), while acting within the scope of duties under the contract,~~ A health care provider licensed under chapter 466, as an agent of the governmental contractor for purposes of s.

768.28(9), may allow a patient, or a parent or guardian of the patient, to voluntarily contribute a monetary amount to cover costs of dental laboratory work related to the services provided to the patient within the scope of duties under the contract. This contribution may not exceed the actual cost of the dental laboratory charges.

(h) A health care provider, as an agent of the governmental contractor for purposes of s. 768.28(9), may collect from a patient, or a parent or guardian of the patient, a nominal fee for administrative costs related to the services provided to the patient under the contract. For purposes of this paragraph, a nominal fee may not exceed $10.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

(5) NOTICE OF AGENCY RELATIONSHIP.—The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing at the initial visit, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to ~~the provisions of~~ s. 768.28. Thereafter, and with respect to any federally funded community health center, the notice requirements may be met by posting in a place conspicuous to all persons a notice that the health care provider ~~federally funded~~

~~community health center~~ is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to ~~the provisions of~~ s. 768.28.

Section 2. Paragraph (b) of subsection (9) of section 768.28, Florida Statutes, is amended to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(9)

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, any health care provider, and its employees or agents, when providing services pursuant to s. 766.1115; any nonprofit independent college or university located and chartered in this state which owns or operates an accredited medical school, and its employees or agents, when providing patient services pursuant to paragraph (10)(f); and any public defender or her or his employee or agent, including, among others, an assistant public defender and an investigator.

Section 3. This act shall take effect July 1, 2015.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 640
INTRODUCER:	Health Policy Committee and Senator Detert
SUBJECT:	Vital Statistics
DATE:	March 10, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 640 amends several sections of ch. 382, F.S., to facilitate the electronic generation and filing of burial-transit permits and death certificates with the Department of Health (DOH) through the electronic death registration system (EDRS).

II. Present Situation:

Vital Statistics in Florida

The Bureau of Vital Statistics (BVS), housed within the DOH and under the direction of a state registrar, is responsible for the uniform and efficient registration, completion, storage, and preservation of all vital records in the state.[1] The registration of birth, death, and fetal death records is both a state and local function. Each local registration district is coextensive with the district for that county health department and the county health department's director or administrator traditionally serves as the local registrar for that county or counties.[2] The

[1] Section 382.003, F.S.

[2] Bureau of Vital Statistics, *Vital Records Registration Handbook*, p. 8 (December 2012) *available at* http://www.floridahealth.gov/certificates/certificates/EDRS/_documents/HB2012Final.pdf, (last visited on Mar. 5, 2015).

registration of death certificates is the responsibility of the funeral director or direct disposer[3] who first assumes custody of the decedent.[4]

Subregistrars

In addition to the local registrar, the state registrar may also appoint one or more subregistrars for each licensed funeral home or registered direct disposal establishment. In order to be appointed as a subregistrar, a licensed funeral director or registered direct disposer must be a notary public, attend a training class, and sign an acceptance form. Subregistrars have the authority to issue burial-transit permits and should review all death records to prevent errors and omissions and to accept or reject records accordingly.[5]

The Electronic Death Registration System

For most deaths, death records are filed with the EDRS which is an online, electronic filing and storage system for death records including death certificates, burial-transit permits, and medical information related to the death. The EDRS is designed to allow the Florida funeral directors to electronically enter the demographic information on a decedent and send that record to the certifying physician who completes the record and sends it to the EDRS for recording.[6]

In 2014, 99.6 percent of the 187,856 death certificates filed were filed online through the EDRS,[7] however fetal death certificates are not filed through the EDRS and a few funeral establishments still file hard copy death records with the local registrar in the district where the death occurred.[8] Such paper records are sent to the DOH by the local registrar, reviewed for errors and omissions, keyed into the EDRS, and scanned for archival storage.

Burial-Transit Permits

The funeral director or direct disposer who first assumes custody of a dead body must obtain a burial-transit permit within 5 days after death or before final disposition of the body.[9] A permit is either generated by the EDRS or produced by a local registrar or subregistrar. To obtain the permit when paper death records were filed, the funeral director or direct disposer must complete and sign the application for burial transit permit and present it to either the local registrar of the county in which the death occurred or to a subregistrar. A funeral director or direct disposer cannot issue a burial transit permit to himself and the permit must be filed with the local registrar within 10 days of final disposition. Burial-transit permits are retained by the local registrar for 3 years after they are filed.[10]

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[3] A direct disposer is someone who is in charge of the final disposition of a body without funeral services, burial services, memorial services, visitation services, or viewings. See s. 497.601(2), F.S.
[4] Supra note 2, at 59.
[5] Supra note 2, at 63.
[6] Id. p. 60.
[7] Florida House of Representatives, *CS/HB 243 Staff Analysis*, p. 3, *available at* http://www.flsenate.gov/Session/Bill/2015/0243/Analyses/h0243c.HHSC.PDF, (last visited on Mar. 5, 2015).
[8] Supra note 2, at 7.
[9] Section 382.006(1), F.S.
[10] See supra note 2, at 64 and ss. 382.006 and 382.007, F.S.

III. Effect of Proposed Changes:

CS/SB 640 amends several sections of ch. 382, F.S., to allow for the electronic generation and filing of burial-transit permits and death certificates with the DOH through the EDRS.

The bill authorizes the DOH to assume responsibility for death certificates and burial-transit permits in order to use the EDRS.

- The bill defines "burial-transit permit," as a permit issued by the DOH that authorizes the final disposition of a dead body and requires the funeral director who first assumes custody of a dead body or fetus to provide a manually produced or electronic burial-transit permit from the EDRS to the person in charge of final disposition;
- The bill removes language requiring the local registrar to keep burial-transit permits for 3 years;
- The bill makes DOH appointed subregistrars, rather than the local registrar, responsible for producing and maintaining paper death certificates and burial-transit permits and allows the department to adopt rules to implement these changes;
- The bill requires all certificates of death or fetal death to be filed electronically with the EDRS and makes the funeral director in charge responsible for filing such certificates with the DOH; however, such certificates may still be filed with the local registrar on a form prescribed by the DOH; and
- If a funeral director is unable to provide the medical certification of cause of death within 72 hours, the bill allows the DOH, rather than the local registrar, to grant the funeral director an extension of time.

The bill amends several provisions in order to facilitate the transition from paper death records to electronic records.

- The bill removes requirements necessary when submitting an application for a burial-transit permit including the funeral director's signature, license number, and attestation that he or she has contacted the medical examiner's office to ensure that the medical examiner will be providing medical certification of the cause of death;
- The bill removes a provision allowing aliases to be written on the backs of paper death certificates;
- The bill requires that the Social Security Administration be notified electronically of deaths through the EDRS; and
- The bill allows any person in charge of a premises where final dispositions are made to use the burial-transit permit on file to satisfy record keeping requirements for all deceased persons disposed of under his or her charge. When disposing of a dead body in a cemetery with no person in charge, the funeral director must enter the date of final disposition, mark the burial-transit permit with "no person in charge," and keep it on file for at least 3 years after final disposition.

The bill replaces "next of kin" with "legally authorized person," as defined in the Funeral, Cemetery, and Consumer Services Act. By this change, the person completing a death certificate may acquire personal information from any of the following persons:

- The decedent, if directions are provided on a will;

- The person designated by the decedent on the United States Department of Defense Record of Emergency Data, if the decedent died while in military service;
- The surviving spouse; unless the spouse has been arrested for committing an act of violence against the decedent;
- The son or daughter who is 18 years of age or older;
- A parent;
- A brother or sister who is 18 years of age or older;
- A grandparent; or
- Any person in the next degree of kinship.

The bill also makes numerous clarifying and technical changes such as using the term "disposition," or "final disposition," in place of more specific types of disposition such as "burial" or "internment"; adding "entombment" to the definition of "final disposition"; and correcting cross references and conforming other provisions as necessary due to changes made in the bill.

The bill establishes an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

County health departments may see a positive fiscal impact by not having to print and store paper burial-transit permits.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 382.002, 382.003, 382.006, 382.007, 382.008, 382.0085, 382.011, and 382.0135.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 10, 2015:
The CS allows funeral directors to provide manually produced, as well as electronic, burial-transit permits to the person in charge of final disposition of a dead body or fetus.

B. Amendments:

None.


864098

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/10/2015	.	
	.	
	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Delete line 75

and insert:

funeral director shall provide the manually produced or electronic burial-transit

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

And the title is amended as follows:

Delete line 8

and insert:

requiring a funeral director to provide

By Senator Detert

28-00744-15 2015640__

A bill to be entitled

An act relating to vital statistics; amending s. 382.002, F.S.; providing and revising definitions; amending s. 382.003, F.S.; authorizing the Department of Health to produce and maintain paper death certificates and fetal death certificates and issue burial-transit permits; amending s. 382.006, F.S.; requiring a funeral director to provide electronic burial-transit permits to certain persons; assigning responsibility for manually filed paper death records to the subregistrar; authorizing the department to adopt rules; amending s. 382.007, F.S.; revising provisions relating to records of final dispositions of dead bodies; requiring maintenance of records for a specified period; amending s. 382.008, F.S.; requiring electronic filing of death and fetal death certificates with the department or local registrar on a prescribed form; authorizing certain legally authorized persons to provide personal data about the deceased; authorizing the department, rather than the local registrar, to grant an extension of time for providing certain information regarding a death or a fetal death; amending s. 382.0085, F.S.; conforming a cross-reference; amending s. 382.011, F.S.; retaining a funeral director's responsibility to file a death or fetal death certificate with the department, rather than with the local registrar; amending s. 382.0135, F.S.; requiring the department to electronically notify the United States Social Security

Administration of deaths in the state; providing an effective date.

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

Section 1. Present subsections (1) through (17) of section 382.002, Florida Statutes, are redesignated as subsections (2) through (18), respectively, present subsections (8) and (9) are amended, and a new subsection (1) is added to that section, to read:

382.002 Definitions.—As used in this chapter, the term:

(1) "Burial-transit permit" means a permit issued by the department that authorizes the final disposition of a dead body.

(9)~~(8)~~ "Final disposition" means the burial, interment, entombment, cremation, removal from the state, anatomical donation, or other authorized disposition of a dead body or a fetus as described in subsection (8) ~~(7)~~. In the case of cremation, dispersion of ashes or cremation residue is considered to occur after final disposition; the cremation itself is considered final disposition. In the case of anatomical donation of a dead body, the donation itself is considered final disposition.

(10)~~(9)~~ "Funeral director" means a licensed funeral director or direct disposer licensed pursuant to chapter 497 who first assumes custody of or effects the final disposition of a dead body or a fetus as described in subsection (8) ~~(7)~~.

Section 2. Subsection (9) of section 382.003, Florida Statutes, is amended to read:

382.003 Powers and duties of the department.—The department

shall:

(9) Appoint one or more suitable persons to act as subregistrars, who shall be authorized to produce and maintain paper ~~receive~~ death certificates and fetal death certificates and to issue burial-transit ~~burial~~ permits in and for such portions of one or more districts as may be designated. A subregistrar may be removed from office by the department for neglect of or failure to perform his or her duty in accordance with this chapter.

Section 3. Subsections (1) and (6) of section 382.006, Florida Statutes, are amended, and subsection (7) is added to that section, to read:

382.006 Burial-transit permit.—

(1) The funeral director who first assumes custody of a dead body or fetus must obtain a burial-transit permit before ~~prior to~~ final disposition and within 5 days after death. The funeral director shall provide the electronic burial-transit permit generated from the electronic death registration system to the person in charge of the place of final disposition. ~~The application for a burial-transit permit must be signed by the funeral director and include the funeral director's license number. The funeral director must attest on the application that he or she has contacted the physician's or medical examiner's office and has received assurance that the physician or medical examiner will provide medical certification of the cause of death within 72 hours after receipt of the death certificate from the funeral director.~~

(6) For manually filed paper death records, the subregistrar in the licensed funeral or direct disposal

establishment is responsible for producing and maintaining death and fetal death certificates and burial-transit permits in accordance with this chapter. ~~Burial-transit permits filed with the local registrar under the provisions of this chapter may be destroyed after the expiration of 3 years from the date of filing.~~

(7) The department may adopt rules to implement this section.

Section 4. Section 382.007, Florida Statutes, is amended to read:

382.007 Final dispositions prohibited without burial-transit permit; records of dead bodies disposed.—A person in charge of any premises on which final dispositions are made shall not dispose ~~inter~~ or permit the ~~interment or other~~ disposition of any dead body unless it is accompanied by a burial-transit permit. ~~Any~~ Such person shall enter ~~endorse~~ upon the permit the date of final ~~interment, or other~~ disposition~~,~~ ~~over his or her signature, and shall return all permits so endorsed to the local registrar of the district where the place of final disposition is located within 10 days from the date of interment or other disposition~~. He or she shall keep a record of all dead bodies ~~interred or otherwise~~ disposed of on the premises under his or her charge, in each case stating the name of each deceased person, place of death, date of final ~~burial or other~~ disposition, and name and address of the funeral director, which record shall at all times be open to official inspection. The burial-transit permit on file may satisfy this requirement. The funeral director, when disposing of ~~burying~~ a dead body in a cemetery having no person in charge, shall enter the date of

final disposition on ~~sign~~ the ~~burial-transit~~ permit, ~~giving the date of burial, and shall~~ write ~~across the face of the permit the words~~ "No person in charge~~,~~" on the permit, and keep the permit on file for at least 3 years after the date of final disposition ~~and file the permit within 10 days after burial with the local registrar of the district in which the cemetery is located~~.

Section 5. Subsection (1), paragraph (a) of subsection (2), and paragraph (a) of subsection (3) of section 382.008, Florida Statutes, are amended to read:

382.008 Death and fetal death registration.—

(1) A certificate for each death and fetal death which occurs in this state shall be filed electronically on the department electronic death registration system or ~~on a form prescribed by the department~~ with the department or local registrar of the district in which the death occurred on a form prescribed by the department. A certificate shall be filed within 5 days after ~~such~~ death and prior to final disposition, and shall be registered by the department ~~such registrar~~ if it has been completed and filed in accordance with this chapter ~~or adopted rules~~. The certificate shall include the decedent's social security number, if available. In addition, each certificate of death or fetal death:

(a) If requested by the informant, shall include aliases or "also known as" (AKA) names of a decedent in addition to the decedent's name of record. Aliases shall be entered on the face of the death certificate in the space provided for name if there is sufficient space~~. If there is not sufficient space, aliases may be recorded on the back of the certificate and shall be~~

~~considered part of the official record of death~~;

(b) If the place of death is unknown, shall be registered in the registration district in which the dead body or fetus was ~~is~~ found within 5 days after such occurrence; and

(c) If death occurs in a moving conveyance, shall be registered in the registration district in which the dead body was first removed from such conveyance.

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall file the certificate of death or fetal death. In the absence of the funeral director, the physician or other person in attendance at or after the death or the district medical examiner of the county in which the death occurred or the body was found shall file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from a legally authorized person as defined in s. 497.005 ~~the next of kin~~ or the best qualified person or source available. The medical certification of cause of death shall be furnished to the funeral director, either in person or via certified mail or electronic transfer, by the physician or medical examiner responsible for furnishing such information. For fetal deaths, the physician, midwife, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.

(3) Within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death shall be completed and made available to the funeral director by the decedent's primary or attending physician or, if s. 382.011 applies, the district medical

examiner of the county in which the death occurred or the body was found. The primary or attending physician or medical examiner shall certify over his or her signature the cause of death to the best of his or her knowledge and belief. As used in this section, the term "primary or attending physician" means a physician who treated the decedent through examination, medical advice, or medication during the 12 months preceding the date of death.

(a) The department ~~local registrar~~ may grant the funeral director an extension of time if ~~upon a good and sufficient showing of~~ any of the following conditions exist:

1. An autopsy is pending.

2. Toxicology, laboratory, or other diagnostic reports have not been completed.

3. The identity of the decedent is unknown and further investigation or identification is required.

Section 6. Subsection (9) of section 382.0085, Florida Statutes, is amended to read:

382.0085 Stillbirth registration.—

(9) This section or s. 382.002(16) ~~s. 382.002(15)~~ may not be used to establish, bring, or support a civil cause of action seeking damages against any person or entity for bodily injury, personal injury, or wrongful death for a stillbirth.

Section 7. Subsection (3) of section 382.011, Florida Statutes, is amended to read:

382.011 Medical examiner determination of cause of death.—

(3) The funeral director shall retain the responsibility for preparation of the death or fetal death certificate, obtaining the necessary signatures, filing with the department

~~local registrar~~ in a timely manner, and arranging for final disposition of the body when ~~disposing of the remains when the remains are~~ released by the medical examiner.

Section 8. Section 382.0135, Florida Statutes, is amended to read:

382.0135 Social security numbers; electronic notification of deaths; enumeration-at-birth program.—The department shall make arrangements with the United States Social Security Administration to provide electronic notification of deaths that occur in the state and to participate in the voluntary enumeration-at-birth program. The State Registrar is authorized to take any actions necessary to administer the program in this state, including modifying the procedures and forms used in the birth registration process.

Section 9. This act shall take effect July 1, 2015.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 950
INTRODUCER:	Health Policy Committee and Senator Hukill
SUBJECT:	Public Health Emergencies
DATE:	March 11, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 950 amends provisions relating to the Department of Health's (DOH) authority to initiate and enforce quarantine orders for persons, animals, and premises. The bill defines the terms "isolation" and "quarantine" and allows the DOH to isolate individuals whenever a quarantine would be allowed under s. 381.00315, F.S. (relating to public health advisories, public health emergencies, and quarantines).

The bill requires law enforcement to assist the department in enforcing orders (as well as rules and laws) adopted under ch. 381, F.S., related to public health. Quarantine and isolation orders are enacted through order by the State Surgeon General or by the director of a county health department or his or her designee. The bill also includes a legislative finding that the act fulfills an important state interest by providing measures for the control of communicable diseases and the protection of public health.

II. Present Situation:

Public Health Emergencies in Florida

Currently, s. 381.00315, F.S., allows the State Surgeon General to declare a public health emergency for a period of up to 60 days unless renewed by the governor. Such declarations can be statewide or localized. During a public health emergency the surgeon general is granted the power to take actions that are necessary to protect the public including, but not limited to:

- Directing prescription drug manufacturers to ship specified drugs to pharmacies and health care providers within specified geographic areas;
- Directing DOH employed pharmacists to compound necessary bulk medications;
- Temporarily reactivating inactive health care practitioner licenses; and
- Ordering individuals to be examined, tested, vaccinated, treated, or quarantined for communicable diseases that have significant morbidity or mortality and present a severe danger to the public health.

Public health emergencies can be declared for various reasons. For example, Governor Charlie Crist directed State Surgeon General Dr. Ana Viamonte Ros to declare a public health emergency for two cases of Swine Flu in Lee and Broward counties in 2009.[1] Additionally, in 2011 the Florida Legislature passed HB 7095 which directed Surgeon General Frank Farmer to issue a statewide public health emergency in response to the ongoing problem of prescription drug abuse.[2]

Quarantine versus Isolation

Quarantine and isolation are two tools used by public health authorities to separate from the public people, animals, or premises that have a potential to threaten the public health. The U.S. Centers for Disease Control and Prevention (CDC) differentiates between isolation and quarantine in that isolation applies to persons who are known to be ill with a contagious disease whereas quarantine applies to those who have been exposed to a contagious disease but who may or may not become ill. In addition to people, the CDC applies the term quarantine to animals and premises who may have been exposed to a dangerous contagious disease agent and have been closed off or separated from the population.[3] Isolation and quarantine orders can also differ in length. The length of an isolation order is typically determined by the length of the communicability of the illness for which the individual is being isolated while the duration and scope of quarantine orders can vary, depending on their purpose, and can last as long as necessary to protect the public.[4]

Quarantines in Florida

Florida Administrative Code Rule 64D-3.038, details how the DOH may initiate and lift a quarantine. Quarantine orders are issue by the surgeon general or a county health department director or their designee and must include an expiration date or specific conditions for the end of the quarantine. The quarantine order must also restrict or compel the movement or actions, including isolation, closure of premises, testing, destruction, disinfection, treatment, and immunization of a person, animal, or a premises. The DOH must have access to the quarantined individual or premises and any transportation or removal of quarantined persons or animals must

[1] See Florida Declares Health Emergency, available at http://swflorida.blogspot.com/2009/05/florida-declares-health-emergency.html, (last visited Mar. 5, 2015).
[2] See http://newsroom.doh.state.fl.us/2011/07/01/emergency-declaration/ (last visited March 5, 2015).
[3] U.S. Centers for Disease Control and Prevention, *Understand Quarantine and Isolation* (February 10, 2014) available at http://emergency.cdc.gov/preparedness/quarantine/ (last visited Mar. 6, 2015).
[4] U.S. Centers for Disease Control and Prevention, *Understand Quarantine and Isolation: Questions & Answers* (February 10, 2014) available at http://emergency.cdc.gov/preparedness/quarantine/qa.asp, (last visited Mar. 6, 2015).

be in accordance with written orders issued by the surgeon general or the county health department director.

The state has used its quarantine power on several occasions. In 1988 the Miami-Dade county health department declared a quarantine of a building in downtown Miami due to a major fire spreading dangerous PCB chemicals within the building. Also, in 2003, a six year old was placed in home isolation by the Okaloosa county health department under suspicion of having SARS and the Miami-Dade county health department persuaded a jewelry salesman who was suspected of having SARS to sequester himself for 10 days. Additionally, a building in Boca Raton Florida was quarantined after an anthrax attack killed a photo-journalist in 2001.[5] For these examples, however, no formal involuntary orders were issued. The last involuntary order that was issued in Florida occurred in 1947.[6]

The most recent example of a quarantine order is from October of 2014 when Governor Rick Scott issued executive order number 14-280. That order directed the DOH to monitor all people leaving an Ebola-affected country for 21 days after their departure and to quarantine for 21 days any high-risk traveler from an Ebola-affected country in West Africa. The order allowed the DOH to make its own determinations on quarantine and other necessary public health interventions.[7]

Law Enforcement

Section 381.0012, F.S., currently requires law enforcement officials and other city and county officials to enforce DOH laws and rules. Orders are not included in this enforcement mandate. However, the flush-left text in s. 381.00315(1), F.S., states that all orders by the State Health Officer (state surgeon general) are immediately enforceable by a law enforcement officer under s. 381.0012, F.S. The conflict in these sections may create some ambiguity for law enforcement officials who are tasked with enforcing quarantine orders.

III. Effect of Proposed Changes:

SB 950 amends s. 381.00315, F.S., to define the terms:

- "Isolation" as the separation of an individual who is reasonably believed to be infected with a communicable from those who are not infected with the disease to prevent the spread of the disease; and
- "Quarantine" as the separation of an asymptomatic individual or a premises reasonably believed to have been exposed to a communicable disease from others who have not been exposed to the disease to prevent the possible spread of the disease.

The bill allows the DOH to use isolation as a preventative measure with similar authority to the authority DOH currently has to order a quarantine and makes any isolation and quarantine order

[5] Wm. Robert Johnston, *Review of Fall 2001 Anthrax Attacks*, (last modified March 16, 2005), available at http://www.cdc.gov/niosh/nas/rdrp/appendices/chapter6/a6-45.pdf, (last visited on March 9, 2015).
[6] Florida Department of Health, *White Paper on the Law of Florida Human Quarantine*, (January 2007), available at http://biotech.law.lsu.edu/cphl/articles/others/Florida-Quarantine-07.pdf, (Last visited March. 5, 2015).
[7] Exec Order No. 14-280, (October 25, 2014), available at http://www.flgov.com/wp-content/uploads/2014/10/SKMBT_C35314102515490.pdf, (last visited on Mar. 5, 2015).

immediately enforceable by law enforcement. In addition, the bill amends s. 381.0012, F.S., to require law enforcement, as well as other city and county officials, to assist the department in enforcing state health orders (in addition to state laws and DOH rules). The bill also contains a Legislative finding that the act fulfills an important state interest by providing measures for the control of communicable diseases and the protection of public health.

According to the DOH, the addition of isolation to s. 381.00315, F.S., clarifies and conforms the statute to current CDC standards and the DOH expects no procedural difference in enforcement between isolation orders and quarantine orders. Additionally, the DOH states that the change to s. 381.0012, F.S., is clarifying and conforming.[8] Current law allows the DOH to issue a quarantine order with similar authority to the authority to isolate added by the bill and, therefore, SB 950 should not increase the DOH's current authority.

The DOH is required to adopt rules regarding imposing and lifting isolation orders.

The bill establishes an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

To the extent this bill requires a local government to expend funds to comply with its terms, the provisions contained in Article VII, section 18(a) of the Florida Constitution, may apply. If those provisions do apply, in order for the law to be binding upon the cities and counties, the Legislature must find that the law fulfills an important state interest, and one of the following relevant exceptions must apply:

- The expenditure is required to comply with a law that applies to all persons similarly situated; or
- The law must be approved by two-thirds of the membership of each house of the Legislature.

The municipality/county mandates provision of the Florida Constitution may apply because this bill requires local law enforcement agencies, county attorneys, and other appropriate city and county officials to use their resources to assist the department or its agents in enforcing isolation and quarantine orders upon the request of the department or its agents. However, it is likely that the costs to the cities or counties of enforcing the isolation and quarantine orders would be insignificant due to the rarity of the DOH invoking its quarantine authority.

Since the bill requires the assistance of both state and local law enforcement, as well as other officials, in enforcing such orders, it appears the bill applies to all persons similarly situated. Additionally, the bill contains a finding of important state interest (section 3). Thus it is appears the bill is binding upon city and county law enforcement and other appropriate city and county officials.

[8] Conversation with Gary Landry, Legislative Planning Office Manager (DOH) (March 9, 2015).

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

CS/SB 950 defines the term quarantine to include individuals and premises; however, the DOH also has the authority in s. 381.0012, F.S., to quarantine animals. The definition of quarantine in the bill should be amended to include animals as well as individuals and premises.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.0012 and 381.00315.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 10, 2015:
The CS amends the definition of "quarantine" to include premises and adds section 3 of the bill which provides a legislative finding that the bill fulfills an important state interest.

B. Amendments:

None.

415722

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/10/2015	.	
	.	
	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Delete lines 126 - 185
and insert:
(d) "Quarantine" means the separation of an asymptomatic individual or a premises reasonably believed to have been exposed to a communicable disease from individuals who have not been exposed to the disease to prevent its possible spread.
(2) Individuals who assist the State Health Officer at his or her request on a volunteer basis during a public health

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emergency are entitled to the benefits specified in s. 110.504(2), (3), (4), and (5).

(3) To facilitate effective emergency management, when the United States Department of Health and Human Services contracts for the manufacture and delivery of licensable products in response to a public health emergency and the terms of those contracts are made available to the states, the department shall accept funds provided by counties, municipalities, and other entities designated in the state emergency management plan required under s. 252.35(2)(a) for the purpose of participation in those contracts. The department shall deposit those funds in the Grants and Donations Trust Fund and expend those funds on behalf of the donor county, municipality, or other entity for the purchase of the licensable products made available under the contract.

(4) The department has the duty and the authority to declare, enforce, modify, and abolish the isolation or quarantine ~~quarantines~~ of persons, animals, and premises as the circumstances indicate for controlling communicable diseases or providing protection from unsafe conditions that pose a threat to public health, except as provided in ss. 384.28 and 392.545-392.60. Any order the department issues pursuant to this subsection is immediately enforceable by a law enforcement officer under s. 381.0012.

(5) The department shall adopt rules to specify the conditions and procedures for imposing and lifting an order for isolation or ~~and releasing a~~ quarantine. The rules must include provisions related to:

(a) The closure of premises.

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(b) The movement of persons or animals exposed to or infected with a communicable disease.

(c) The tests or treatment, including vaccination, for communicable disease required prior to employment or admission to the premises or to comply with an isolation or ~~a~~ quarantine order.

(d) Testing or destruction of animals with or suspected of having a disease transmissible to humans.

(e) Access by the department to persons in isolation or quarantine or to premises housing persons in isolation or in quarantine ~~quarantined premises~~.

(f) The disinfection of isolated or quarantined animals, persons, or premises.

(g) Methods of isolation or quarantine.

(6) The rules adopted under this section and actions taken by the department pursuant to a declared public health emergency, isolation, or quarantine shall supersede all rules enacted by other state departments, boards or commissions, and ordinances and regulations enacted by political subdivisions of the state. Any person who violates any rule adopted under this section, any order of isolation or quarantine, or any requirement adopted by the department pursuant to a declared public health emergency, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 3. The Legislature finds that this act fulfills an important state interest by providing measures for the control of communicable diseases and the protection of public health.

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

415722

And the title is amended as follows:

Between lines 14 and 15

insert:

providing a legislative finding of important state interest;

By Senator Hukill

8-00719-15 2015950__

A bill to be entitled

An act relating to public health emergencies; amending s. 381.0012, F.S.; requiring certain state and local officers to assist in enforcing rules and orders issued by the Department of Health under ch. 381, F.S.; amending s. 381.00315, F.S.; authorizing the State Health Officer to issue orders to isolate individuals; defining terms; clarifying the responsibilities of the department for isolation and quarantine; specifying that any order the department issues is immediately enforceable by a law enforcement officer; requiring the department to adopt rules for the imposing and lifting of isolation orders; providing a penalty for violating an isolation order; providing an effective date.

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

Section 1. Subsection (5) of section 381.0012, Florida Statutes, is amended to read:

381.0012 Enforcement authority.—

(5) It shall be the duty of every state and county attorney, sheriff, police officer, and other appropriate city and county officials upon request to assist the department or any of its agents in enforcing the state health laws, rules, and orders ~~the rules~~ adopted under this chapter.

Section 2. Section 381.00315, Florida Statutes, is amended to read:

381.00315 Public health advisories; public health

emergencies; isolation and quarantines.—The State Health Officer is responsible for declaring public health emergencies, issuing public health advisories, and ordering isolation or ~~and~~ quarantines ~~and issuing public health advisories~~.

(1) As used in this section, the term:

(a) "Isolation" means the separation of an individual who is reasonably believed to be infected with a communicable disease from those who are not infected with the disease to prevent the spread of the disease.

(b) ~~(a)~~ "Public health advisory" means any warning or report giving information to the public about a potential public health threat. Prior to issuing any public health advisory, the State Health Officer must consult with any state or local agency regarding areas of responsibility which may be affected by such advisory. Upon determining that issuing a public health advisory is necessary to protect the public health and safety, and prior to issuing the advisory, the State Health Officer must notify each county health department within the area which is affected by the advisory of the State Health Officer's intent to issue the advisory. The State Health Officer is authorized to take any action appropriate to enforce any public health advisory.

(c) ~~(b)~~ "Public health emergency" means any occurrence, or threat thereof, whether natural or manmade ~~man made~~, which results or may result in substantial injury or harm to the public health from infectious disease, chemical agents, nuclear agents, biological toxins, or situations involving mass casualties or natural disasters. Prior to declaring a public health emergency, the State Health Officer shall, to the extent possible, consult with the Governor and shall notify the Chief

of Domestic Security. The declaration of a public health emergency shall continue until the State Health Officer finds that the threat or danger has been dealt with to the extent that the emergency conditions no longer exist and he or she terminates the declaration. However, a declaration of a public health emergency may not continue for longer than 60 days unless the Governor concurs in the renewal of the declaration. The State Health Officer, upon declaration of a public health emergency, may take actions that are necessary to protect the public health. Such actions include, but are not limited to:

1. Directing manufacturers of prescription drugs or over-the-counter drugs who are permitted under chapter 499 and wholesalers of prescription drugs located in this state who are permitted under chapter 499 to give priority to the shipping of specified drugs to pharmacies and health care providers within geographic areas that have been identified by the State Health Officer. The State Health Officer must identify the drugs to be shipped. Manufacturers and wholesalers located in the state must respond to the State Health Officer's priority shipping directive before shipping the specified drugs.

2. Notwithstanding chapters 465 and 499 and rules adopted thereunder, directing pharmacists employed by the department to compound bulk prescription drugs and provide these bulk prescription drugs to physicians and nurses of county health departments or any qualified person authorized by the State Health Officer for administration to persons as part of a prophylactic or treatment regimen.

3. Notwithstanding s. 456.036, temporarily reactivating the inactive license of the following health care practitioners,

when such practitioners are needed to respond to the public health emergency: physicians licensed under chapter 458 or chapter 459; physician assistants licensed under chapter 458 or chapter 459; licensed practical nurses, registered nurses, and advanced registered nurse practitioners licensed under part I of chapter 464; respiratory therapists licensed under part V of chapter 468; and emergency medical technicians and paramedics certified under part III of chapter 401. Only those health care practitioners specified in this paragraph who possess an unencumbered inactive license and who request that such license be reactivated are eligible for reactivation. An inactive license that is reactivated under this paragraph shall return to inactive status when the public health emergency ends or prior to the end of the public health emergency if the State Health Officer determines that the health care practitioner is no longer needed to provide services during the public health emergency. Such licenses may only be reactivated for a period not to exceed 90 days without meeting the requirements of s. 456.036 or chapter 401, as applicable.

4. Ordering an individual to be examined, tested, vaccinated, treated, <u>isolated,</u> or quarantined for communicable diseases that have significant morbidity or mortality and present a severe danger to public health. Individuals who are unable or unwilling to be examined, tested, vaccinated, or treated for reasons of health, religion, or conscience may be subjected to <u>isolation or</u> quarantine.

a. Examination, testing, vaccination, or treatment may be performed by any qualified person authorized by the State Health Officer.

b. If the individual poses a danger to the public health, the State Health Officer may subject the individual to isolation or quarantine. If there is no practical method to isolate or quarantine the individual, the State Health Officer may use any means necessary to vaccinate or treat the individual.

Any order of the State Health Officer given to effectuate this paragraph shall be immediately enforceable by a law enforcement officer under s. 381.0012.

(d) "Quarantine" means the separation of an individual reasonably believed to have been exposed to a communicable disease, but who is not yet showing symptoms, from others who have not been exposed to the disease to prevent the possible spread of the disease.

(2) Individuals who assist the State Health Officer at his or her request on a volunteer basis during a public health emergency are entitled to the benefits specified in s. 110.504(2), (3), (4), and (5).

(3) To facilitate effective emergency management, when the United States Department of Health and Human Services contracts for the manufacture and delivery of licensable products in response to a public health emergency and the terms of those contracts are made available to the states, the department shall accept funds provided by counties, municipalities, and other entities designated in the state emergency management plan required under s. 252.35(2)(a) for the purpose of participation in those contracts. The department shall deposit those funds in the Grants and Donations Trust Fund and expend those funds on behalf of the donor county, municipality, or other entity for

the purchase of the licensable products made available under the contract.

(4) The department has the duty and the authority to declare, enforce, modify, and abolish the isolation or quarantine ~~quarantines~~ of persons, animals, and premises as the circumstances indicate for controlling communicable diseases or providing protection from unsafe conditions that pose a threat to public health, except as provided in ss. 384.28 and 392.545-392.60. Any order the department issues pursuant to this subsection shall be immediately enforceable by a law enforcement officer under s. 381.0012.

(5) The department shall adopt rules to specify the conditions and procedures for imposing and lifting an order for isolation or ~~and releasing a~~ quarantine. The rules must include provisions related to:

(a) The closure of premises.

(b) The movement of persons or animals exposed to or infected with a communicable disease.

(c) The tests or treatment, including vaccination, for communicable disease required prior to employment or admission to the premises or to comply with an isolation or ~~a~~ quarantine order.

(d) Testing or destruction of animals with or suspected of having a disease transmissible to humans.

(e) Access by the department to persons in isolation or quarantine or to premises housing persons in isolation or in quarantine ~~quarantined premises~~.

(f) The disinfection of isolated or quarantined animals, persons, or premises.

(g) Methods of isolation or quarantine.

(6) The rules adopted under this section and actions taken by the department pursuant to a declared public health emergency, isolation, or quarantine shall supersede all rules enacted by other state departments, boards or commissions, and ordinances and regulations enacted by political subdivisions of the state. Any person who violates any rule adopted under this section, any order of isolation or quarantine, or any requirement adopted by the department pursuant to a declared public health emergency, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 3. This act shall take effect July 1, 2015.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 996
INTRODUCER:	Senator Richter
SUBJECT:	Home Medical Equipment
DATE:	March 6, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Favorable**
2.			AHS	
3.			FP	

I. Summary:

SB 996 amends s. 400.93, F.S., to exempt physicians who sell or rent electrostimulation medical equipment to their patients in the course of their practice from the requirement to be licensed as a home medical equipment provider.

II. Present Situation:

Home Medical Equipment Providers

Part VII of ch. 400, F.S., requires the Agency for Health Care Administration (AHCA) to license and regulate any person or entity that holds itself out to the public as performing any of the following functions:

- Providing home medical equipment[1] and services;[2]
- Accepting physician orders for home medical equipment and services; or
- Providing home medical equipment that typically requires home medical services.[3]

[1] Defined in s. 400.925, F.S., as any product as defined by the federal Food and Drug Administration's Drugs, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits, or any products reimbursed under the Florida Medicaid durable medical equipment program. Home medical equipment includes oxygen and related respiratory equipment; manual, motorized, or customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner; motorized scooters; personal transfer systems; and specialty beds, for use by a person with a medical need.

[2] Defined in s. 400.925, F.S., as equipment management and consumer instruction, including selection, delivery, set-up, and maintenance of equipment, and other related services for the use of home medical equipment in the consumer's regular or temporary place of residence.

[3] Section 400.93(1) and (2), F.S.

The following are exempt from the licensure requirement for home medical equipment providers:[4]

- Providers operated by the Department of Health (DOH) or the federal government;
- Nursing homes;
- Assisted living facilities;
- Home health agencies;
- Hospices;
- Intermediate care facilities;
- Homes for special services;
- Transitional living facilities;
- Hospitals;
- Ambulatory surgical centers;
- Manufacturers and wholesale distributors that do not sell directly to the consumer;
- Licensed health care practitioners who utilize home medical equipment in the course of their practice but do not sell or rent home medical equipment to their patients; and
- Pharmacies.

Currently there are 1,003 licensed home medical equipment providers, including those providers that are located out of the state but hold a Florida license.[5]

Any person or entity applying for a license as a home medical equipment provider must provide the AHCA with:

- A report of the medical equipment that will be provided, indicating whether it will be provided directly or by contract;
- A report of the services that will provided, indicating whether the services will be provided directly or by contract;
- A list of the persons and entities with whom they contract;
- Documentation of accreditation, or an application for accreditation, from an organization recognized by the AHCA;
- Proof of liability insurance; and
- A $300 application fee and a $400 inspection fee, unless exempt from inspection.[6]

As a requirement of licensure, home medical equipment providers must comply with a number of minimum standards including, but not limited to:

- Offering and providing home medical equipment and services, as necessary, to consumers who purchase or rent any equipment that requires such services;
- Providing at least one category of equipment directly from their own inventory;
- Responding to orders for other equipment from either their own inventory or from the inventory of other contracted companies;
- Maintaining trained personnel to coordinate orders and scheduling of equipment and service deliveries;

[4] Section 400.93(5), F.S.
[5] *See* AHCA, Florida Health Finder, *Home Health Care in Florida*, (printed list of home medical equipment providers on file with Senate Committee on Health Policy).
[6] Section 400.931, F.S.

- Ensuring that their delivery personnel are appropriately trained;
- Ensuring that patients are aware of their service hours and emergency service procedures;
- Answering any questions or complaints a consumer has about an item or the use of an item;
- Maintaining and repairing, either directly or through contract, items rented to consumers;
- Maintaining a safe premises;
- Preparing and maintaining a comprehensive emergency management plan that must be updated annually and provide for continuing home medical equipment services for life-supporting or life-sustaining equipment during an emergency;
- Maintaining a prioritized list of patients who need continued services during an emergency;[7]
- Complying with AHCA rules on minimum qualifications for personnel, including ensuring that all personnel have the necessary training and background screening;[8] and
- Maintaining a record for each patient that includes the equipment and services the provider has provided and which must contain:
  - Any physician's order or certificate of medical necessity;
  - Signed and dated delivery slips;
  - Notes reflecting all services, maintenance performed, and equipment exchanges;
  - The date on which rental equipment was retrieved; and,
  - Any other appropriate information.[9]

Licensed home medical equipment providers are subject to periodic inspections, including biennial licensure inspections, inspections directed by the federal Centers for Medicare and Medicaid Services, and licensure complaint investigations. A home medical equipment provider may submit a survey or inspection by an accrediting organization in lieu of a licensure inspection if the provider's accreditation is not provisional and the AHCA receives a report from the accrediting organization. A copy of a valid medical oxygen retail establishment permit issued by the DOH may also be submitted in lieu of a licensure inspection.[10]

Electrostimulation Medical Equipment

Devices that provide electrical stimulation can be used medically to treat a number of symptoms and conditions. Electrical stimulators can provide direct, alternating, pulsed, and pulsed waveforms of energy to the human body through electrodes that may be indwelling, implanted in the skin, or used on the surface of the skin.[11] Such devices may be used to exercise muscles, demonstrate a muscular response to stimulation of a nerve, relieve pain, relieve incontinence, and provide test measurements.[12]

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[7] Section 400.934, F.S.
[8] AHCA, Rule 59A-25.004, F.A.C. All home medical equipment provider personnel are also subject to a level 2 background screening per s. 400.953, F.S.
[9] Section 400.94, F.S.
[10] Section 400.933, F.S.
[11] United Healthcare Medical Policy, *Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation*, p. 4, (December 1, 2014) https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/Electrical_Stim_Tx_Pain_Muscle_Rehab.pdf, (last visited Mar. 6, 2015).
[12] Id.

Functional electrical stimulation (FES), also known as therapeutic electrical stimulation (TES), is used to prevent or reverse muscular atrophy and bone loss by stimulating paralyzed limbs. FES is designed to be used as a part of a self-administered, home-based rehabilitation program for the treatment of upper limb paralysis. An FES system consists of a custom-fitted device and control unit that allows the user to adjust the stimulation intensity and a training mode which can be gradually increased to avoid muscle fatigue.[13]

A second type of electrical stimulation is Transcutaneous Electrical Nerve Stimulation, or TENS. TENS is the application of electrical current through electrodes placed on the skin for pain control. It has been used to treat a variety of painful conditions, but there is "much controversy over which conditions to treat with TENS and the adequate parameters to use."[14] Despite this controversy, there is some clinical evidence that TENS is able to relieve certain types of pain and "experimental pain studies and clinical trials are beginning to refine parameters of stimulation to obtain the best pain relief."[15] For example, studies have shown that TENS increases the pressure and heat pain thresholds in people who are healthy and reduces mechanical and heat hyperalgesia in arthritic animals.[16]

Other types of electrical stimulation include interferential therapy (IFT) and neuromuscular electrical stimulation (NMES). IFT uses two alternating currents simultaneously applied to the affected area through electrodes and which is proposed to relieve musculoskeletal pain and increase healing in soft tissue injuries and bone fractures. NMES involves the application of electrical currents through the skin to cause muscle contractions and is used to promote the restoration of nerve supply, prevent or slow atrophy, relax muscle spasms, and to promote voluntary control of muscles in patients who have lost muscle function.[17]

III. Effect of Proposed Changes:

The bill amends s. 400.93, F.S., to exempt physicians who sell or rent electrostimulation medical equipment to their patients in the course of their practice from the requirement to be licensed as a home medical equipment provider.

The bill establishes an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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[13] Supra note 11.
[14] Effectiveness of Transcutaneous Electrical Nerve Stimulation for Treatment of Hyperalgesia and Pain, *Curr Rheumatol Rep. Dec 2008; 10(6): 492–499*, found at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2746624/, (last visited Mar. 6, 2015).
[15] *Id.*
[16] Effects of Transcutaneous Electrical Nerve Stimulation on Pain, Pain Sensitivity, and Function in People With Knee Osteoarthritis: A Randomized Controlled Trial, *Physical Therapy 2012 Jul; 92(7): 898–910* found at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3386514/, (last visited Mar. 6, 2015).
[17] *Supra* note 11

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Any exempted physicians may see a positive fiscal impact from SB 996 due to no longer having to pay licensure and inspection fees or meet the licensure requirements of part VII of ch. 400, F.S.

C. Government Sector Impact:

The AHCA may experience a negative fiscal impact due to fewer licensed home medical equipment providers.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 400.93 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Richter

23-01119-15 2015996__

A bill to be entitled

An act relating to home medical equipment; amending s. 400.93, F.S.; exempting allopathic, osteopathic, and chiropractic physicians who sell or rent electrostimulation medical equipment and supplies to their patients in the course of their practice from licensure as home medical equipment providers; providing an effective date.

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

Section 1. Paragraph (k) is added to subsection (5) of section 400.93, Florida Statutes, to read:

400.93 Licensure required; exemptions; unlawful acts; penalties.—

(5) The following are exempt from home medical equipment provider licensure, unless they have a separate company, corporation, or division that is in the business of providing home medical equipment and services for sale or rent to consumers at their regular or temporary place of residence pursuant to the provisions of this part:

(k) Physicians licensed pursuant to chapter 458, chapter 459, or chapter 460 for the sale or rental of electrostimulation medical equipment and electrostimulation medical equipment supplies to their patients in the course of their practice.

Section 2. This act shall take effect July 1, 2015.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 792
INTRODUCER:	Health Policy Committee and Senator Bean
SUBJECT:	Pharmacy
DATE:	March 11, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 792 authorizes a registered pharmacy intern to administer certain immunizations or vaccines to adults under the supervision of a pharmacist who is certified to administer vaccines and within the framework of a protocol under a supervising physician. The bill requires a ratio of one pharmacist to one intern when a registered intern is administering vaccines. Prior to administering vaccines, a pharmacy intern will need to obtain certification which is based on at least 20 hours of coursework that has been approved by the Board of Pharmacy.

The bill also expands the specified list of vaccines that a pharmacist may administer, which may also be administered by a registered intern, to include immunizations or vaccines listed in schedules established by the United States Centers for Disease Control and Prevention, any additional updates to those lists which are authorized by rules of the Board of Pharmacy, and immunizations or vaccines approved by the board in response to a state of emergency declared by the Governor.

II. Present Situation:

Pharmacists and Pharmacy Interns

Pharmacists and pharmacy interns are regulated under ch. 465, F.S., the Florida Pharmacy Act (Act), by the Board of Pharmacy (board) within the Department of Health (DOH or department).

A "pharmacist" is a person licensed under the Act to practice the profession of pharmacy.[1] A "pharmacy intern" is a person who is currently registered in and attending an accredited college or school of pharmacy, or who is a graduate of such a school or college of pharmacy, and who is registered as a pharmacy intern with the department.[2]

The practice of the profession of pharmacy includes:

- Compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug.
- Consulting concerning therapeutic values and interactions of patent or proprietary preparations.
- Monitoring a patient's drug therapy, assisting the patient in managing his or her drug therapy, and reviewing the patient's drug therapy and communicating with the patient's prescribing health care provider or the provider's agent or other persons as specifically authorized by the patient, regarding the drug therapy.
- Transmitting information from persons authorized to prescribe medicinal drugs to their patients.
- Administering vaccines to adults.[3]

To be licensed as a pharmacist in Florida, one must:[4]

- Complete an application and remit an examination fee;
- Be at least 18 years of age;
- Have received a degree from an accredited and approved school or college of pharmacy; or is a graduate of a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States, has demonstrated proficiency in English, has passed the board-approved Foreign Pharmacy Graduate Equivalency Examination, and has completed a minimum of 500 hours in a supervised work activity program within Florida under the supervision of a pharmacist licensed by the DOH, which program is approved by the board;
- Have completed an internship program of 2,080 hours, approved by the board; and
- Successfully completed the board-approved examination.

The internship experience for the purposes of qualifying for the examination must be obtained in a community pharmacy, institutional pharmacy, or any board-approved pharmacy practice which includes significant aspects of the practice of pharmacy.[5] One of many requirements for a pharmacy in which an approved internship may occur is that the pharmacy establish that it fills, compounds, and dispenses a sufficient number, kind, and variety of prescriptions during the course of a year so as to afford to an intern a broad experience in the filling, compounding, and dispensing of prescription drugs.[6] Proponents of the bill contend that in order to more fully fulfill the educational objectives of an internship, an intern should be authorized to administer vaccines

[1] Section 465.003(10), F.S.
[2] Section 465.003(12), F.S.
[3] Section 465.003(13), F.S.
[4] Section 465.007, F.S. The department may also issue a license by endorsement to a pharmacist who is licensed in another state upon meeting the applicable requirements that are set forth in law and rule. *See* s. 465.0075, F.S.
[5] Fla. Admin. Code R. 64B16-26.2032(5).
[6] Fla. Admin. Code R. 64B16-26.2032(6)(c).

to adults under appropriate supervision since the administration of vaccines to adults is a component of the practice of pharmacy.

An intern may not perform any acts relating to filing, compounding, or dispensing of medicinal drugs unless it is done under the direct and immediate personal supervision of a person actively licensed to practice pharmacy in Florida.[7] Neither the Act nor the board's rules limit the number of interns a pharmacist may supervise. A pharmacy student or graduate is required to be registered by the DOH before being employed as an intern in a pharmacy in Florida. In Fiscal Year 2013-2014, there were 10,914 registered pharmacy interns actively practicing in the state.[8]

Vaccines and Immunizations

A vaccine is a product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease. Vaccines are usually administered through needle injections, but can also be administered by mouth or sprayed into the nose. Immunization is a process by which a person becomes protected against a disease through vaccination. This term is often used interchangeably with vaccination or inoculation.[9]

Authorization in Florida

Currently, a pharmacist licensed in Florida may administer vaccines for influenza, pneumococcal, meningococcal, and shingles to an adult in accordance with a protocol under a supervising physician and guidelines of the U.S. Centers for Disease Control and Prevention (CDC). A pharmacist may also administer epinephrine using an autoinjector delivery system to address any unforeseen allergic reaction to an administered vaccine.[10]

Prior to administering vaccines, a pharmacist must be certified to administer the vaccines pursuant to a 20-hour certification program approved by the board in consultation with the boards of medicine and osteopathic medicine.[11] Additionally, the pharmacist must submit to the board a copy of his or her protocol. A pharmacist may not enter into a protocol unless he or she maintains at least $200,000 of professional liability insurance. A pharmacist who administers vaccines must also maintain applicable patient records. Approximately 11,323 or 37 percent of the actively licensed pharmacists are certified to administer vaccines.[12]

The Legislature has acted three times since 2007 addressing the authorization for pharmacists to administer vaccines. Chapter 2007-152, L.O.F., established the framework for pharmacists to administer vaccines. At that time, the only vaccination authorized was influenza. In 2012, the Legislature authorized the administration of the pneumococcal vaccine, the administration of the shingles vaccine pursuant to a physician's prescription, and the use of epinephrine for an allergic reaction.[13] Then in 2014, the Legislature added meningococcal to the list of vaccines and

[7] Fla. Admin. Code R. 64B16-26.2032(4).
[8] Department of Health, *Senate Bill 792 Analysis* (Feb. 11, 2015) (on file with the Senate Committee on Health Policy).
[9] *See* U.S. Centers for Disease Control and Prevention, *Immunizations: The Basics*, (updated Sept. 25, 2014) *available at* http://www.cdc.gov/vaccines/vac-gen/imz-basics.htm, (last visited Mar. 6, 2015)
[10] Section 465.189, F.S.
[11] Section 465.189, F.S., and Fla. Admin. Code. R. 64B16-26.1031
[12] *Supra* note 8.
[13] Ch. 2012-60, Laws of Fla.

eliminated the requirement for a physician's prescription as the basis for a pharmacist to administer the shingles vaccine.[14]

Authorizations in Other States

Forty-four states or territories currently authorize pharmacy interns to administer vaccines. Most commonly, the intern must be trained, such as having completed a certificate training program, and must operate under the supervision of a trained pharmacist.[15] Florida is one of a handful of states that does not authorize pharmacists to administer a more expansive list of vaccines, including Td/Tdap and HPV.[16]

Recommended Adult Immunization Schedule

Annually, the CDC publishes a recommended schedule of immunizations for adults (anyone 19 years of age or older).[17] The schedule includes the recommended age groups, number of doses, and medical indications for which administration of the currently licensed and listed vaccine is commonly indicated. Prior to being published each year, the Advisory Committee on Immunization Practices (ACIP) reviews the recommended adult immunization schedule to ensure that the schedule reflects current recommendations for the listed vaccines.[18]

The recommended adult immunization schedule is also approved by the ACIP, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American College of Nurse-Midwives.[19]

The adult immunization schedule as of February 2015, lists the following vaccines:[20]

- Influenza (flu)*
- Tetanus, diphtheria, pertussis (Td/Tdap)
- Varicella (chickenpox)
- Human papillomavirus (HPV) Female
- Human papillomavirus (HPV) Male
- Zoster (shingles)*
- Measles, mumps, rubella (MMR)
- Pneumococcal 13-valent conjugate (PCV13)*
- Pneumococcal polysaccharide (PPSV23)*
- Meningococcal*
- Hepatitis A
- Hepatitis B

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[14] Ch. 2014-113, Laws of Fla.
[15] American Pharmacists Association, *Pharmacist Administered Vaccines*, slide 6 (updated January 31, 2015), *available at* http://www.pharmacist.com/sites/default/files/files/Pharmacist_IZ_Authority_1_31_15.pdf, (last visited Mar. 6, 2015).
[16] *Id.* slides 1, 9, and 11.
[17] The most current recommended adult immunization schedule for 2015, *is available at* http://www.cdc.gov/vaccines/schedules/hcp/adult.html, (last visited Mar. 6, 2015). For past immunization schedules *see* http://www.cdc.gov/vaccines/schedules/past.html, (last visited Mar. 6, 2015).
[18] U.S. Centers for Disease Control and Prevention, *Adult Immunization Schedules* (2015) *available at* http://www.cdc.gov/vaccines/schedules/hcp/adult.html, (last visited Mar. 11, 2015).
[19] *Id.*
[20] *Id.*

- Haemophilus influenza type b (Hib)

* Currently authorized in Florida.

The recommended adult immunization schedule does change from year-to-year, typically with respect to the footnotes and full ACIP vaccine recommendations. For example, the list of 13 vaccines did not change from 2014 to 2015; however, the recommendation for PCV13 changed from "recommended if some other risk is present" for those aged 65 and older to "recommended." The list for 2010 included 10 vaccines. Changes over the last few years include the addition of: HPV Male in 2012, PCV13 in 2013, and Hib in 2014.[21]

International Travel

Some types of international travel, especially to developing countries and rural areas, have higher health risks. These risks depend on a number of factors including where one is traveling, activities while traveling, current health status, and vaccination history. Vaccine-preventable diseases that are rarely seen in the United States, like polio, can still be found in other parts of the world.[22]

The CDC recommends seeing one's healthcare professional, or visiting a travel clinic since not all primary care physicians stock travel vaccines, at least 4-6 weeks prior to any international travel. This allows time to complete any vaccine series and gives the body time to build up immunity.

The CDC maintains an interactive website for both travelers and clinicians, by destination and certain traveler conditions, which provides recommendations on vaccines. Options for traveler conditions include, but is not limited to, pregnant, immune-compromised, or providing mission/disaster relief.[23]

Vaccine Information Statement and Adverse Incident Reporting

A Vaccine Information Statement (VIS) is a document, produced by the CDC, which informs vaccine recipients, or their parents or legal representatives, about the benefits and risks of a vaccine they are receiving. All vaccine providers are required by the National Vaccine Childhood Injury Act[24] to give the appropriate VIS to the patient, or parent or legal representative, prior to every dose of specified vaccines. The CDC also requires providers of other vaccines to provide a VIS under certain conditions. The VIS must be given regardless of the age of the recipient.[25]

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[21] Go to: http://www.cdc.gov/vaccines/schedules/past.html, and select the applicable year, (last visited Mar. 6, 2015).
[22] U.S. Centers for Disease Control and Prevention, *Travel Smart: Get Vaccinated*, http://www.cdc.gov/Features/vaccines-travel/index.html, (last visited Mar. 6, 2015).
[23] U.S. Centers for Disease Control and Prevention, *Traveler's Health: Destinations*, http://wwwnc.cdc.gov/travel/destinations/list, (last visited Feb. 23, 2015).
[24] NCVIA - 42 U.S.C. § 300aa-26
[25] U.S. Centers for Disease Control and Prevention, *Vaccine Information Statements*, (last update June 18, 2013) (last reviewed June 13, 2014) http://www.cdc.gov/vaccines/hcp/vis/about/facts-vis.html, (last visited Mar. 6, 2015).

In addition to distributing a VIS, providers are required to record specific information in the patient's medical record or in a permanent office log. The information that must be recorded is:[26]

- The edition date of the VIS, (a VIS may be updated frequently);
- The date the VIS is provided, i.e., the date of the visit when the vaccine is administered;
- The office address and name and title of the person who administers the vaccine;
- The date the vaccine is administered; and
- The vaccine manufacturer and lot number.

The Vaccine Adverse Event Reporting System (VAERS) is primarily concerned with monitoring adverse health events following vaccination but it accepts all reports, including reports of vaccination errors. Using clinical judgment, healthcare professionals can decide whether or not to report a medical error at their own discretion. For example, a healthcare professional may elect to report vaccination errors that do not have an associated adverse health event, especially if they think the vaccination error may pose a safety risk (e.g., administering a live vaccine to an immunocompromised patient) or that the error would be preventable with public health action or education. There are three ways to report to VAERS – online, by facsimile, or by mail.[27]

III. Effect of Proposed Changes:

CS/SB 792 expands access and availability of certain immunizations for adults by expanding the list of vaccines that a pharmacist may administer and authorizing a registered pharmacy intern, once certified, to administer those same vaccines under the supervision of a pharmacist who is certified to administer vaccines.

Rather than specifying individual immunizations or vaccines that may be administered by a pharmacist or registered intern, the bill authorizes administration of the immunizations or vaccines that are listed in the adult immunization schedule as of February 2015, by the U.S. Centers for Disease Control and Prevention. Currently, the statute authorizes the administration of vaccines for influenza, pneumococcal, meningococcal and shingles to adults (19 years of age or older).[28] By referencing the CDC adult immunization schedule as of February 2015, this bill adds:

- Tetanus, diphtheria, pertussis (Td/Tdap)
- Varicella (chickenpox)
- Human papillomavirus (HPV) Female
- Human papillomavirus (HPV) Male
- Measles, mumps, rubella (MMR)
- Hepatitis A
- Hepatitis B
- Haemophilus influenza type b (Hib)

[26] *Id.*
[27] *See* Vaccine Adverse Events Reporting System, http://vaers.hhs.gov/esub/index (last visited Mar. 6, 2015).
[28] Section 465.189, F.S., does not define an adult. However, this section of law authorizes administration in accordance with the guidelines of the CDC, which defines an adult as a person who is 19 years of age or older.

The administration of immunizations or vaccines that are recommended by the CDC for international travel as of July 1, 2015, as well as those approved by the board in response to a Governor-declared state of emergency may also be administered in accordance with the requirements in this section of law.

The bill grants rulemaking authority for the board to authorize additional immunizations or vaccines as the CDC adds to the adult immunization schedule or the CDC recommends additional immunizations or vaccines for international travel.

The bill requires a registered pharmacy intern to be certified to administer vaccines pursuant to a program approved by the board, and the boards of medicine and osteopathic medicine, which includes at least 20 hours of coursework. Additionally the bill sets a supervision ratio of one registered intern to one pharmacist when the intern is administering immunizations.

The effective date of the bill is July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Pharmacy interns seeking certification to administer vaccinations will incur a $55 initial application fee. The public may be able to obtain applicable vaccinations at their local pharmacy, which may be more expedient and possibly less expensive than scheduling an appointment at a physician’s office, however any such savings is indeterminate.

C. Government Sector Impact:

The department[29] estimates potential certification fees of $259,820[30] less the 8 percent general revenue surcharge of $20,786, for a net revenue in the first biennium of $239,034. The department estimates total expenditures of $36,328 related to the costs for processing certification applications, based on the processing cost of $7.69 per application.

The department indicates that the increase in workload associated with application and website modifications, updates to the Licensing and Enforcement Information Database System, and rulemaking can be absorbed within existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the section 465.189 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 10, 2015:
The CS requires the supervising pharmacist to be certified to administer vaccines, and references a more current recommended adult immunization list which is the one in effect as of February 2015. The CS also requires a one to one supervision ratio when the intern administers an immunization.

B. Amendments:

None.

[29] *Supra* note 8.
[30] The certification fee estimate of $259,820 is based on 4,038 currently registered interns (calculated as 10,914 total registered inters X 37%, number of certified pharmacists) + 686 newly registering interns (calculated as 1,855 new registered intern applications X 37%) for 4,724 applications for certification X $55 application fee.

814874

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/10/2015	.	
	.	
	.	
	.	

The Committee on Health Policy (Bean) recommended the following:

Senate Amendment

Delete lines 21 - 27
and insert:
or vaccine, a pharmacist who is certified under subsection (6), or a registered intern who is under the supervision of a pharmacist, if both the pharmacist and the registered intern are certified under subsection (6), may administer the following vaccines to an adult within the framework of an established protocol under a supervising physician licensed under chapter 458 or chapter 459:

814874

(a) Immunizations or vaccines listed in the recommended adult immunization schedule as of February 2015 by the United

252628

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/10/2015	.	
	.	
	.	
	.	

The Committee on Health Policy (Bean) recommended the following:

Senate Amendment to Amendment (814874) (with title amendment)

Delete line 6
and insert:
or a registered intern who is under the direct and immediate supervision of a

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:
Delete line 4

252628

and insert:
direct and immediate supervision of a pharmacist to
administer specified

219884

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/10/2015	.	
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	.	
	.	

The Committee on Health Policy (Galvano) recommended the following:

Senate Amendment (with title amendment)

Delete line 40
and insert:
(d) ~~Shingles vaccine~~ When an intern administers an immunization under this subsection, that intern must be supervised by a pharmacist at a ratio of one pharmacist to one intern.

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

219884

And the title is amended as follows:

Delete line 7

and insert:

under the supervision of a pharmacist; requiring a one to one ratio for a pharmacists supervising interns when the intern is administering vaccinations; requiring a

By Senator Bean

4-00513C-15 2015792__

A bill to be entitled

An act relating to pharmacy; amending s. 465.189, F.S.; authorizing a registered intern under the supervision of a pharmacist to administer specified vaccines to an adult; revising which vaccines may be administered by a pharmacist or a registered intern under the supervision of a pharmacist; requiring a registered intern seeking to administer vaccines to be certified to administer such vaccines and to complete a minimum amount of coursework; providing an effective date.

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

Section 1. Subsections (1) and (6) of section 465.189, Florida Statutes, are amended to read:

465.189 Administration of vaccines and epinephrine autoinjection.—

(1) In accordance with guidelines of the Centers for Disease Control and Prevention for each recommended immunization or vaccine, a pharmacist, or a registered intern under the supervision of a pharmacist, may administer the following vaccines to an adult within the framework of an established protocol under a supervising physician licensed under chapter 458 or chapter 459:

(a) Immunizations or vaccines listed in the adult immunization schedule as of February 1, 2014, by the United States Centers for Disease Control and Prevention. The board may authorize, by rule, additional immunizations or vaccines as they

are added to the adult immunization schedule ~~Influenza vaccine~~.

(b) Immunizations or vaccines recommended by the United States Centers for Disease Control and Prevention for international travel as of July 1, 2015. The board may authorize, by rule, additional immunizations or vaccines as they are recommended by the United States Centers for Disease Control and Prevention for international travel ~~Pneumococcal vaccine~~.

(c) Immunizations or vaccines approved by the board in response to a state of emergency declared by the Governor pursuant to s. 252.36 ~~Meningococcal vaccine~~.

~~(d) Shingles vaccine.~~

(6) Any pharmacist or registered intern seeking to administer vaccines to adults under this section must be certified to administer such vaccines pursuant to a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program shall, at a minimum, require that the pharmacist attend at least 20 hours of continuing education classes approved by the board and that the registered intern complete at least 20 hours of coursework approved by the board. The program shall have a curriculum of instruction concerning the safe and effective administration of such vaccines, including, but not limited to, potential allergic reactions to such vaccines.

Section 2. This act shall take effect July 1, 2015.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 482
INTRODUCER:	Senators Braynon and Joyner
SUBJECT:	Community Health Worker Certification
DATE:	March 6, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 482 creates section 381.989, F.S., which requires the Department of Health (DOH) to approve one or more third-party credentialing entities to offer a voluntary certification program for community health workers (CHW). CHWs are defined as frontline health care workers who are trusted members of the community they serve or have an unusually deep understanding of that community and who meet other specified criteria.

In order to be approved by the DOH, the bill requires third-party credentialing entities to:

- Establish professional requirements and standards for CHWs;
- Develop and apply core competencies and examinations for certification as a CHW;
- Maintain a code of professional ethics and disciplinary procedures for CHWs;
- Maintain a publicly accessible database of certified CHWs;
- Require continuing education for recertification as a CHW;
- Administer a continuing education provider program; and
- Establish and maintain a CHW advisory committee.

The bill requires approved credentialing entities to grandfather current CHWs who meet the credentialing entity's grandfathering standards for a period of 15 months after the implementation of the CHW certification program.

II. Present Situation:

Community Health Workers

Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments. Typically they share ethnicity, language, socioeconomic status, and life experiences with the communities they serve. CHWs have been identified by many titles, such as community health

advisors, lay health advocates, "promotores(as)," outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.[1]

References in U.S. literature to CHWs begin in the middle of the 1960s when attempts to engage CHWs in low-income communities were experimental responses to the persistent problems of the poor and related more to antipoverty strategies than to specific models of intervention for disease prevention and health care. The documented CHW activities evolved in the subsequent years from special projects funded by short-term public and private grants to a period reflecting discussions of standardized training for CHWs and then to a period where legislation specifically addressing CHWs—their use and certification—passed in a number of states.[2] By the end of 2013, fifteen states and the District of Columbia had enacted laws addressing CHW infrastructure, professional identity, workforce development, or financing.[3]

In 2009, the Agency for Healthcare Research and Quality (AHRQ) conducted a systematic review of the evidence on CHW interventions, outcomes of such interventions, costs and cost-effectiveness of CHW interventions, and characteristics of CHW training. The report concluded that CHWs can serve as a means to improving outcomes for underserved populations for some health conditions. The effectiveness of CHWs in numerous areas, however, requires further research that addresses the methodological limitations of prior studies.[4]

The first federal effort authorizing CHW programs—the Patient Navigator Outreach and Chronic Disease Prevention Act—passed in 2005. The legislation authorized $25 million in HRSA-administered grants for patient navigator (a type of CHW) programs to coordinate health care services, provide health screening and health insurance information, conduct outreach to medically underserved populations, and perform other duties common to CHWs.[5] This program was reauthorized in 2010 under the Patient Protection and Affordable Care Act.

In 2000, there were an estimated 86,000 CHWs nationwide. Florida had 2,650 paid and 1,556 volunteer CHWs, which ranked Florida fourth in the nation for the most CHWs in the

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Community Health Worker National Workforce Study*, pp. iii-iv (March 2007) http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf (last visited Mar. 6, 2014).
[2] *Id.* at iv.
[3] U.S. Centers for Disease Control and Prevention, *A Summary of State Community Health Worker Laws* (July 2013) http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCQQFjAA&url=http%3A%2F%2Fwww.cdc.gov%2Fdhdsp%2Fpubs%2Fdocs%2FCHW_State_Laws.pdf&ei=_1ThUq-IB7jKsQSzooCICg&usg=AFQjCNEud90XB-Dxd9c95sYOnoOijIAkrA (last visited Mar. 6, 2014).
[4] Agency for Healthcare Research and Quality, *Outcomes of Community Health Worker Interventions* (June 2009) http://www.ahrq.gov/research/findings/evidence-based-reports/comhwork-evidence-report.pdf (last visited Mar. 6, 2015).
[5] Pub. Law No. 109-18, H.R. 1812, 109th Cong. (June 29, 2005).

workforce.[6] In 2010, the U.S. Department of Labor included Community Health Workers in the Standard Occupational Classification (SOC).[7]

Florida Community Health Worker Coalition

In October 2010, the DOH received a grant from the Centers for Disease Control to assist cancer coalitions in improving outcomes through policy, environment, or system change. The Cancer Control and Research Advisory Council (CCRAB)—the statewide cancer council—opted to use the funds to develop and promote the work of CHWs in the state. The DOH convened a task force which became the Florida Community Health Worker Coalition (Coalition). The Coalition is a statewide partnership housed within the University of Florida's College of Pharmacy and dedicated to the support and promotion of the CHW profession.[8] The Coalition has identified six key issues of interest:

- Institute a standard definition of CHW in Florida.[9]
- Establish a database of CHWs.
- Standardize training and curriculum standards for CHWs.
- Pursue passage of legislation that recognizes the efforts of CHWs throughout Florida.
- Continue recruiting membership and stakeholder support.
- Pursue reimbursement for CHWs through Medicaid and private insurance.[10]

Medically Underserved in Florida

Medically underserved areas or populations are those areas or populations designated by the Health Resources Services Administration as having too few primary care providers, high infant mortality, high poverty, and/or high elderly population.[11] Medically underserved areas may consist of a whole county or group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services. Medically underserved populations may include groups of persons who face economic, cultural,

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[6] *Supra* note 1, at 14.

[7] The 2010 SOC system is used by federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data. All workers are classified into one of 840 detailed occupations according to their occupational definition.

[8] University of Florida, College of Pharmacy, *Florida Community Health Worker Coalition* http://floridachwn.pharmacy.ufl.edu/ (last visited Mar. 6, 2015).

[9] The coalition has adopted the following definition: "A CHW is a frontline health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. Some activities performed by the CHW include providing information on available resources, providing social support and informal counseling, advocating for individuals and community health needs, and providing services such as first aid and blood pressure screening. They may also collect data to help identify community health needs." *Community Health Worker: A Year in Review*, available at http://file.cop.ufl.edu/pop/CHW%20Website%20(fr%20desktop)/Coalition/Community%20Health%20Worker-Year%20In%20Review%20Draft%20Nov%202011.pdf, (last visited Mar. 6, 2015).

[10] Id.

[11] HRSA, *Find Shortage Areas: MUA/P by State and County*, available at: http://muafind.hrsa.gov/ (last visited Mar. 6, 2015).

or linguistic barriers to health care.[12] Medically underserved areas and populations are found in every county in Florida.[13]

Credentialing of Community Health Workers

A number of states have instituted credentialing programs for CHWs including, among others, Massachusetts, Minnesota, Ohio, Oregon and Texas.[14,15] Most states with credentialing programs opt for a certification structure rather than a licensure structure. Some states, such as Indiana and Nebraska, have instituted certificate and training programs for CHWs independent of state statutes being passed.[16] One of the benefits of a CHW certification system is that it allows a CHW to identify him or herself as certified which signals to employers and payers that the CHW is trained and qualified to perform certain tasks. In many cases certification is a requirement for a CHW to receive payment for their work, however, certification is still distinct from a licensure system which is a barrier to practicing for those without the license.[17]

States typically have ways for CHW experience in the field to count toward training requirements, whether by grandfathering practicing CHWs into certification or through a work experience route for new CHWs to enter the field. Final qualification is typically not through a qualifying exam and it is most common for states to set training standards, identifying the skills and core competencies needed for CHW practice and then approve programs that meet these standards. Finally, states typically develop policies with the active participation of CHWs, whether informally or through specific state agencies tasked with policy development.[18]

Florida's Community Health Worker Coalition has worked with the Florida Certification Board[19] to establish a certification program for CHWs and full credentialing will begin taking place starting January 1, 2016. In order to be certified, a CHW must meet the training requirement of at least four hours of training in each of Communication and Education, Resources, Advocacy, Foundations of Health, and Professional Responsibility as well as 10 hours of electives. Current CHWs can receive a grandfathered certification between January 1, 2015 and December 31, 2015, if the CHW:

- Can show that he or she has at least 500 hours of volunteer or paid experience as a CHW in the past 5 years;

[12] HRSA, *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations,* http://www.hrsa.gov/shortage/ (last visited Mar. 6, 2015).
[13] *Supra* note 11.
[14] See *Community Health Workers Training/Certification Standards - Current Status* (updated March 6, 2015), available at http://www.astho.org/Public-Policy/Public-Health-Law/Scope-of-Practice/CHW-Certification-Standards/, (last visited Mar. 6, 2015).
[15] See Center for Health Law and Policy Innovation, Harvard Law School, *Community Health Worker Credentialing: State Approaches* (June 16, 2014) http://www.chlpi.org/wp-content/uploads/2014/06/CHW-Credentialing-Paper.pdf, (last visited on Mar. 6, 2014)
[16] Supra note 14.
[17] Supra note 15.
[18] Id.
[19] The Florida Certification Board is a private entity that designs, develops, and manages programs for 32 health and human services professions in Florida and nationally including, among others, certified addiction professionals, child welfare professionals, certified mental health professionals, and certified behavioral health technicians. The Florida Certification Board currently certifies more than 20,000 professionals statewide. See http://flcertificationboard.org/, (last visited Mar. 9, 2015).

- Can show that he or she has 30 hours of training in the topics listed above in the last 5 years; and
- Can submit two letters of reference validating his or her experience and training.[20]

III. Effect of Proposed Changes:

SB 482 creates s. 381.989, F.S., which requires the DOH to approve one or more third-party credentialing entities for the certification of CHWs.

The bill defines the terms:

- "Community health worker" as a frontline health care worker who is a trusted member of, or who has an unusually deep understanding of, the community that he or she serves and who:
  - Serves as an intermediary between health care services or service providers and members of the community in order to improve those services, facilitate access to care, and improve the cultural competency of health care providers;
  - Provides information regarding available resources and social support and serves as a health care advocate for the community;
  - Builds individual and community capacity to prevent disease and promote health by increasing knowledge regarding wellness programs, disease prevention, and self-sufficiency among members of the community; and
  - Collects data to help identify the health care needs in a medically underserved community by:
    - Assisting members of the community in improving their ability to effectively communicate with health care providers;
    - Providing culturally and linguistically appropriate health and nutrition education;
    - Advocating for improved individual and community health; and
    - Providing referral services, follow-up services, and coordination of care.
- "Certification" as the voluntary process by which a department-approved third-party credentialing entity grants a credential to an eligible individual to practice as a certified CHW;
- "Certified community health worker" as a CHW to whom the department-approved third-party credentialing entity has issued a credential that demonstrates that individual's mastery of CHW core competencies.
- "Core competencies" as the minimum set of knowledge, skill, and abilities necessary for a community health worker to carry out his or her work responsibilities.
- "Department" as the Department of Health.
- "Grandfathering" as a time-limited process by which the credentialing entity grants CHW certification to a qualified individual who was providing CHW services before the establishment of the CHW certification program;
- "Medically underserved community" as a community in a geographic area that has a shortage of health care providers and a population that includes individuals who do not have public or private health insurance, are unable to pay for health care, and have incomes at or below 185 percent of the federal poverty level; and
- "Recertification" as the biennial renewal of a CHW certification.

[20] Florida Community Health Worker Coalition, *CHW Certification Begins in Florida!* (2015), available at http://floridachwn.pharmacy.ufl.edu/files/2015/02/CHW-Certification-Begins-bilingual.pdf, (last visited Mar. 6, 2015).

The bill requires the DOH to approve one or more third-party credentialing entities to develop and administer voluntary CHW certification programs. The entity must request approval in writing and must be able to demonstrate its ability to:

- Establish professional requirements and standards that an applicant must achieve to be certified as a CHW;
- Develop and apply core competencies and examination instruments according to nationally recognized psychometric standards;
- Maintain a professional code of ethics and disciplinary procedures for certified CHWs;
- Maintain a publicly accessible database of all certified CHWs including any ethical violations committed by the CHW;
- Require continuing education for recertification or reinstatement of the certification of a CHW;
- Administer a continuing education provider program to ensure all CHW education providers are qualified; and
- Create and maintain a CHW advisory committee of between eight and fifteen members consisting of at least two members representing the DOH, five members representing the Florida Community Health Worker Coalition, and up to two members from other stakeholder organizations identified by the DOH. The organization a member represents must appoint the member and the credentialing entity may appoint additional members to the committee.

The bill also requires third-party credentialing entities to issue grandfathered certifications to CHWs who meet the credentialing entities' grandfathering requirements for a period of 15 months after implementation of the certification program. The applying CHW must pay $50 for such a certification.

The provisions in the bill take effect when becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CHWs who wish to be certified may see a cost associated with additional training they may be required to receive, as determined by the credentialing entity. The impact to CHWs who wish to be credentialed is indeterminant since the amount of training required, training costs, and application fees are not specified in the bill. CHWs who meet the requirements and wish to be grandfathered in will be required to pay $50.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Sub-paragraph 381.989(1)(a)4. created by the bill requires that a CHW "collect data to help identify the health care needs in a medically underserved community" however sub-sub-paragraphs 381.989(1)(a)4.a.-d. list requirements that are not related to data collection. Sub-paragraph 381.989(1)(a)4. should be amended to relate to the sub-sub-paragraphs or should be separated from the sub-sub-paragraphs.

VII. Related Issues:

The bill requires that the credentialing entities create professional requirements, training programs, core competencies, and a code of ethics for CHWs but does not specify minimum standards for any of these requirements. As such, if more than one credentialing entity is approved by the DOH, the requirements to be certified as a CHW could vary widely between different credentialing entities. Additionally, the bill requires the DOH to approve at least one credentialing organization regardless of the substance and credibility of the credentialing program should only one organization seek approval.

The bill requires the DOH to both approve credentialing entities and to appoint members to the advisory committee as well as identify key stakeholders who may appoint members to the committee. The DOH states that these requirements could create a conflict of interest and recommends that the DOH not be required to appoint members to the advisory committee or identify key stakeholders.[21]

The bill describes the duties of a CHW and some of the duties as described could constitute unlicensed practice of a profession if the CHW is not otherwise licensed. For example, providing nutrition education, as required by 381.989(1)(a)4.b., could be considered the practice of dietetics and nutrition as defined in s. 468.503, F.S.[22]

VIII. Statutes Affected:

This bill creates section 381.989 of the Florida Statutes.

[21] Department of Health, *Senate Bill 482 Analysis* (February 2, 2015) (on file with Senate Committee on Health Policy).
[22] Id.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Braynon

36-00219-15 2015482__

A bill to be entitled

An act relating to community health worker certification; creating s. 381.989, F.S.; defining terms; requiring the Department of Health to approve qualified third-party credentialing entities to administer voluntary community health worker certification programs; establishing criteria for the approval of a third-party credentialing entity; requiring a third-party credentialing entity to issue a certification to certain qualified individuals who meet the grandfathering standards established by the entity; establishing a maximum fee for such certification; providing an effective date.

WHEREAS, Florida continues to experience a critical shortage of health care providers in primary care, oral health, and behavioral health, particularly in rural and inner-city areas, and

WHEREAS, there is substantial evidence that the comprehensive coordination of care for individuals who have chronic diseases and the provision of information regarding preventive care can improve individual health, create a healthier population, reduce health care costs, and increase appropriate access to health care, and

WHEREAS, community health workers have demonstrated success in increasing access to health care in medically underserved communities, providing culturally appropriate education regarding disease prevention and management, providing translation and interpretation services for non-English

speakers, improving health outcomes through the coordination of care, increasing individual health care literacy and advocacy, and improving the health care of medically underserved communities, while reducing the overall costs to the state's health care system, and

WHEREAS, the Legislature recognizes that the services provided by community health workers are an essential component of the health care delivery system in this state, and

WHEREAS, the Florida Community Health Worker Coalition has begun to develop a voluntary process that will ensure that only qualified individuals are designated as certified community health workers by a department-approved third-party credentialing entity, which will allow community health workers to earn a living wage and be part of an integrated health delivery team, NOW, THEREFORE,

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

Section 1. Section 381.989, Florida Statutes, is created to read:

381.989 Community health worker.—

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

(a) "Community health worker" means a frontline health care worker who is a trusted member of, or who has an unusually deep understanding of, the community that he or she serves and who meets all of following criteria:

1. Serves as a liaison, link, or intermediary between health care services or social services or service providers and members of the community in order to facilitate access to health

care services and to improve the quality of such services and the cultural competency of health care providers.

2. Provides information regarding available resources and social support and serves as a health care advocate for individuals in a community setting.

3. Builds individual and community capacity to prevent disease and promote health by increasing knowledge regarding wellness programs, disease prevention, and self-sufficiency among the members of the community through a range of activities, such as community outreach, education, and advocacy.

4. Collects data to help identify the health care needs in a medically underserved community by:

a. Assisting members of the community in improving their ability to effectively communicate with health care providers.

b. Providing culturally and linguistically appropriate health and nutrition education.

c. Advocating for improved individual and community health, including oral health, behavioral health, and nutrition.

d. Providing referral services, followup services, and coordination of care.

(b) "Certification" means the voluntary process by which a department-approved third-party credentialing entity grants a credential to an eligible individual to practice as a certified community health worker.

(c) "Certified community health worker" means a community health worker to whom the department-approved third-party credentialing entity has issued a credential that demonstrates that individual's mastery of community health worker core competencies.

(d) "Core competencies" means the minimum set of knowledge, skill, and abilities necessary for a community health worker to carry out his or her work responsibilities.

(e) "Department" means the Department of Health.

(f) "Grandfathering" means a time-limited process by which a department-approved third-party credentialing entity grants community health worker certification to a qualified individual who was providing community health worker services before the establishment of the community health worker certification program as provided in this section.

(g) "Medically underserved community" means a community in a geographic area that has a shortage of health care providers and a population that includes individuals who do not have public or private health insurance, are unable to pay for health care, and have incomes at or below 185 percent of the federal poverty level.

(h) "Recertification" means the biennial renewal of a community health worker certification.

(2) THIRD-PARTY CREDENTIALING ENTITIES.—The department shall approve one or more third-party credentialing entities to develop and administer voluntary community health worker certification programs for individuals who provide community health worker services. A third-party credentialing entity shall request such approval from the department in writing. In order to obtain department approval, the third-party credentialing entity must demonstrate its ability to:

(a) Establish professional requirements and standards that an applicant must achieve in order to obtain a community health worker certification, including forms and procedures for the

receipt, review, and action upon applications for initial community health worker certification and for recertification, or to qualify for grandfathering, as that term is defined in this section.

(b) Develop and apply core competencies and examination instruments according to nationally recognized certification and psychometric standards.

(c) Maintain a professional code of ethics and disciplinary procedures that apply to certified community health workers.

(d) Maintain a publicly accessible database of all individuals holding a community health worker certification, which must include any ethical violations committed by the individual.

(e) Require continuing education for recertification or reinstatement of a community health care worker certification.

(f) Administer a continuing education provider program to ensure that only qualified providers offer continuing education to a certified community health worker.

(g) Maintain a community health worker advisory committee of at least 8 and no more than 15 members consisting of at least two representatives of the department, five representatives of the Florida Community Health Worker Coalition, and up to two representatives of other key stakeholder organizations identified by the department. Such members shall be appointed by the organization they represent. The department-approved third-party credentialing entity may appoint additional members to the advisory committee.

(3) GRANDFATHERING.—Department-approved third-party credentialing entities shall, for a period of at least 15 months

after implementation of the community health worker certification program, award a community health worker certification to an individual who meets the entity's grandfathering standards. The cost of certification for a grandfathered community health worker may not exceed $50.

Section 2. This act shall take effect upon becoming a law.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 768
INTRODUCER:	Health Policy Committee and Senator Gaetz
SUBJECT:	Patient Observation Status Notification
DATE:	March 10, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.			CF	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 768 requires a hospital to document the placement of a patient on observation status in that patient's discharge papers. The bill requires that the patient or his or her proxy be notified of the observation status through the discharge papers and allows the facility to also notify the patient through brochures, signage, or other forms of communication.

II. Present Situation:

Observation Status

Observation services are services that are given in a hospital in order to help the treating physician decide whether the patient needs to be admitted to the hospital or if the patient can be discharged. These services can occur in the hospital's emergency department or in another area of the hospital.[1]

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Although generally a physician should order a patient admitted who is expected to spend 24 hours or more

[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Product No. 11435, *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* (May 2014) https://www.medicare.gov/Pubs/pdf/11435.pdf (Last visited Feb. 23, 2015).

in the hospital, such a decision is a complex medical judgment which the physician should only make after considering a number of factors including:

- The severity of signs and symptoms exhibited by the patient;
- The medical probability of something adverse happening to the patient;
- The need for diagnostic studies to assist in the admitting decision; and
- The availability of diagnostic procedures at the time when the patient presents.[2]

Observation services are considered outpatient services even if the patient spends one or more nights in the hospital. Outpatient services are covered under Medicare Part B, rather than Part A, so some patients with Medicare can see increased out of pocket costs for observation services versus being admitted to the hospital.[3] For example, hospital inpatient services are covered under Medicare Part A which requires the patient to pay a one-time deductible ($1,260) for all hospital services for the first 60 days of his or her stay. However, hospital outpatient services, including observation services, are covered under Medicare Part B and the patient must pay the Part B deductible ($147) as well as 20 percent of the Medicare-approved amount for doctor services.[4] Also, a patient may be responsible for the costs of a skilled nursing facility stay once discharged from the hospital and any prescription drug costs which typically are not covered under Medicare Part B.[5]

According to a study published in 2014, between 2001 and 2009, the rate of hospitals' use of observation services for Medicare patients has approximately doubled. Additionally, the number of Medicare patients who were placed on observation status and then released without being admitted to the hospital has increased by 131 percent over the same time period.[6] The federal Centers for Medicare and Medicaid Services (CMS) has also noted an increase in the percentage of hospital patients receiving observation services for longer than 48 hours from approximately 3 percent in 2006 to approximately 8 percent in 2011.[7] This trend concerns CMS since "beneficiaries who are treated for extended periods of time as hospital outpatients receiving observation services may incur greater financial liability…[from] Medicare Part B copayments, the cost of self-administered drugs that are not covered under Part B, and the cost of post hospital skilled nursing facility care."[8]

Part of the cause of the upward trend in longer periods on observation status may be due to hospitals' wariness of the denial of their Medicare Part A inpatient claims due to a Medicare review contractor determining that the inpatient admission was not reasonable and necessary. To combat this, CMS, enacted the 48 hour benchmark which is guidance that states that "the

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[2] Medicare Benefit Policy Manual, Chapter 1 at 10, available at http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf (last visited March 6, 2015).
[3] AARP Public Policy Institute, *Rapid Growth in Medicare Hospital Observation Services: What's Going On?*, p. 1 (September 2013) http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf (Last visited Feb. 23, 2015.)
[4] See supra note, at 1, and Medicaid.gov., *Medicare 2015 costs at a glance* http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html (Last visited Feb. 23, 2015).
[5] *Note: Some Medicare beneficiaries purchase separate Medicare Part D coverage for prescription drugs.*
[6] Supra note 3, at 6.
[7] Fed. Reg., Vol. 78, No. 160, pp. 50495-50907 (August 19, 2013) http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf (last visited Feb. 25, 2015).
[8] Id. *Note: For skilled nursing facility care to be covered under Medicare Part A the patient must have a prior 3-day stay in the hospital as an inpatient.*

decision to admit a beneficiary should be made within 24 to 48 hours of observation care [and that] only in rare and exceptional cases do reasonable and necessary outpatient observation services in the hospital span more than 48 hours."[9] In addition, starting April 1, 2015,[10] Medicare's review contractors are required to presume as reasonable and necessary admissions for patients that are expected to require more than one Medicare utilization day (defined as spanning two midnights).[11]

III. Effect of Proposed Changes:

CS/SB 768 amends s. 395.301, F.S., to require a hospital[12] to document the placement of a patient on observation status in that patient's discharge papers. The bill requires that the patient or his or her proxy be notified of the observation status through the discharge papers and allows the facility to also notify the patient through brochures, signage, or other forms of communication.

These provisions take effect on July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 768 may provide a positive fiscal impact for some patients who are placed on observation status in a hospital if such placement would require that they pay high out of

[9] Id.
[10] See Amanda Cassidy, *The Two-Midnight Rule*, Health Affairs, Health Policy Briefs (January 22, 2015) available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=133, (last visited Feb. 25, 2015).
[11] Supra note 10, at 50908
[12] The bill refers to any licensed facility which also includes ambulatory surgical centers and mobile surgical facilities. However, patients are not permitted to stay overnight in either of those facility types and, therefore, it is unlikely the provisions in this bill would affect such facilities.

pocket costs for outpatient services not covered by their insurance and if through receiving the notification the patient can avoid such costs.

The bill may cause a negative fiscal impact for facilities that fail to document observation status in a patient's discharge papers since failing to do so would constitute a licensure violation for that facility.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 395.301 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 10, 2015:
The CS removes the requirement that a hospital, ambulatory surgical center, or mobile surgical facility provide written and oral notification immediately to a patient when that patient is placed on observation status, as well as the details required to be in such a notification. The CS adds a requirement that a hospital, ambulatory surgical center, or mobile surgical facility document observation services in a patient's discharge papers and that the patient, or his or her proxy, must be notified of the observation services through such documentation. The CS also allows the facility to notify the patient through brochures, signage, or other forms of communication.

B. Amendments:

None.

436444

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/10/2015	.	
	.	
	.	
	.	

The Committee on Health Policy (Gaetz) recommended the following:

Senate Amendment (with title amendment)

Delete lines 108 - 132

and insert:

(9) If a licensed facility places a patient on observation rather than inpatient status, observation services shall be documented in the patient's discharge papers. The patient or patient's proxy shall be notified of observation services through discharge papers and also may be notified through brochures, signage, or other forms of communication for this

436444

purpose.

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

And the title is amended as follows:

Delete lines 4 - 7

and insert:

a licensed facility to document observation services in a patient's discharge papers when the facility places the patient on observation status; requiring a licensed facility to notify a patient or patient's proxy of observation status through discharge papers; authorizing a licensed facility to notify a patient or patient's proxy of observation status through other forms of communication; providing an effective date.

By Senator Gaetz

1-00728-15 2015768__

A bill to be entitled

An act relating to patient observation status notification; amending s. 395.301, F.S.; requiring licensed facilities to notify patients if they place them in observation status rather than admitted status; requiring facilities to provide certain notice; providing an effective date.

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

Section 1. Section 395.301, Florida Statutes, is amended, to read:

395.301 Itemized patient bill; form and content prescribed by the agency; patient observation status notification.—

(1) A licensed facility not operated by the state shall notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. Within 7 days following the patient's discharge or release from a licensed facility not operated by the state, the licensed facility providing the service shall, upon request, submit to the patient, or to the patient's survivor or legal guardian as may be appropriate, an itemized statement detailing in language comprehensible to an ordinary layperson the specific nature of charges or expenses incurred by the patient, which in the initial billing shall contain a statement of specific services received and expenses incurred for such items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed

facility, as prescribed by the agency.

(2)(a) Each such statement submitted pursuant to this section:

1. May not include charges of hospital-based physicians if billed separately.

2. May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

3. Shall list drugs by brand or generic name and not refer to drug code numbers when referring to drugs of any sort.

4. Shall specifically identify therapy treatment as to the date, type, and length of treatment when therapy treatment is a part of the statement.

(b) Any person receiving a statement pursuant to this section shall be fully and accurately informed as to each charge and service provided by the institution preparing the statement.

(3) On each itemized statement submitted pursuant to subsection (1) there shall appear the words "A FOR-PROFIT (or NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially similar words sufficient to identify clearly and plainly the ownership status of the licensed facility. Each itemized statement must prominently display the phone number of the medical facility's patient liaison who is responsible for expediting the resolution of any billing dispute between the patient, or his or her representative, and the billing department.

(4) An itemized bill shall be provided once to the patient's physician at the physician's request, at no charge.

(5) In any billing for services subsequent to the initial

billing for such services, the patient, or the patient's survivor or legal guardian, may elect, at his or her option, to receive a copy of the detailed statement of specific services received and expenses incurred for each such item of service as provided in subsection (1).

(6) No physician, dentist, podiatric physician, or licensed facility may add to the price charged by any third party except for a service or handling charge representing a cost actually incurred as an item of expense; however, the physician, dentist, podiatric physician, or licensed facility is entitled to fair compensation for all professional services rendered. The amount of the service or handling charge, if any, shall be set forth clearly in the bill to the patient.

(7) Each licensed facility not operated by the state shall provide, prior to provision of any nonemergency medical services, a written good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition upon written request of a prospective patient. The estimate shall be provided to the prospective patient within 7 business days after the receipt of the request. The estimate may be the average charges for that diagnosis related group or the average charges for that procedure. Upon request, the facility shall notify the patient of any revision to the good faith estimate. Such estimate shall not preclude the actual charges from exceeding the estimate. The facility shall place a notice in the reception area that such information is available. Failure to provide the estimate within the provisions established pursuant to this section shall result in a fine of $500 for each instance of the facility's failure to provide the

requested information.

(8) Each licensed facility that is not operated by the state shall provide any uninsured person seeking planned nonemergency elective admission a written good faith estimate of reasonably anticipated charges for the facility to treat such person. The estimate must be provided to the uninsured person within 7 business days after the person notifies the facility and the facility confirms that the person is uninsured. The estimate may be the average charges for that diagnosis-related group or the average charges for that procedure. Upon request, the facility shall notify the person of any revision to the good faith estimate. Such estimate does not preclude the actual charges from exceeding the estimate. The facility shall also provide to the uninsured person a copy of any facility discount and charity care discount policies for which the uninsured person may be eligible. The facility shall place a notice in the reception area where such information is available. Failure to provide the estimate as required by this subsection shall result in a fine of $500 for each instance of the facility's failure to provide the requested information.

(9)(a) A licensed facility, upon placing a patient in an observation status rather than an admission status, shall immediately notify the patient orally and in writing of his or her observation status and include the written notice of such status in the patient's record. Such oral and written notice shall include:

1. A statement that the patient has not been or is no longer admitted to the facility but has been placed in an observation status;

2. A statement that placement in an observation status may affect the patient's Medicare, Medicaid, or private insurance coverage for:

a. Hospital services, including medications and pharmaceutical supplies; and

b. Home or community-based care or care at a skilled nursing facility, including rehabilitative services, upon the patient's discharge.

3. A statement recommending that the patient contact his or her health insurance provider to determine the implications of his or her placement in an observation status and his or her right to appeal the placement by the facility.

(b) The patient or the patient's legal guardian, conservator, or other authorized representative must sign and date the written notice to be placed in the patient's record at the time of oral notification.

(10) ~~(9)~~ A licensed facility shall make available to a patient all records necessary for verification of the accuracy of the patient's bill within 30 business days after the request for such records. The verification information must be made available in the facility's offices. Such records shall be available to the patient prior to and after payment of the bill or claim. The facility may not charge the patient for making such verification records available; however, the facility may charge its usual fee for providing copies of records as specified in s. 395.3025.

(11) ~~(10)~~ Each facility shall establish a method for reviewing and responding to questions from patients concerning the patient's itemized bill. Such response shall be provided

within 30 days after the date a question is received. If the patient is not satisfied with the response, the facility must provide the patient with the address of the agency to which the issue may be sent for review.

(12) ~~(11)~~ Each licensed facility shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration pursuant to s. 408.05(3)(k). The facility shall place a notice in the reception area that the information is available electronically and the facility's Internet website address.

Section 2. This act shall take effect July 1, 2015.