By Senators Brown-Waite, Myers, Bankhead, Burt and Silver

10-899A-98

A bill to be entitled

An act relating to children's health care; amending s. 409.904, F.S.; providing for children under specified ages who are not otherwise eligible for the Medicaid program to be eligible for optional payments for medical assistance; amending s. 409.9126, F.S.; making the Children's Medical Services network available to certain children who are eligible for the Florida Kids Health program; revising provisions to reflect the transfer of duties to the Department of Health; creating s. 409.810, F.S.; providing a short title; creating s. 409.811, F.S.; providing definitions; creating s. 409.812, F.S.; creating and providing the purpose for the Florida Kids Health program; creating s. 409.813, F.S.; specifying program components; specifying that certain program components are not an entitlement; creating s. 409.8135, F.S.; providing for program enrollment and expenditure ceilings; creating s. 409.814, F.S.; providing eligibility requirements; creating s. 409.815, F.S.; establishing requirements for health benefits coverage under the Florida Kids Health program; creating s. 409.816, F.S.; providing for limitations on premiums and cost-sharing; creating s. 409.817, F.S.; providing for approval of health benefits coverage as a condition of financial assistance; creating s. 409.818, F.S.; providing for program

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

administration; specifying duties of the Department of Children and Family Services, the Department of Health, the Agency for Health Care Administration, the Department of Insurance, and the Florida Healthy Kids Corporation; authorizing application for federal waiver for alternative coverage; transferring, renumbering, and amending s. 154.508, F.S., relating to outreach activities to identify low-income, uninsured children; creating s. 409.820, F.S.; requiring that the Department of Health develop standards for quality assurance and program access; establishing performance measures and standards for the Florida Kids Health program; providing an appropriation; providing for application of the act to certain contracts between providers and the Florida Healthy Kids Corporation; providing an effective date.

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

Section 1. 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.

(1) A person who is age 65 or older or is determined to be disabled, whose income is at or below 100 percent of federal poverty level, and whose assets do not exceed established limitations.

(2) A family, a pregnant woman, a child under age 18, 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 this group, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person in this group, which group is 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.

(3) A person who is in need of the services of a licensed nursing facility, a licensed intermediate care facility for the developmentally disabled, or a state mental hospital, whose income does not exceed 300 percent of the SSI income standard, and who meets the assets standards established under federal and state law.

(4) A low-income person who meets all other requirements for Medicaid eligibility except citizenship and who is in need of emergency medical services. The eligibility of such a recipient is limited to the period of the emergency, in accordance with federal regulations.

(5) Subject to specific federal authorization, a postpartum woman living in a family that has an income that is at or below 185 percent of the most current federal poverty level is eligible for family planning services as specified in s. 409.905(3) for a period of up to 24 months following a pregnancy for which Medicaid paid for pregnancy-related services.

(6) A child under 1 year of age who lives in a family whose income is above 185 percent of the most current federal poverty level but equal to or below 200 percent of the most current federal poverty level. In determining the eligibility of such a child, an assets test is not required.

(7) A child under 19 years of age who is not eligible for coverage under subsection (6) or under s. 409.903(5), (6), or (7) and who lives in a family whose income is at or below 100 percent of the most current federal poverty level. In determining the eligibility of such a child, an assets test is not required.

Section 2. Subsections (2), (3), and (10) of section 409.9126, Florida Statutes, are amended to read:

409.9126 Children with special health care needs.--

(2) The Legislature finds that ~~Medicaid-eligible~~ children with special health care needs require a comprehensive, continuous, and coordinated system of health care that links community-based health care with multidisciplinary, regional, and tertiary care. The Legislature finds that Florida's Children's Medical Services program provides a full continuum of coordinated, comprehensive services for children with special health care needs.

(3) Except as provided in subsections (8) and (9), children eligible for Children's Medical Services who receive Medicaid benefits, and other Medicaid-eligible children with special health care needs, shall be exempt from the provisions of s. 409.9122 and shall be served through the Children's Medical Services network. The Children's Medical Services network shall also be available to children with special health care needs who are eligible for health benefits coverage other that Medicaid through the Florida Kids Health program.

(10) The agency, in consultation with the Department of Health ~~and Rehabilitative Services~~, shall adopt rules that address Medicaid requirements for referral, enrollment, and disenrollment of children with special health care needs who are enrolled in Medicaid managed care plans and who may benefit from the Children's Medical Services network.

Section 3. Section 409.810, Florida Statutes, is created to read:

409.810 Short title.--Sections 409.810-409.820 may be cited as the "Florida Kids Health Act."

Section 4. Section 409.811, Florida Statutes, is created to read:

409.811 Definitions.--As used in ss. 409.810-409.820, the term:

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

(2) "Alternative coverage" means health benefits coverage provided through a community-based health-delivery system authorized under s. 2105 of Title XXI of the Social Security Act, subject to federal approval of a waiver request. Such health-delivery system may include:

(a) A network of health care providers owned, operated, or under contract with a county, political subdivision, or tax district;

(b) A rural health network established under s. 381.0406;

(c) A federally qualified health center that receives funds under s. 330 of the Public Health Service Act;

(d) A migrant health center that receives funds under s. 329 of the Public Health Service Act;

(e) The Children's Medical Services network established in s. 409.9126; or

(f) A hospital that receives Medicaid disproportionate share payments under s. 409.911.

(3) "Applicant" means a parent or guardian of a child or a child whose disability of nonage has been removed under chapter 743 who applies for determination of eligibility for health benefits coverage under ss. 409.810-409.820.

(4) "Benchmark benefit plan" means the form and level of health benefits coverage established in s. 409.815.

(5) "Benchmark premium" means the premium ceiling price for which federal and state assistance payments are available.

(6) "Child" means any person under 19 years of age.

(7) "Child with special health care needs" means a child whose serious or chronic physical or developmental condition requires extensive preventive and maintenance care beyond that required by typically healthy children. Health care utilization by such a child exceeds the statistically expected usage of the normal child matched for chronological age and such child often needs complex care requiring multiple

providers, rehabilitation services, and specialized equipment in a number of different settings.

(8) "Community rate" means a method used to develop premiums for a health insurance plan that spreads financial risk across a large population.

(9) "Enrollee" means a child who has been determined eligible for and is receiving coverage under ss. 409.810-409.820.

(10) "Enrollment ceiling" means the maximum number of children, excluding children enrolled in Medicaid, that may be enrolled at any time in the Florida Kids Health program. The maximum number shall be established annually in the General Appropriations Act or by general law.

(11) "Family" means the group or the individuals whose income is considered in determining eligibility for the Florida Kids Health program. The family includes a child, custodial parent, or caretaker relative who resides in the same house or living unit or, in the case of a child whose disability of nonage has been removed under chapter 473, the child. The family may also include individuals whose income and resources are considered in whole or in part in determining eligibility of the child.

(12) "Family income" means cash received at periodic intervals from any source, such as wages, benefits, contributions, or rental property. Income also may include any money that would have been counted as income under the AFDC state plan in effect prior to August 22, 1996.

(13) "Guarantee issue" means the health benefits coverage that must be offered to an individual regardless of the individual's health status, preexisting condition, or claims history.

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

(15) "Health insurance plan" means health benefits coverage under the following:

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

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

(16) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and ss. 409.901-409.9205, as administered in this state by the agency.

(17) "Medically necessary" means the use of any medical treatment, service, equipment, or supply necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity and which is:

(a) Consistent with the symptom, diagnosis, and treatment of the enrollee's condition;

(b) Provided in accordance with generally accepted standards of medical practice;

(c) Not primarily intended for the convenience of the enrollee, the enrollee's family, or the health care provider;

(d) The most appropriate level of supply or service for the diagnosis and treatment of the enrollee's condition; and

(e) Approved by the appropriate medical body or health care specialty involved as effective, appropriate, and essential for the care and treatment of the enrollee's condition.

(18) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(19) "Premium" means the entire cost of an insurance plan, including the administration fee or the risk assumption charge.

(20) "Premium assistance payment" means the monthly consideration paid by the agency per enrollee in the Florida Kids Health program towards health insurance premiums.

(21) "Program" means the Florida Kids Health program, the medical assistance program authorized by Title XXI of the Social Security Act as part of the federal Balanced Budget Act of 1997.

(22) "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.

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

Section 5. Section 409.812, Florida Statutes, is created to read:

409.812 Program created; purpose.--The Florida Kids Health program is created to provide a defined set of health benefits to previously uninsured, low-income children through the establishment of a variety of affordable health benefits coverage options from which families may select coverage and through which families may contribute financially to the health care of their children.

Section 6. Section 409.813, Florida Statutes, is created to read:

409.813 Program components; entitlement and nonentitlement.--The Florida Kids Health program includes health benefits coverage provided to children through:

(1) Medicaid;

(2) The Florida Healthy Kids Corporation program as created in s. 624.91;

(3) Health insurance plans approved under ss. 409.810-409.820; and

(4) Alternative coverage approved under ss. 409.810-409.820.

Except for coverage under the Medicaid program, coverage under the Florida Kids Health program is not an entitlement.

Section 7. Section 409.8135, Florida Statutes, is created to read:

409.8135 Program enrollment and expenditure ceilings.--

(1) Except for the Medicaid program, a ceiling shall be placed on annual federal and state expenditures and on enrollment in the Florida Kids Health program as provided each year in the General Appropriations Act. The agency, in consultation with the Department of Health, may propose to increase the enrollment ceiling in accordance with chapter 216.

(2) Except for the Medicaid program, whenever the Social Services Estimating Conference determines that there is presently, or will be by the end of the current fiscal year, insufficient funds to finance the current or projected enrollment in the program, all additional enrollment must cease and additional enrollment may not resume until sufficient funds are available to finance such enrollment.

(3) The agency shall collect and analyze the data needed to project program enrollment, including participation rates, caseloads, and expenditures. The agency shall report the caseload and expenditure trends to the Social Services Estimating Conference in accordance with chapter 216.

Section 8. Section 409.814, Florida Statutes, is created to read:

409.814 Eligibility.--A child whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kids Health program as provided in this section. In determining the eligibility of such a child, an assets test is not required.

(1) A child who is eligible for Medicaid coverage under s. 409.903 or s. 409.904 must be enrolled in Medicaid

and is not eligible to receive health benefits under any other health benefits coverage authorized under ss. 409.810-409.820.

(2) A child who is not eligible for Medicaid, but who is eligible for the program, may obtain coverage under any of the other types of health benefits coverage authorized in ss. 409.810-409.820 if such coverage is approved and available in the county in which the child resides.

(3) A child who is eligible for the program under subsection (1) or (2) and who is a child with special health care needs, as determined through a risk-screening instrument, is eligible for health benefits coverage from and may be referred to the Children's Medical Services network. Eligibility for coverage under the Children's Medical Services network for a child who is eligible for the program under subsection (2) is subject to federal approval of the network as alternative coverage.

(4) The following children are not eligible to receive health benefits coverage under ss. 409.810-409.820, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

(a) A child who is eligible for coverage under a state health benefits plan on the basis of a family member's employment with a public agency in the state;

(b) A child who is covered under a group health benefit plan or under other health insurance coverage, excluding coverage provided under the Florida Healthy Kids Corporation as established under s. 624.91;

(c) A child who is an alien, but who does not meet the definition of qualified alien, in the United States; or

(d) A child who is an inmate of a public institution or a patient in an institution for mental diseases.

(5) A child whose family income is above 200 percent of the federal poverty level may participate in the program; however, the family is not eligible for premium assistance payments and must pay the full cost of the premium. Children described in this subsection may not be counted in the annual enrollment ceiling for the Florida Kids Health program.

(6) Once a child is determined eligible for the program, the child is eligible for coverage under the program for 6 months without a redetermination or reverification of eligibility if the family continues to pay the applicable premium.

Section 9. Section 409.815, Florida Statutes, is created to read:

409.815 Health benefits coverage; limitations.--

(1) MEDICAID BENEFITS.--For purposes of this program, benefits available under the Medicaid program include those goods and services provided under the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, as administered in this state by the agency. This includes those mandatory Medicaid services authorized under s. 409.905 and optional Medicaid services authorized under s. 409.906, rendered on behalf of eligible individuals by qualified providers, in accordance with federal requirements for Title XIX, subject to any limitations or directions provided for in the General Appropriations Act or chapter 216, and according to methodologies and limitations set forth in agency rules and policy manuals and handbooks incorporated by reference thereto.

(2) BENCHMARK BENEFITS.--In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.820, the health benefits

coverage, except for coverage under the Medicaid program, must include the following minimum benefits as medically necessary.

(a) Preventive health services.--Covered services include:

1. Well-child care, including services recommended in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics;

2. Immunizations and injections;

3. Health education counseling and clinical services;

4. Vision screening; and

5. Hearing screening.

(b) Inpatient hospital services.--All covered services provided for the medical care and treatment of an enrollee who is admitted as an inpatient to a hospital licensed under part I of chapter 395, with the following exceptions:

1. All admissions must be authorized by the enrollee's health benefits coverage provider.

2. The length of the patient stay shall be determined on the medical condition of the enrollee in relation to the necessary and appropriate level of care.

3. Room and board may be limited to semiprivate accommodations unless a private room is considered medically necessary or semiprivate accommodations are not available.

4. Admissions for rehabilitation and physical therapy are limited to 15 days per contract year.

(c) Emergency services.--Covered services include visits to an emergency room or other licensed facility if needed immediately due to an injury or illness and delay means risk of permanent damage to the enrollee's health.

(d) Maternity services.--Covered services include maternity and newborn care, including prenatal and postnatal care with the following limitations:

1. Coverage may be limited to vaginal deliveries; and

2. Initial inpatient care for newborn infants of enrolled adolescents shall be covered, including normal newborn care, nursery charges, and the initial pediatric or neonatal examination, and the infant may be covered for up to 3 days following birth.

(e) Organ transplantation services.--Covered services include pretransplant, transplant, and postdischarge services and treatment of complications after transplantation for transplants deemed necessary and appropriate within the guidelines set by the Agency for Health Care Administration Organ Transplant Advisory Council under s. 381.0602 or the Agency for Health Care Administration Bone Marrow Transplant Advisory Panel under s. 627.4236.

(f) Outpatient services.--Covered services include preventive, diagnostic, therapeutic, palliative care, and other services provided to an enrollee in the outpatient portion of a health facility licensed under chapter 395, except for the following limitations:

1. Services must be authorized by the enrollee's health benefits coverage provider; and

2. Treatment for temporomandibular joint disease (TMJ) is specifically excluded.

(g) Behavioral health services.--

1. Mental health benefits include:

a. Inpatient services, limited to not more than 15 inpatient days per contract year for psychiatric admissions; and

b. Outpatient services, including outpatient visits for psychological or psychiatric evaluation, diagnosis, and treatment by a licensed mental health professional, limited to a maximum of twenty outpatient visits each contract year.

2. Drug abuse detoxification and rehabilitation services for pregnant adolescents, including inpatient and outpatient services, with inpatient admissions for alcoholism and drug addiction limited to diagnosis and medical detoxification.

(h) Durable medical equipment.--Covered services include equipment and devices that are medically indicated to assist in the treatment of a medical condition and specifically prescribed as medically necessary, with the following limitations:

1. Low vision and telescopic aides are not included.

2. Corrective lenses and frames may be limited to one pair every 2 years, unless the prescription or head size of the enrollee changes.

3. Hearing aids shall be covered only when medically indicated to assist in the treatment of a medical condition.

4. Covered prosthetic devices include artificial eyes and limbs, braces, and other artificial aids.

(i) Health practitioner services.--Covered services include services and procedures rendered to an enrollee when performed to diagnose and treat diseases, injuries, or other conditions, including care rendered by health practitioners acting within the scope of their practice, with the following exceptions:

1. Chiropractic services may be limited to six visits in 6 months and one service per day for manual manipulation of the spine and screenings.

2. Podiatric services may be limited to one visit per day totaling two visits per month for specific foot disorders.

(j) Home health services.--Covered services include prescribed home visits by both registered and licensed practical nurses to provide skilled nursing services on a part-time intermittent basis, subject to the following limitations:

1. Coverage may be limited to include skilled nursing services only;

2. Meals, housekeeping, and personal comfort items may be excluded; and

3. Private duty nursing is limited to circumstances where such care is medically necessary.

(k) Hospice services.--Covered services include reasonable and necessary services for palliation or management of an enrollee's terminal illness, with the following exceptions:

1. Once a family elects to receive hospice care for an enrollee, other services that treat the terminal condition will not be covered; and

2. Services required for conditions totally unrelated to the terminal condition are covered to the extent that the services are included in this section.

(l) Laboratory and X-ray services.--Covered services include diagnostic testing, including clinical radiologic, laboratory, and other diagnostic tests.

(m) Nursing facility services.--Covered services include regular nursing services, rehabilitation services, drugs and biologicals, medical supplies, and the use of appliances and equipment furnished by the facility, with the following limitations:

1. All admissions must be authorized by the health benefits coverage provider.

2. The length of the patient stay shall be determined on the medical condition of the enrollee in relation to the necessary and appropriate level of care, but is limited to not more than 100 days per contract year.

3. Room and board may be limited to semiprivate accommodations, unless a private room is considered medically necessary or semiprivate accommodations are not available.

4. Specialized treatment centers and independent kidney disease treatment centers are excluded.

5. Private duty nurses, television, and custodial care are excluded.

6. Admissions for rehabilitation and physical therapy are limited to 15 days per contract year.

(n) Prescribed drugs.--

1. Coverage shall include drugs prescribed for the treatment of illness or injury when prescribed by a licensed health practitioner acting within the scope of his or her practice.

2. Prescribed drugs may be limited to generics if available and brand name products if a generic substitution is not available, unless the prescribing licensed health practitioner indicates that a brand name is medically necessary.

3. Prescribed drugs covered under this section shall include all prescribed drugs covered under the Florida Medicaid program.

(o) Therapy services.--Covered services include rehabilitative services, including occupational, physical,

respiratory, and speech therapies, with the following limitations:

1. Services must be for short-term rehabilitation where significant improvement in the enrollee's condition will result; and

2. Services shall be no more than twenty-four treatment sessions within a 60-day period per episode or injury, with the 60-day period beginning with the first treatment.

(p) Transportation services.--Covered services include emergency transportation required in response to an emergency situation.

(q) Lifetime maximum.--Health benefits coverage obtained under ss. 409.810-409.820 shall pay an enrollee's covered expenses at a lifetime maximum of $1 million per covered child.

(r) Cost-sharing.--Cost-sharing provisions must comply with s. 409.816.

(s) Exclusions.--

1. Experimental or investigational procedures that have not been clinically proven by reliable evidence are excluded;

2. Services performed for cosmetic purposes only or for the convenience of the enrollee are excluded; and

3. Abortion may be covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(t) Enhancements to minimum requirements.--

1. This section sets the minimum benefits that must be included in any health benefits coverage, other than Medicaid coverage, offered under ss. 409.810-409.820. Health benefits

coverage may include additional benefits not included under this subsection, but may not include benefits excluded under paragraph (h).

2. Health benefits coverage may extend any limitations beyond the minimum benefits described in this section.

The agency may not adjust the benchmark premium for either additional benefits provided beyond the minimum benefits described in this section or the imposition of less restrictive service limitations.

(u) Applicability of other state laws.--Health insurers, health maintenance organizations, and their agents are subject to the provisions of the Florida Insurance Code, except for any such provisions waived in this section.

1. Except as expressly provided in this section, a law requiring coverage for a specific health care service or benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to an insurance health plan policy or contract offered or delivered under ss. 409.810-409.820 unless that law is made expressly applicable to such policies or contracts.

2. Notwithstanding chapter 641, a health maintenance organization may issue contracts providing benefits equal to the benchmark benefit plan authorized by this section.

Section 10. Section 409.816, Florida Statutes, is created to read:

409.816 Limitations on premiums and cost-sharing.--The following limitations on premiums and cost-sharing are established for the program.

(1) Enrollees who receive coverage under the Medicaid program may not be required to pay:

(a) Enrollment fees, premiums, or similar charges; or

(b) Copayments, deductibles, coinsurance, or similar charges.

(2) Enrollees in families with a family income equal to or below 150 percent of the federal poverty level and who are not receiving coverage under the Medicaid program may not be required to pay:

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

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

(3) Enrollees in families with a family income above 150 percent of the federal poverty level and who are not receiving coverage under the Medicaid program may be required to pay enrollment fees, premiums, copayments, deductibles, coinsurance, or similar charges on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all children in a family may not exceed 5 percent of the family's income. However, copayments, deductibles, coinsurance, or similar charges may not be imposed for preventive services, including well-baby and well-child care, age-appropriate immunizations, and routine hearing and vision screenings.

Section 11. Section 409.817, Florida Statutes, is created to read:

409.817 Approval of health benefits coverage; financial assistance.--In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.820, the health benefits coverage must:

(1) Be certified by the Department of Insurance under s. 409.818 as meeting, or exceeding, the benchmark benefit plan;

(2) Be guarantee issued;

(3) For health insurance coverage, be community rated;

(4) Not impose any preexisting condition exclusion for covered benefits; however, group health insurance plans may permit the imposition of a preexisting condition exclusion, but only insofar as it is permitted under s. 627.6561;

(5) Comply with the applicable limitations on premiums and cost-sharing in s. 409.816;

(6) Comply with the quality assurance and access standards developed under s. 409.820;

(7) Establish periodic open enrollment periods, which may not occur more frequent than quarterly; and

(8) For alternative coverage, not cost more for the benchmark benefit plan, on an average per child basis, than the cost of coverage under the health insurance component of the program.

Section 12. Section 409.818, Florida Statutes, is created to read:

409.818 Administration.--In order to implement ss. 409.810-409.820, the following agencies shall have the following duties:

(1) The Department of Children and Family Services shall:

(a) Develop a simplified eligibility application form to be used for determining the eligibility of children for coverage under the program in consultation with the agency, the Department of Health, and the Florida Healthy Kids Corporation. The simplified eligibility application form must include an item that provides an opportunity for the applicant to indicate whether coverage is being sought for a child with special health care needs.

(b) Establish and maintain the eligibility determination process under the program. The department shall directly, or through the services of a contracted third-party administrator, establish and maintain a process for determining eligibility of children for coverage under the program. The eligibility determination process must include an initial determination of eligibility for any coverage offered under the program, as well as a redetermination or reverification of eligibility each subsequent 6 months. In conducting an eligibility determination, the department shall determine if the child has special health care needs.

(c) Inform program applicants about eligibility determinations and that eligibility information may be shared with the Medicaid program, the Florida Healthy Kids Corporation, insurers and their agents, and alternative coverage providers through a centralized coordinating office.

(d) Adopt rules necessary for conducting program eligibility functions.

(2) The Department of Health shall:

(a) Design an eligibility intake process. The eligibility intake process may include local intake points

that are determined by the Department of Health in coordination with the Department of Children and Family Services.

(b) Design and implement program outreach activities under s. 409.819.

(c) Adopt rules necessary to implement outreach activities.

(3) The Agency for Health Care Administration, under the authority granted in s. 409.914(1), shall:

(a) Calculate the annual benchmark premium. For the first year of program operation, the benchmark premium shall be an actuarially determined premium for the benchmark benefit plan. For subsequent years, the benchmark premium shall be calculated based on the average premiums for all health insurance plans provided under the program.

(b) Calculate the premium assistance payment necessary to comply with the premium and cost-sharing limitations specified in s. 409.816. In calculating the premium assistance payment levels for children with family coverage, the agency shall set the premium assistance payment levels for each child proportionately to the total cost of family coverage.

(c) Annually calculate the program enrollment ceiling based on estimated per-child premium assistance payments and the estimated appropriation available for the program.

(d) Make premium assistance payments to health insurance plans on a periodic basis and reimburse alternative coverage providers for covered services at Medicaid reimbursement rates. The agency may use its Medicaid fiscal agent or a contracted third-party administrator in making these payments.

(e) Monitor compliance with quality assurance and access standards developed under s. 409.820.

(f) Establish a mechanism for investigating and resolving complaints and grievances from program applicants, enrollees, and health benefits coverage providers, and maintain a record of complaints and confirmed problems. In the case of a child who is enrolled in a health maintenance organization, the agency must use the provisions of s. 641.511 to address grievance reporting and resolution requirements.

(g) Approve health benefits coverage for participation in the program, following certification by the Department of Insurance under subsection (3).

(h) Adopt rules necessary for calculating the annual benchmark premium, calculating premium assistance payment levels, calculating the program enrollment ceiling, making premium assistance payments, monitoring access and quality assurance standards, investigating and resolving complaints and grievances, and approving health benefits coverage.

(4) The Department of Insurance shall certify that health benefits coverage plans that seek to provide services under the program, except those offered through the Florida Healthy Kids Corporation, meet or exceed the benchmark benefit plan and that health insurance plans will be offered at an approved rate. The department shall adopt rules necessary for certifying health benefits coverage plans.

(5) The Florida Healthy Kids Corporation shall retain its functions as authorized in s. 624.91, with the exception of its eligibility determination functions relating to coverage under the Florida Kids Health program which shall be assumed by the Department of Children and Family Services.

(6) The Agency for Health Care Administration, in conjunction with the Department of Health, shall seek a federal waiver to authorize providers of alternative coverage to participate in the program.

Section 13. Section 154.508, Florida Statutes, is transferred, renumbered as section 409.819, Florida Statutes, and amended to read:

409.819 ~~154.508~~ Identification of low-income, uninsured children; determination of ~~Medicaid~~ eligibility for the Florida Kids Health program; alternative health care information.--The Department of Health ~~Agency for Health Care Administration~~ shall develop a program, in conjunction with the Department of Education, the Department of Children and Family Services, the Agency for Health Care Administration, the Florida Healthy Kids Corporation ~~the Department of Health~~, local governments, employers ~~school districts~~, and other stakeholders to identify low-income, uninsured children and, to the extent possible and subject to appropriation, refer them to the Department of Children and Family Services for ~~a~~ ~~Medicaid~~ eligibility determination and provide parents with information about choices ~~alternative sources~~ of health benefits coverage under the Florida Kids Health program ~~care~~.

Section 14. Section 409.820, Florida Statutes, is created to read:

409.820 Quality assurance and access standards.--The Department of Health, in consultation with the agency and the Florida Healthy Kids Corporation, shall develop a common set of quality assurance and access standards for all program components. The standards must include a process for granting exceptions to specific requirements for quality assurance and

access. Compliance with the standards shall be a condition of program participation by health benefits coverage providers.

Section 15. The following performance measures and standards are adopted for the Florida Kids Health program.--

(1) The total number of previously uninsured children who receive health benefits coverage as a result of state activities under Title XXI of the Social Security Act: 235,000 uninsured children expected to obtain coverage during the 1998-1999 fiscal year.

(a) The number of children enrolled in the Medicaid program as a result of eligibility expansions under Title XXI of the Social Security Act: 35,000 children enrolled in Medicaid under new eligibility groups during the 1998-1999 fiscal year.

(b) The number of children enrolled in the Medicaid program as a result of outreach efforts under Title XXI of the Social Security Act who are eligible for Medicaid but who have not enrolled in the program: 80,000 children previously eligible for Medicaid, but not enrolled in Medicaid, who enroll in Medicaid during the 1998-1999 fiscal year.

(c) The number of uninsured children added to the enrollment for the Florida Healthy Kids Corporation program under Title XXI of the Social Security Act: 60,000 additional children enrolled in the Florida Healthy Kids Corporation program during the 1998-1999 fiscal year.

(d) The number of uninsured children enrolled in health insurance coverage under Title XXI of the Social Security Act: 50,000 uninsured children enrolled in health insurance coverage during the 1998-1999 fiscal year.

(e) The number of uninsured children enrolled in alternative coverage offered under Title XXI of the Social

Security Act: 10,000 uninsured children enrolled in alternative coverage during the 1998-1999 fiscal year.

(2) The percentage of uninsured children in this state as of July 1, 1998, who receive health benefits coverage under the Florida Kids Health program: 28.5 percent of uninsured children enrolled in the Florida Kids Health program during the 1998-1999 fiscal year.

(3) The percentage of children enrolled in the Florida Kids Health program with up-to-date immunizations: 80 percent of enrolled children with up-to-date immunizations.

(4) The percentage of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible for the Florida Kids Health program and served under:

(a) Medicaid;

(b) The Florida Healthy Kids Corporation program;

(c) Health insurance products; and

(d) Alternative coverage.

For each category of coverage, the health care provided is in compliance with the health supervision standards for 80 percent of enrolled children.

Section 16. The sum of $20,360,500 is appropriated from funds available under Title XXI of the Social Security Act and shall be used for school health services during the 1998-1999 fiscal year.

Section 17. The provisions of this act which would require changes to contracts in existence on June 30, 1998, between the Florida Healthy Kids Corporation and its

contracted providers shall be applied to such contracts upon the renewal of the contracts, but not later than July 1, 1999.

Section 18. This act shall take effect July 1, 1998.

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SENATE SUMMARY

Creates the Florida Kids Health program to provide health care benefits to uninsured, low-income children. Provides for the program to include benefits provided under the Medicaid program and the Florida Healthy Kids Corporation program. Provides for an enrollment ceiling for the program to be established each year in the General Appropriations Act. Specifies the minimum benefits to be provided under the program. Provides certain limitations on and requirements for enrollment fees, copayments, and similar charges. Requires the Department of Children and Family Services to develop a process for determining eligibility. Requires the Department of Health to design an intake process and outreach activities for administering the program. Requires that the Agency for Health Care Administration calculate the annual benchmark premium and enrollment ceiling, establish a mechanism for investigating and resolving grievances, and approve health benefits provided under the program. (See bill for details.)