The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Appropriations

BILL: CS/SB 1816

INTRODUCER: Appropriations Committee (Recommended by Appropriations Subcommittee on Health and Human Services) and Appropriations Committee

SUBJECT: Health Care

DATE: April 25, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Hansen		**AP SPB 7038 as introduced**
2.	Brown	Pigott	AHS	**Fav/CS**
3.	Brown	Hansen	AP	**Fav/CS**
4.				
5.				
6.				

I. Summary:

CS/SB 1816 amends several sections of the Florida Kidcare Program Act under Part II of chapter 409, Florida Statutes, to remove obsolete provisions and conform other provisions with changes in federal laws and regulations relating to the implementation of the federal Patient Protection and Affordable Care Act (Public Law 2011-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 2011-152), known collectively as "PPACA," and the Supreme Court ruling in *National Federation of Independent Business v. Sebelius.*[1]

The bill adds definitions for "modified adjusted gross income" and "household income" to align with changes in Medicaid and Children's Health Insurance Program (CHIP) program eligibility laws and regulations and removes definitions that are no longer applicable to the program. The bill removes authority and provisions for an employer-sponsored insurance premium assistance program component in Florida Kidcare. Notification requirements for certain Florida Kidcare disenrollees regarding other insurance options on the exchange, as defined under PPACA, are added, and the non-subsidized program under Florida Kidcare is phased-out. The bill includes provisions for electronic eligibility matching through the exchange hub and an option for written documentation when matching is not feasible.

The bill includes appropriations of $10.93 million general revenue (GR) and $1.29 billion from the Medical Care Trust Fund for the 2013-2014 fiscal year to implement the bill.

[1] *National Federation of Independent Business v. Sebelius, 567 U.S.___(2012).*

The bill revises the eligibility process to reflect the procedures that will be used under the modified adjusted gross income (MAGI) method beginning January 1, 2014. The bill further revises the responsibilities of the Department of Children and Family Services (DCF), the Agency for Health Care Administration (AHCA), the Department of Health (DOH), the Florida Healthy Kids Corporation (FHKC), and the Office of Insurance Regulation (OIR) under the Florida Kidcare Program. The bill clarifies that the AHCA is directed to contract with the FHKC for the administration of the Healthy Kids and Healthy Florida programs.

The bill amends s. 624.91, Florida Statutes – the Florida Healthy Kids Corporation Act – to revise legislative intent to include a new program, Healthy Florida. The bill modifies FHKC's corporate governance structure, medical loss ratio guidelines for health plan contracts, and corporate responsibilities. The bill creates s. 624.917, Florida Statutes, to provide definitions, eligibility criteria, enrollment, and benefits for the Healthy Florida program. The FHKC is also authorized to make changes to the program to negotiate for the approval of the Healthy Florida program with the federal Department of Health and Human Services (HHS), if necessary.

The bill repeals the authority for an operating fund for the FHKC under section 624.915, Florida Statutes.

The bill includes a conflict of laws statement indicating that if there is a conflict between a provision in the bill and the PPACA, the provision must be interpreted to comply with the requirements of federal law.

The bill prohibits an insurer, health maintenance organization (HMO), or prepaid limited health service organization from contracting with a licensed dentist to provide services to an insured or subscriber at a specified fee unless such services are "covered services" under the applicable contract. The bill prohibits an insurer, HMO, or prepaid limited health services organization from requiring that a contracted dentist participate in a discount medical plan. The bill also prohibits an insurer from requiring that a contracted health care provider accept the terms of other practitioner contracts with a prepaid limited health service organization that is under common management and control with the contracting insurer.

The bill authorizes a dentist who is a government-contracted health care provider under the Access to Health Care Act, to allow a patient, or a parent or guardian of a patient, to voluntarily contribute a fee to cover costs of dental laboratory work. The contribution may not exceed the actual cost of the laboratory fee. When the voluntary contribution is accepted from the patient for dental laboratory fees, it is not considered compensation for services so that sovereign immunity protection is not lost.

The bill is effective upon becoming law.

This bill substantially amends the following sections of the Florida Statutes: 409.811, 409.813, 409.8132, 409.8135, 409.814, 409.815, 409.8177, 409.818, 409.820, 624.91, 627.6474, 636.035, 641.315, and 766.1115.

The bill creates section 624.917, Florida Statutes.

The bill repeals the following sections the Florida Statutes: 409.817, 409.8175, and 624.915.

II. Present Situation:

Florida provides health insurance coverage options to low income Floridians through a variety of programs utilizing state and federal funds. As of February 28, 2013, more than 3.2 million individuals received coverage through some Medicaid eligibility category.[2] Enrollment in the Florida Kidcare program (non-Medicaid funded components) for the same time period was an additional 256,721 children.[3]

Florida's Medicaid program is expected to expend $21 billion for the 2012-13 state fiscal year to provide coverage to its enrollees, making it the fifth largest in the nation in terms of expenditures.[4] The Florida Medicaid program is jointly funded between the state and federal governments; 57.73 percent of the cost for health care services is paid by federal funds and 42.27 percent is state share in the current state fiscal year. Funding for the Florida Kidcare program's Title XXI components has an enhanced federal match of 70.66 percent for federal fiscal year 2012-13.[5]

According to the most recent data from the American Community Survey (ACS) of the federal Census Bureau, an estimated 4 million Floridians are uninsured.[6] Of that number according to the ACS data, 594,000 are children.[7] Dividing Florida's uninsured by income level, more than 1.9 million adults are under 139% of the federal poverty level (FPL), according to statistics for 2010-2011.[8] Lower income adults, or those below 100 percent of the FPL, number at 1.1 million of the 1.9 million for that same time period.[9]

Eligibility for the Medicaid program is based on a number of factors, including age, household or individual income, and assets.

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[2] Agency for Health Care Administration, *Report of Medicaid Eligibles*, http://ahca.myflorida.com/Medicaid/about/pdf/age_assistance_category_130228.pdf (last visited Mar. 17, 2013).
[3] Agency for Health Care Administration, *Florida KidCare Enrollment Report – February 2013,* (copy on file with the Senate Health Policy Committee).
[4] Agency for Health Care Administration, Presentation to House Health and Human Services Committee, *Florida Medicaid: An Overview - December 5, 2012,* http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2714&Session=2013&DocumentType=Meeting Packets&FileName=HHSC_Mtg_ 12-5-12_ONLINE.pdf (last visited Mar. 17, 2013).
[5] Florida KidCare Coordinating Council, *2013 Annual Report and Recommendations*, p. 5, (January 2013), http://www.floridakidcare.org/council/reports/2013_KCC_Report.pdf (last visited Mar. 17, 2013).
[6] 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.floridakidcare.org/council/reports/2013_Recommendations.pdf (last visited Mar. 17, 2013).
[7] Ibid.
[8] Kaiser Family Foundation, statehealthfacts.org, *Health Insurance Coverage of the Non-Elderly (0-64) with Incomes up to 139% of FPL (2010-2011),* http://www.statehealthfacts.org/profileind.jsp?ind=849&cat=3&rgn=11&cmprgn=1 (last visited Mar. 17, 2013).
[9] Kaiser Family Foundation, statehealthfacts.org, *Health Insurance Coverage of the Non-Elderly (0-64) with Incomes up to 139% of FPL (2010-2011),* http://www.statehealthfacts.org/profileind.jsp?ind=849&cat=3&rgn=11&cmprgn=1 (last visited Mar. 17, 2013).

The Department of Children and Families (DCF) determines eligibility for the Medicaid program but the AHCA is the single state Medicaid agency and has the lead responsibility for the overall program.[10]

Recipients in the Medicaid program receive their benefits through several different delivery systems, depending on their individual situation. Delivery systems currently include fee-for-service providers, prepaid dental plans, provider service networks, and Medicaid managed care plans. In July 2006, the AHCA implemented the Medicaid Managed Pilot Program as directed by the 2005 Legislature through s. 409.91211, F.S. The pilot program operates under an 1115 Research and Demonstration Waiver approved by the federal Centers for Medicare and Medicaid Services. The pilot program was initially authorized for Broward and Duval counties with expansion to Baker, Clay and Nassau the following year.

Under the current pilot program, most Medicaid recipients in the five pilot counties (Broward, Duval, Baker, Clay, and Nassau counties) are required to receive their benefits through either health maintenance organizations (HMOs), provider service networks (PSNs), or a specialty plan. In addition to the minimum benefits package, plans may provide enhanced services such as over the counter benefits, preventive dental care for adults, and health and wellness benefits.

Medicaid Statewide Managed Medical Care Program

In 2011, the Legislature passed HB 7107, creating the Statewide Medicaid Managed Medical Assistance (SMMC) Program as part IV of ch. 409, F.S. The SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits, for the delivery of primary and acute care. The SMMC has two components: the Long Term Care Managed Care program and the Managed Medical Assistance (MMA) program.

As the single state agency for Medicaid under s. 409.963, F.S., the AHCA has primary responsibility for the management and operations of the state's Medicaid program, including seeking waiver authority from the federal government. To implement these two programs and receive federal Medicaid funding, the AHCA was required to seek federal authorization through two different Medicaid waivers from the Centers for Medicare and Medicaid Services. The first component authorized was the LTC Managed Care Program's 1915(b) and (c) waiver. Approval was granted on February 1, 2013.

The LTC Managed Care Program will serve those individuals who are 65 years of age or old or who are eligible for Medicaid by reason of a disability, subject to wait list prioritization and availability of funds. The recipients must also be determined to require a nursing facility level of care. Medicaid recipients who qualify will receive all of their long-term care services from the long-term care managed care plan.

The AHCA is responsible for administering the LTC Managed Care Program but may delegate specific duties to the Department of Elderly Affairs and other state agencies. Implementation of

[10] Agency for Health Care Administration, *Welcome to Medicaid!*, http://ahca.myflorida.com/Medicaid/index.shtml (last visited Mar. 17, 2013).

the LTC Managed Care program started July 1, 2012, with completion expected by October 1, 2013. The AHCA released an Invitation to Negotiate (ITN) on June 29, 2012, and on January 15, 2013, notices of contract awards to managed care plans under that ITN were announced.

For the SMMC component, the AHCA sought to modify the existing Medicaid Reform 1115 Demonstration waiver with the Centers for Medicare and Medicaid Services to expand the program statewide. The AHCA initiated the SMMC project in January 2012 and released a separate ITN to competitively procure managed care plans on a statewide basis on December 28, 2012. Bids are due to the AHCA on March 29, 2013 and awards are expected to be announced on September 16, 2013.

Plans can supplement the minimum benefits in their bids and offer enhanced options. The number of plans to be selected by region is prescribed under s. 409.974, F.S. Specialty plans that serve specific, targeted populations based on age, medical condition, and diagnosis, are also included under the SMMC program. 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 is expected to be completed by October 1, 2014. Final approval of the necessary Medicaid waiver by the federal government has not yet been received; however, on February 20, 2013 the AHCA and the Centers for Medicare and Medicaid Services reached an "Agreement in Principle" on the proposed plan.

Under SMMC, persons meeting applicable eligibility requirements of Title XIX of the Social Security Act must be enrolled in a managed care plan. Medicaid recipients who (a) have other creditable care coverage, excluding Medicare; (b) reside in residential commitment facilities operated through the Department of Juvenile Justice, group care facilities operated by the DCF, and treatment facilities funded through the DCF Substance Abuse and Mental Health Program; (c) are eligible for refugee assistance; or (d) are residents of a developmental disability center, may voluntarily enroll in the SMMC program. Those recipients who elect not to enroll in SMMC voluntarily will be served through the Medicaid fee-for-service system.

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 chapter 409; ss. 409.810 through 409.821, F.S.

The Program includes four operating components: Medicaid for children, Medikids, the Children's Medical Services Network, and the FHKC. Section 409.813, F.S., includes five components for the Program. The fifth component – the employer sponsored group health insurance plan – has never been implemented. The AHCA submitted a state plan amendment in December 1998 for implementation of that component; however, the plan amendment was

disapproved by the federal Centers for Medicare and Medicaid Services in November 1999 and was not re-submitted.[11] The Title XXI-funded components of Florida Kidcare serve distinct populations under the program:[12]

- Medicaid for Children: Children from birth until age 1 for family incomes between 185 percent and 200 percent of the FPL.
- Medikids: Title XXI funding is available from age 1 until age 5 for family incomes between 133 percent and 200 percent of the FPL.
- Healthy Kids: Title XXI funding is available from age 5 through age 6 for family incomes between 133 and 200 percent of the FPL. For age 6 through age 18, Title XXI funding is available for family incomes between 100 percent and 200 percent of the FPL.
- 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.

Coverage for the non-Medicaid components of the Florida Kidcare Program is funded through Title XXI of the federal Social Security Act (CHIP coverage). Title XIX of the Social Security Act (Medicaid coverage), state funds for CHIP coverage, and family contributions also provide funding for the Florida Kidcare Program. 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). Currently, the income limit for premium assistance is 200 percent of the FPL.

The Medikids program was created under s. 409.8132, F.S., as a Medicaid "look-alike" program for enrollees age 1 through 4. Medikids is administered by the AHCA and enrollees receive the same mandatory and optional benefits covered under ss. 409.905 and 409.906, F.S. Enrollees are offered a choice of health plans or, if two plans are not offered in a particular county, MediPass is provided as one of the options. Many provisions of the Medicaid program also apply to the Medikids program; such as program integrity, provider fraud and abuse preventions, and quality of care.

Under s. 409.814, F.S., the Program's eligibility guidelines are described in conformity with current Title XIX and Title XXI terminology and requirements for each funding component. Other eligibility factors related to premium assistance under this section include whether a child:

- Is covered under other employer-based coverage costing less than five percent of the family income;
- Is an alien, but does not meet the definition of a qualified alien;

[11] *See* State of Florida, Florida KidCare Program, Title XXI State Child Health Insurance Plan, Amendment #22, July 1, 2012, pg. 6, http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/CHIP-SPAs/FL-CSPA-22-FINAL.pdf (last visited: March 15, 2013).
[12] *See* State of Florida, Florida KidCare Program, Title XXI State Child Health Insurance Plan, Amendment #22, July 1, 2012, pg.5., http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/CHIP-SPAs/FL-CSPA-22-FINAL.pdf (last visited: March 15, 2013).

- Is an inmate in a public institution or a patient in an institution for mental disease; or,
- Has dropped employer-sponsored coverage within 60 days of applying for premium assistance. Current law does provide good cause exceptions that may be taken into consideration for individuals that drop employer-sponsored coverage resulting in a waiver of the 60-day waiting period for premium assistances.

Families with income above 200 percent of the FPL or who do not meet the qualifications for premium assistance may still be able to purchase the coverage under Medikids or Healthy Kids at the non-subsidized rate.

To enroll in Kidcare, families utilize a form that is both a Medicaid and a CHIP application. Families may apply using either an online or a paper application. Both formats are available in English, Spanish, or Creole. Eligibility is determined through electronic data matching using available databases, or, when income cannot be verified electronically, through submission of current paystubs, tax returns, or W-2 forms. Families may also apply for Medicaid through the DCF web portal (ACCESS) online, at an ACCESS community partner site, or with a paper form via the mail, fax, or in person at a Customer Service Center.[13]

Under s. 409.815, F.S., benefits under the Florida Kidcare program vary by program component. For Medicaid, Medikids, and the Children's Medical Services Network, enrollees receive the mandatory and optional medical benefits covered under ss. 409.905 and 409.906, F.S. For Healthy Kids and the employer-sponsored component, a benchmark benefit package is provided. The comprehensive benefit package includes preventive services, specialty care, hospitalization, prescription drug coverage, behavioral health and substance abuse services, dental care, vision and hearing services, and emergency care and transportation.

Limits on premiums and cost sharing in the Program are covered under s. 409.816, F.S., and 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 in the Healthy Kids component 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.[14]

Under s. 409.8175, F.S., a health maintenance organization may reimburse providers in a rural county according to the Medicaid fee schedule provided the provider agrees to such a schedule.

[13] Florida Department of Children and Families, *ACCESS Florida Website, http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash* (last visited March 15, 2013).
[14] *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).

The AHCA contracts for an annual evaluation of the Program to address the statutory components of s. 409.8177, F.S. The annual reports are posted to the AHCA's website for public review and submitted to the Centers for Medicare and Medicaid Services.[15]

Several state agencies and the FHKC share responsibilities for the Program. Section 409.818, F.S., delineates the responsibilities for each of the entities under the Program, and subsection (5) preserves the FHKC's eligibility determination functions for the Healthy Kids program. Annually, the Legislature provides administrative funds through the AHCA's appropriation to contract with the FHKC to conduct the eligibility and administrative functions related to the Program.[16] The DCF determines eligibility for Medicaid and the FHKC determines eligibility for CHIP, which includes a Medicaid screening and referral process to the DCF, as appropriate.

During the 2012 Legislature, the DCF was directed to collaborate with the AHCA to develop an internet-based system for eligibility determination for Medicaid and CHIP.[17] The Legislature provided DCF with specific business and functional requirements for the project and timeframes for project completion.[18]

The following chart reflects current roles and responsibilities of the agencies and the FHKC:

Agency for Health Care Administration	**Department of Children and Families**	**Department of Health**	**Florida Healthy Kids Corporation**
Medicaid program and policy	Medicaid eligibility determination	Oversight of the Children's Medical Services Network program	Oversight of the Florida Healthy Kids Program
Lead state agency for Title XIX and XXI Compliance and federal funding	Manage B-NET program – specialized behavioral health care program	KidCare Coordinating Council	Conduct Title XXI (CHIP) eligibility and administration
Oversight of the Medikids program		Develop Quality Assurance Standards	Conduct Kidcare Outreach and Marketing
Monitor quality assurance standards			
Maintain Kidcare Grievance Process			

The Florida Kidcare Coordinating Council falls under the responsibility of the DOH; the secretary of the DOH chairs the Council. The Coordinating Council is specifically created under s. 409.818(2)(b), F.S., and is charged with making recommendations concerning the implementation and operation of the program. The Council includes representatives from the partner agencies and stakeholder representatives from the insurance industry, consumers, and

[15] Agency for Health Care Administration, *Medikids Publications*, *http://www.fdhc.state.fl.us/medicaid/medikids/publications.shtml*, (last visited: Mar. 15, 2013).
[16] See Conference Report on HB 5001, 2012-2013 General Appropriations Act, Proviso for Line Item 162. (http://www.flsenate.gov/Session/Bill/2012/5001/Amendment/657521/PDF) (last visited Mar. 15, 2013).
[17] s. 409.902(3), F.S.
[18] ss. 409.902(4) and (5), F.S.

providers. For 2013, the Council developed a single priority state recommendation: "To fully fund the Florida Kidcare program, including its annualization and medical trend needs, projected growth, outreach and increased medical and dental costs in order to maximize the use of Florida's CHIP federal funds and include all eligible uninsured children."[19]

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.[20]

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 under subsection (4).

Under s. 624.91(5), F.S., 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;
- Accept voluntary local match for Title XXI and Title XXI;
- Accept supplemental local match for Title XXI;
- 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;
- Provide quarterly enrollment information on the full pay population; and,
- Establish benefit packages that conform to the Florida Kidcare benchmark benefit.

[19] Florida KidCare Website, KidCare Coordinating Council, *2013 Recommendations,* http://www.floridakidcare.org/council/reports/2013_Recommendations.pdf (last visited Mar. 17, 2013).
[20] Florida Healthy Kids Corporation, *History,* https://www.healthykids.org/healthykids/history/ (last visited Mar. 15, 2013).

The FHKC is governed by a 13-member board of directors, chaired by Florida's chief financial officer or his or her designee.[21] The 12 other board members are:

- Secretary of the AHCA;
- One member appointed by the commissioner of education from the Office of School Health Programs from the Department of Education;
- One member, appointed by the chief financial officer from among three members nominated by the Florida Pediatric Society;
- One member, appointed by the governor, who represents the Children's Medical Services Program;
- One member appointed by the chief financial officer from among three members nominated by the Florida Hospital Association;
- One member, appointed by the governor, who is an expert on child health policy;
- One member, appointed by the chief financial officer, from among three members nominated by the Florida Academy of Family Physicians;
- One member, appointed by the governor, who represents the state Medicaid program;
- One member, appointed by the chief financial officer, from among three members nominated by the Florida Association of Counties;
- The state health officer or his or her designee;
- The secretary of the DCF, or his or her designee; and,
- 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.[22]

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.[23]

The Patient Protection and Affordable Care Act of 2010

In March 2010, the Congress passed and the President signed the PPACA.[24] Under PPACA, one of the key components required the states to expand Medicaid to a minimum national eligibility threshold of 133 percent of the FPL, or, as it is sometimes expressed, 138 percent of the FPL with application of an automatic five percent income disregard, effective January 1, 2014.[25] While the funding for the newly eligible under this expansion would be initially funded at 100 percent federal funds for the first 3 calendar years, 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

[21] *See* s. 624.91(6), F.S.
[22] *See* s. 624.91(5), F.S.
[23] *See* s. 624.91(7), F.S.
[24] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).
[25] 42 U.S.C. s. 1396a(1).

in 2020.[26] 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.[27]

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.[28] 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.[29]

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, 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.[30] 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.[31]

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.[32] Under Section 1937, state Medicaid programs have the option of providing certain groups with benchmark or benchmark equivalent coverage based on four products: (1) the standard Blue Cross/Blue Shield Preferred Provider option offered to federal employees; (2) state employee coverage that is generally offered to all state employees; (3) the commercial HMO with the largest insured, non-Medicaid enrollment in the state or (4) Secretary-approved coverage.[33] 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, which was interpreted by the U.S. Supreme Court as a tax. 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

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[26] 42 U.S.C. s. 1396d(y)(1).
[27] 42 U.S.C. s. a1396c
[28] *See supra* note 1.
[29] 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. 16, 2013).
[30] *Letter to National Governor's Association from Secretary Sebelius*, January 14, 2013 (copy on file with Senate Health Policy Committee).
[31] Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid,* (December 10, 2012), http://cciio.cms.gov/resources/factsheets/index.html, pp. 15-16, (last visited Mar. 17, 2013).
[32] 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).
[33] *See supra* note 30 at 2.

unknown number of currently eligible individuals coming forward and enrolling 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.

To facilitate coverage, PPACA authorized the state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges. These exchanges are to be administered by governmental agencies or non-profit organizations and be ready to accept applications for coverage beginning October 1, 2013, for January 1, 2014, coverage dates. The exchanges, at a minimum, must:[34]

- 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.

The initial guidance from HHS in November 2010 set forward a number of principles and priorities for the exchanges. Further guidance was issued on May 16, 2012, detailing the proposed operations of a federally-facilitated exchange for those states that elect not to implement a state-based exchange. On November 16, 2012, Florida Governor Rick Scott notified 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.[35]

PPACA also includes a tax penalty for those individuals that do not have qualifying health insurance coverage beginning January 1, 2014. The penalty is the greater of $695 per year up to a maximum of three times that amount per family or 2.5% of household income. The penalty, however, is phased-in and exemptions apply.

The following persons are exempt from the PPACA's requirement to maintain coverage:[36]

- Individuals with a religious objection;
- individuals not lawfully present; and
- Incarcerated individuals.

The following persons are exempt from the PPACA's penalty for failure to maintain coverage:[37]

[34] Centers for Medicare and Medicaid Services, Initial Guidance to States on Exchanges, November 18, 2010, http://cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html (last visited Mar. 16, 2013).
[35] *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. 16, 2013).
[36] *See* Sec. 5000A(d), Internal Revenue Code of 1986, as created or amended by the Patient Protection and Affordable Care Act of 2010 and/or the Health Care and Education Reconciliation Act of 2010.

- Individuals who cannot afford coverage, i.e. those whose required premium contributions exceed eight percent of household income;
- Individuals with income below the income tax filing threshold;
- American Indians;
- Individuals without coverage for less than three months; and
- Individuals determined by the HHS secretary to have suffered a hardship with respect to the capability to obtain coverage under a qualified plan.

Qualifying coverage may be obtained through an employer, the federal or state exchanges created under PPACA, or private individual or group coverage meeting the minimum essential benefits coverage standard.

Employers with more than 50 full time employees also share a financial responsibility under PPACA. Employers with more than 50 full-time employees that do not offer coverage meeting the essential benefits coverage standard and who have at least one employee receive a premium tax credit will be assessed a fee of $2,000 per full time employee, after the 30th employee.[38] If an employer does offer coverage and an employee receives a premium tax credit, the employer is assessed the lesser of $3,000 per employee receiving the credit or $2,000 per each employee after the 30th employee.[39]

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 five years are eligible for premium credits.[40] 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.

[37] *See* Sec. 5000A(e), Internal Revenue Code of 1986, as created or amended by the Patient Protection and Affordable Care Act of 2010 and/or the Health Care and Education Reconciliation Act of 2010.
[38] Kaiser Family Foundation, *Summary of New Health Reform Law,* Last Modified April 15, 2011, http://www.kff.org/healthreform/upload/8061.pdf (last viewed Mar. 16, 2013).
[39] Kaiser Family Foundation, *Summary of New Health Reform Law,* Last Modified April 15, 2011, http://www.kff.org/healthreform/upload/8061.pdf (last viewed Mar. 16, 2013).
[40] 26 U.S.C. s. 36B(c).

The amount for premium tax credits, as a percentage of income, are set in section 36B of the Internal Revenue Code follows:[41]

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%

Subsidies for cost sharing are also applicable for those 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.[42] Actuarial value reflects the average share of covered benefits paid by the insurer or health plan.[43] 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. Under the PPACA, the maximum amount of cost sharing under this component range from 94 percent for those between 100 percent to 150 percent of the FPL, to 70 percent for those between 250 percent and 400 percent of the FPL.[44]

Prohibition Against "All Products" Clauses in Health Care Provider Contracts

Section 627.6474, F.S., prohibits a health insurer from requiring that a contracted health care practitioner accept the terms of other practitioner contracts (including Medicare and Medicaid practitioner contracts) with the insurer or with another insurer, HMO, preferred provider organization, or exclusive provider organization that is under common management and control with the contracting insurer. The statute exempts practitioners in group practices who must accept the contract terms negotiated by the group. These contractual provisions are referred to as "all products" clauses. Before being prohibited by the 2001 Legislature, these clauses typically required the health care provider, as a condition of participating in any of the health plan products, to participate in *all* of the health plan's current or future health plan products. The 2001 Legislature outlawed "all products" clauses after concerns were raised by physicians that the clauses:

- May force providers to render services at below market rates;
- Harm consumers through suppressed market competition;

[41] 26 U.S.C. s. 36B(c).
[42] Kaiser Family Foundation, *Summary of New Health Reform Law, Last Modified April 15, 2011*, http://www.kff.org/healthreform/upload/8061.pdf (last viewed Mar. 16, 2013).
[43] Lisa Bowen Garrett, et al., The Urban Institute, *Premium and Cost Sharing Subsidies under Health Reform: Implications for Coverage, Costs and Affordability* (December 2009), http://www.urban.org/UploadedPDF/411992_health_reform.pdf (last visited Mar. 16, 2013).
[44] Kaiser Family Foundation, *Summary of New Health Reform Law,* Last Modified April 15, 2011, http://www.kff.org/healthreform/upload/8061.pdf (last viewed Mar. 16, 2013).

- May require physicians to accept future contracts with unknown and unpredictable business risk; and
- May unfairly keep competing health plans out of the marketplace.

Prepaid Limited Health Service Organizations Contracts

Prepaid limited health service organizations (PLHSO) provide limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment, and are authorized in ch. 636, F.S. Limited health services are ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services.[45] Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

Health Maintenance Organization Provider Contracts

An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in, a designated service area.[46] Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for the out-of-network services rendered to the member. Section 641.315, F.S., specifies requirements for the HMO provider contracts with providers of health care services.

Discount Medical Plan Organizations

Discount medical plan organizations (DMPOs)[47] offer a variety of health care services to consumers at a discounted rate. These plans are not health insurance and therefore do not pay for services on behalf of members. Instead, the plans offer members access to specific health care products and services at a discounted fee. These health products and services may include, but are not limited to, dental services, emergency services, mental health services, vision care, chiropractic services, and hearing care. Generally, a DMPO has a contract with a provider network under which the individual providers render the medical services at a discount.

The DMPOs are regulated by the Office of Insurance Regulation (OIR) under part II of ch. 636, F.S. That statute establishes licensure requirements, annual reporting, minimum capital requirements, authority for examinations and investigations, marketing restrictions, prohibited activities, and criminal penalties, among other regulations.

Before transacting business in Florida, a DMPO must be incorporated and possess a license as a DMPO.[48] As a condition of licensure, each DMPO must maintain a net worth requirement of

[45] Section 636.003(5), F.S.
[46] Section 641.19(12), F.S.
[47] Section 636.202(2), F.S.
[48] Section 636.204, F.S.

$150,000.[49] All charges to members of such plans must be filed with OIR and any charge to members greater than $30 per month or $360 per year must be approved by OIR before the charges can be used by the plan.[50] All forms used by the organization must be filed with and approved by OIR.

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.[51] This section 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.

Health care providers under the Act include:[52]

- A birth center licensed under ch. 383, F.S.;[53]
- An ambulatory surgical center licensed under ch. 395, F.S.;[54]
- A hospital licensed under ch. 395, F.S.;[55]
- A physician or physician assistant licensed under ch. 458, F.S.;[56]
- An osteopathic physician or osteopathic physician assistant licensed under ch. 459, F.S.;[57]
- A chiropractic physician licensed under ch. 460, F.S.;[58]
- A podiatric physician licensed under ch. 461, F.S.;[59]
- 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 which employs nurses licensed or registered under part I of ch. 464, F.S., to supply all or part of the care delivered under this section.;[60]
- A dentist or dental hygienist licensed under ch. 466, F.S.;[61]
- A midwife licensed under ch. 467, F.S.;[62]
- A health maintenance organization certificated under part I of ch. 641, F.S.;[63]

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[49] Section 636.220, F.S.
[50] Section 636.216(1), F.S.
[51] 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.
[52] Section 766.1115(3)(d), F.S.
[53] Section 766.1115(3)(d)1., F.S.
[54] Section 766.1115(3)(d)2., F.S.
[55] Section 766.1115(3)(d)3., F.S.
[56] Section 766.1115(3)(d)4., F.S.
[57] Section 766.1115(3)(d)5., F.S.
[58] Section 766.1115(3)(d)6., F.S.
[59] Section 766.1115(3)(d)7., F.S.
[60] Section 766.1115(3)(d)8., F.S.
[61] Section 766.1115(3)(d)9., F.S.
[62] Section 766.1115(3)(d)10., F.S.
[63] Section 766.1115(3)(d)11., F.S.

- A health care professional association and its employees or a corporate medical group and its employees.;[64]
- 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.;[65]
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.;[66]
- 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 766.1115(3)(d)4-9, F.S.;[67] and
- 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 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 of Health (DOH or department), a county health department, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.[68]

The definition of contract under the Act provides that the contract must be for 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.[69]

The Act further specifies 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;
- 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 must make patient selection and initial referrals;
- The health care provider must accept all referred patients; however, the contract may specify limits on the number of patients to be referred;

[64] Section 766.1115(3)(d)12., F.S.
[65] Section 766.1115(3)(d)13., F.S.
[66] Section 766.1115(3)(d)14., F.S.
[67] Section 766.1115(3)(d)15., F.S.
[68] Section 766.1115(3)(c), F.S.
[69] Section 766.1115(3)(a), F.S.

- Patient care, including any follow-up or hospital care is subject to approval by the governmental contractor; and
- The health care provider is subject to supervision and regular inspection by the governmental contractor.

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.

The individual accepting services through this contracted provider must not have medical or dental care coverage for the illness, injury, or condition in which medical or dental care is sought.[70] The services not covered under this program include experimental procedures and clinically unproven procedures. The governmental contractor shall determine whether or not a procedure is covered.

The health care provider may not subcontract for the provision of services under this chapter.[71]

Currently, s. 766.1115, F.S., is interpreted differently across the state. In certain parts of the state one medical director interprets this law to mean that as long as there is transparency and clear proof that the volunteer provider is providing services, without receiving personal compensation, then the patient can pay a nominal amount per visit to assist in covering laboratory fees. In other parts of the state, a medical director suggests that if any monetary amount is accepted then sovereign immunity is lost. Patients sometimes offer to pay a nominal contribution to cover some of the cost of laboratory fees that the provider incurs to pay outside providers for items such as dentures for the patient. In many areas, the dentist is paying the cost of these fees from his or her own resources.[72]

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, s. 13, of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the right 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, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

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[70] Rule 64I-2.002, F.A.C.
[71] *Id.*
[72] Staff of Committee on Health Policy's discussion with representatives from the Florida Dental Association on March 8, 2013.

Instead, the state steps in as the party litigant and defends against the claim. Subsection (5) limits the recovery of any one person to $200,000 for one incidence and limits all recovery related to one incidence to a total of $300,000. 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.[73]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[74] 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.[75]

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.[76] 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. *National Sur. Corp. v. Windham*, 74 So. 2d 549, 550 (Fla. 1954) ("The [principal's] right to control depends upon the terms of the contract of employment…") The CMS requires each consultant, as a condition of participating in the CMS program, to agree to abide by the terms published in its HRS[77] Manual and CMS Consultants 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.[78]

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[73] Section 768.28(5), F.S.
[74] *Stoll v. Noel*, 694 So. 2d 701, 703(Fla. 1997).
[75] *Id.* (quoting The Restatement of Agency).
[76] *Stoll v. Noel*, 694 So. 2d 701 at 703.
[77] Florida Department of Health and Rehabilitative Services.
[78] *Stoll v. Noel*, 694 So. 2d 701, 703(Fla. 1997).

III. Effect of Proposed Changes:

Section 1 amends s. 409.811, F.S. adding, deleting, and modifying definitions relating to the Florida Kidcare Act. Definitions applicable to the overall Act, which is identified as ss. 409.810 through 409.821, F.S., are updated or added to align with requirements under PPACA:

- CHIP (Children's Health Insurance Program)
- Combined Eligibility Notice
- Household Income
- Modified Adjusted Gross Income (MAGI)
- Patient Protection and Affordable Care Act (Act)

Other definitions under this section are deleted as obsolete if related to the employer-sponsored component of the Florida Kidcare program. This program component was never implemented and is deleted under this bill. Definitions that have been modified or rendered obsolete by PPACA have also been deleted.

Section 2 amends s. 409.813, F.S., relating to the program components of the Florida Kidcare program. The bill also adds the FHKC to the list of entities for which a cause of action cannot be brought if coverage is not provided under the non-entitlement portion of the program. The FHKC is the only Kidcare component excluded.

Section 3 amends s. 409.8132, F.S., relating to the Medikids program component of the Florida Kidcare program. The bill deletes language permitting a Medikids enrollee who is a younger sibling of a Healthy Kids enrollee, to enroll in a Healthy Kids plan. An obsolete reference to receiving approval from the predecessor agency to the Centers for Medicare and Medicaid Services for MediPass coverage authorization is removed. The MediPass option in Medikids has been approved since the program was implemented in 1998.

Section 4 makes technical changes to s. 409.8134, F.S., relating to program expenditures and enrollment in the Florida Kidcare program.

Section 5 amends section s. 409.814, F.S., relating to eligibility for the Florida Kidcare program. The bill modifies references to align with changes under PPACA. Obsolete references related to the employer-sponsored component have been deleted. An option has been provided to Medicaid enrollees to elect coverage under the CHIP component and permit a transfer back to Medicaid at any time without a break in coverage.

Under s. 409.814(6)(c), F.S., the FHKC is directed to notify full pay enrollees of the availability of coverage under the exchanges, as created under PPACA. No new applications for full-pay or non-subsidized coverage are permitted after September 30, 2013.

Modifications to the eligibility determination process are made under s. 409.814(8), F.S., to reflect changes in the eligibility process under PPACA and the role of the federal data hub.

Section 6 amends s. 409.815, F.S., relating to the benefits under the Florida Kidcare program. Obsolete dates and references are deleted under certain benefits.

Section 7 amends s. 409.816, F.S, relating to lifetime benefits on premiums and limitations on cost sharing. References to “family,” “family income,” and “modified adjusted income” are updated to align with federal definitions under PPACA.

Section 8 repeals s. 409.817, F.S., relating to approval of health benefits, coverage, and financial assistance. The other requirements of this section have been preempted under PPACA.

Section 9 repeals s. 409.8175, F.S., relating to the delivery of services in rural counties. Health maintenance organizations and health insurers may contract with providers in accordance with any fee schedule that may be agreed upon by the parties. The language under this section is permissive and not mandatory under current law.

Section 10 amends s. 409.8177, F.S., relating to evaluation of the Florida Kidcare program. A reference to family income is updated to household income to align with PPACA.

Section 11 amends s. 409.818, F.S., relating to the administration of the Florida Kidcare program. The duties and responsibilities of the DCF are modified to recognize the modernization efforts and process changes under PPACA. The department is required to develop a combined eligibility notice, in consultation with the AHCA and the FHKC. A reference to a centralized coordinating office is deleted.

Specific administrative responsibilities for the Florida Kidcare program for the DOH are deleted. Obsolete provisions for designing the eligibility intake process are removed, as is the requirement for the DOH to establish a toll-free hotline. The FHKC provides customer service for the Florida Kidcare program, including operation of the toll-free hotline, under its Florida Kidcare eligibility determination responsibilities.

The responsibilities for the AHCA under this section are modified to reflect the removal of the employer-sponsored component and accompanying deletion of the OIR involvement. Technical references to a more general definition of managed care organizations rather than the more limited term of HMOs are made in this section. References to specific topics for rulemaking are deleted. A direction to contract with the FHKC for the Healthy Kids program and the Healthy Florida program is added. Direction to the AHCA for Healthy Kids has been included annually in proviso or implementing bill language in the past.

Responsibilities under the Florida Kidcare program for the OIR have been deleted. Their removal reflects the deletion of the employer sponsored component from the program.

Section 12 amends s. 409.820, F.S., relating to the quality assurance and access standards for the Florida Kidcare program. The quality assurance and access standards are clarified to show that such standards are for the pediatric and adolescent populations.

Section 13 amends s. 624.91, F.S., relating to the FHKC. The legislative intent for the Florida Healthy Kids Corporation Act is expanded to include a new program called “Healthy Florida.” The legislative intent states that Healthy Florida will cover uninsured adults utilizing a unique network of providers and contracts through which enrollees will receive a comprehensive set of benefits and services.

The Florida Healthy Kids Corporation Act is modified in several subsections to reflect the addition of the Healthy Florida program. Cross references are added to the Florida Kidcare program and the Florida Medicaid program, as appropriate.

Section 624.91(5)(b), F.S., is amended to incorporate the Healthy Florida program and to align with changes made to the Florida Kidcare Act.

Provisions under s. 624.91(5)(b)10., F.S., are separated into individual sub-subparagraphs by topic. No substantive change is made in sub-subparagraphs a. and b. The medical loss ratio requirement for the Healthy Kids program is modified under sub-subparagraph c. to include all health care contracts and language relating to the exemption of dental contracts is deleted. Clarification on how the calculations for the medical loss ratios will be computed is added and a cross reference to federal guidelines for classification of funds is included.

Under s. 624.91(5)(b)12., F.S., the FHKC's responsibility for the development of a plan for publicity of the Florida Kidcare program, public awareness, eligibility procedures, and requirements and to maintain public awareness is expanded to include both the Florida Kidcare program and the Healthy Florida program.

Requirements for separate reporting on the full-pay program by the FHKC are repealed effective December 31, 2013. The repeal aligns with the closure of new enrollment in the full-pay program effective September 30, 2013, and the availability of the exchange on January 1, 2014. A new subparagraph 16 requires the FHKC to notify existing full-pay enrollees of the availability of the exchange and how to access services. No new applications for full-pay coverage may be accepted after September 30, 2013.

Amendments to s. 624.91(5)(d), F.S., provides that the FHKC and any committees formed by the FHKC are subject to the conflict of interest provisions of ch. 112, F.S., the public records provisions of ch. 119, F.S., and the public meeting requirements of ch. 286, F.S.

The membership of the FHKC board of directors is changed to require that the chair of the board be appointed by the governor, rather than the chief financial officer or his or her designee. The specific membership and nominating guidelines for the 12 other members of the FHKC board are repealed and replaced with a board of 15 members designated or appointed as follow:

- The secretary of the AHCA, or his or her designee, as an ex-officio member;
- The state surgeon general, or his or her designee, as an ex-officio member;
- The secretary of the DCF, or his or her designee, as an ex-officio member;
- Four members appointed by the governor;
- Two members appointed by the president of the Senate;
- Two members appointed by the Senate minority leader;
- Two members appointed by the speaker of the House of Representatives; and
- Two members appointed by the House minority leader.

The chair and other members of the board will be subject to Senate confirmation. Members of the board will serve three-year terms and appointed members will serve at the pleasure of the official who appointed them. A provision is also included that any current board member serving

at the time of enactment may remain until July 1, 2013, to provide the governor time to appoint a new board after the enactment of the law.

An executive steering committee of agency secretaries is created to provide management direction and support to the board and its programs. The steering committee comprises the secretary of the AHCA, the secretary of the DCF, and the state surgeon general.

Section 14 repeals s. 624.915, F.S., relating to the Florida Healthy Kids Corporation Operating Fund. This language is obsolete and the option is not being utilized by the FHKC.

Section 15 creates a new section of statute, s. 624.917, F.S., relating to the Healthy Florida program. Healthy Florida will be administered by the FHKC as a program for lower income, uninsured adults who meet eligibility guidelines established by the FHKC. Definitions are provided that are specific to the Healthy Florida program under s. 624.917(2), F.S.

Eligibility for the Healthy Florida program is prescribed under s. 624.917(3), F.S. To be eligible and remain eligible, an individual must be a Florida resident and meet the definition of being “newly eligible” under PPACA, maintain their eligibility with the FHKC, and meet any renewal requirements to renew their coverage at least annually.

Under s. 624.917(4), F.S., enrollment may begin on October 1, 2013, with coverage effective no earlier than January 1, 2014. Enrollment in the program may occur through a third party administrator, referrals from other agencies, or through the exchange, as defined under PPACA. When an enrollee leaves the program, the FHKC is required to provide information about other insurance affordability options that may be available.

Delivery of services under Healthy Florida is provided for under s. 624.917(5), F.S. The FHKC is directed to contract with authorized insurers licensed under ch. 627, F.S., managed care organizations authorized under ch. 641, F.S., and provider service networks authorized under ss. 409.912(4)(d) and 409.962(13) that are prepaid plans meeting standards established by the FHKC to deliver services to enrollees. The FHKC must also establish access and network standards to ensure an adequate number of providers are available to deliver the benefits and services. Standards are to be developed in consultation with and under consideration of National Committee on Quality Assurance recommendations, stakeholders, and other existing performance standards for public and commercial populations.

Under this subsection, enrollees must also be provided a choice of plans. A lock-in period is specifically included and the FHKC is directed to offer exceptions to that lock-in period that take into consideration good cause reasons and qualifying events.

The bill permits the FHKC to consider contracts that include family plans that would provide coverage for members that are enrolled across multiple state or federally funded programs. The medical loss ratio provisions of s. 624.91, F.S., are applicable to the Healthy Florida program. These provisions mirror those used for the Healthy Kids contracts.

Under s. 624.917(6), F.S., the bill provides the benefits for the Healthy Florida program. The FHKC is directed to establish a benefit plan for the program that is actuarially equivalent to the

Florida Kidcare benchmark plan, excluding dental. The benefits package must also meet the alternative benefits package requirements under section 1937 of the Social Security Act. Benefits must be offered as an integrated, single package, without carve-outs.

The bill also requires that a health reimbursement account or comparable health savings account be established for Healthy Florida enrollees. The account may be established and managed either by the FHKC directly or by a contractor. Under s. 624.917(6)(a), F.S., the bill provides examples of the types of behaviors for which enrollees may be rewarded and how funds may be utilized by enrollees. Paragraph (b) of this same subsection also permits the offering of other enhanced benefits and services, provided these services generate savings to the overall plan. Paragraph (c) requires the FHKC to establish a process for the delivery of medically necessary wrap-around services that are not covered by the benchmark plan but that may be required under PPACA. The FHKC's capitation process with its contracted plans for the wrap-around services will be subject to a separate reconciliation process, and the medical loss ratio provisions will also apply to the wrap-around capitation. Prior authorization processes and other utilization controls for any benefit are authorized under this subsection, if approved by the FHKC.

Under s. 624.917(7), F.S., the bill establishes requirements for cost sharing under the Healthy Florida program. The FHKC is authorized to collect premiums and copayments from enrollees in accordance with federal law and in amounts that will be established annually in the General Appropriations Act. The bill provides that payment of a monthly premium may be required prior to an enrollee receiving a coverage start date under the program. Enrollees with a family income above the federal poverty level may also be required to make nominal copayments, in accordance with federal rules, as a condition of receiving a health care service. Providers will be responsible for collecting any copayment for a service and failure to collect any amount due from the enrollee will reduce the provider's reimbursement by the uncollected enrollee's copayment amount.

Management of the Healthy Florida program is described under s. 624.917(8), F.S. The FHKC is designated as the entity responsible for the oversight of the program. The AHCA is directed to seek the necessary state plan amendment to implement the program and to consult with the FHKC on the development of the amendment. The bill provides an amendment submission deadline by the AHCA of June 14, 2013. The AHCA is also directed under this subsection to contract with the FHKC for the administration of this program and for the purposes of the timely release of state and federal funds. The AHCA is recognized as the state's single entity for the administration of the Medicaid program.

Under s. 624.917(8)(a), F.S., the FHKC is directed to establish a grievance and resolutions process under which Healthy Florida recipients can be notified of their rights under the Medicaid Fair Hearing process as well as of any other processes that may be adopted by the FHKC for the program.

Under paragraph (b), the FHKC is required to establish a program integrity process to ensure compliance with the program's guidelines and to combat applicant and enrollee fraud. Timelines for the notification of when benefits may be withheld, reasons for loss of benefits, and the identification of individuals who can be prosecuted for fraud under s. 414.39, F.S., are specified.

Cross references to the applicability of certain Medicaid statutes to the Healthy Florida program are included under s. 624.917(9), F.S. The referenced statutes are s. 409.902, F.S., relating to the AHCA as the designated single state agency for Medicaid; s. 409.9128, F.S., relating to providing emergency services and care; and, s. 409.920, F.S, relating to Medicaid provider fraud. These provisions would apply to the Healthy Florida program in the same manner in which they apply in Medicaid.

The requirement for an evaluation of the Healthy Florida program is added under s. 624.917(10), F.S. The FHKC is required to collect eligibility and enrollment data on its applicants and enrollees and utilization and encounter data from its contracted entities for health care services. Monthly enrollment reports to the Legislature are also required. The bill provides for an interim evaluation by July 1, 2015, with annual evaluations thereafter. Components of the evaluation report are detailed and include information on application and enrollment trends, utilization and cost data, and customer satisfaction.

Section 624.917(11), F.S., sets an expiration date for the program for the end of the state fiscal year in which any of several conditions happen, whichever occurs first. The trigger events are identified as the federal match falling below 90 percent; the federal match contribution falling below the "Increased FMAP for Medical Assistance for Newly Eligible Mandatory Individuals" as specified under PPACA; or a blended federal match formula for Healthy Florida and the Medicaid program is enacted under federal law or regulation which causes the overall federal contribution to be reduced compared to separate, non-blended federal contributions under the status quo.

Section 16 creates a non-statutory provision of law that authorizes the FHKC to make program changes to comply with objections raised by HHS that are necessary to gain approval of the Healthy Florida program in compliance with PPACA, upon giving notice to the Legislature of the proposed changes. The Healthy Florida program requires approval of an amendment to the state's Medicaid state plan prior to implementation and to receive federal funds. The section also includes a conflict of laws interpretation clause that provides that if there is conflict between any provision in this section and PPACA, the provision should be interpreted as an intention to comply with federal requirements.

Section 17 amends s. 627.6474, F.S., relating to provider contracts for health insurance policies.

Under current law, a health insurer cannot require that a contracted health care practitioner accept the terms of other practitioner contracts (including Medicare and Medicaid practitioner contracts) with the insurer or with an insurer, HMO, preferred provider organization, or exclusive provider organization that is under common management and control with the contracting insurer. The bill adds to that list by prohibiting the insurer from requiring that a contracted health care provider accept the terms of other practitioner contracts with a PLHSO that is under common management and control with the contracting insurer.

The bill prohibits insurers from executing a contract with a licensed dentist that requires the dentist to provide services to an insured or subscriber at a specified fee unless such services are "covered services" under the applicable contract. "Covered services" are defined as those services that are listed as a benefit that the subscriber is entitled to receive under the contract.

This will prevent contracts between dentists and insurers from containing provisions that subject non-covered services to negotiated payment rates. The bill also prohibits insurers from providing merely de minimis reimbursement or coverage to avoid the requirements of the bill. The bill requires that fees for covered services must be set in good faith and cannot be nominal. The bill prohibits insurers from requiring that a contracted dentist participate in a DMPO.

The bill also addresses the criminal penalty specified in s. 624.15, F.S.,[79,80] by limiting the exemption from the criminal penalty currently contained in s. 627.6474, F.S., to subsection (1) of s. 627.6474, F.S. The provisions of subsection (2) of s. 627.6474, F.S., as created by the bill, are not specifically exempted from the criminal penalty. This leaves the current law exemption in place for the statutory provisions to which it currently applies, without applying the exemption to the bill's new provisions in subsection (2).

Section 18 amends s. 636.035, F.S., relating to prepaid limited health service organizations, by prohibiting PLHSOs from executing a contract with a licensed dentist that requires the dentist to provide services to an insured or subscriber at a specified fee unless such services are "covered services" under the applicable contract. "Covered services" are defined as those services that are listed as a benefit that the subscriber is entitled to receive under the contract. This will prevent contracts between dentists and PLHSOs from containing provisions that subject non-covered services to negotiated payment rates. The bill also prohibits PLHSOs from providing merely de minimis reimbursement or coverage to avoid the requirements of the bill. The bill requires that fees for covered services must be set in good faith and cannot be nominal. The bill prohibits PLHSOs from requiring that a contracted dentist participate in a DMPO.

Section 19 amends s. 641.315, F.S., relating to HMO provider contracts, by prohibiting HMOs from executing a contract with a licensed dentist that requires the dentist to provide services to an insured or subscriber at a specified fee unless such services are "covered services" under the applicable contract. "Covered services" are defined as those services that are listed as a benefit that the subscriber is entitled to receive under the contract. This will prevent contracts between dentists and HMOs from containing provisions that subject non-covered services to negotiated payment rates. The bill also prohibits HMOs from providing merely de minimis reimbursement or coverage to avoid the requirements of the bill. The bill requires that fees for covered services must be set in good faith and cannot be nominal. The bill prohibits HMOs from requiring that a contracted dentist participate in a DMPO.

Section 20 amends s. 766.1115, F.S., relating to the Access to Health Care Act, to authorize a dentist, who is a government contracted health care provider under the Act, to allow a patient, or a parent or guardian of a patient to voluntarily contribute a fee to cover costs of dental laboratory work. The contribution may not exceed the actual cost of the laboratory fee. When the voluntary contribution is accepted from the patient for dental laboratory fees it is not considered compensation for services so that sovereign immunity protection is not lost.

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[79] Section 624.15, F.S., provides that, unless a greater specific penalty is provided by another provision of the Insurance Code or other applicable law or rule of the state, each willful violation of the Insurance Code is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, F.S., and that each instance of such violation shall be considered a separate offense.

[80] Section 775.082, F.S., provides that a person convicted of a misdemeanor of the second degree may be sentenced to a term of imprisonment not exceeding 60 days. Section 775.083, F.S., provides that a person convicted of a misdemeanor of the second degree may be sentenced to pay a fine not exceeding $500 plus court costs.

Section 21 creates a non-statutory provision of law to provide that the bill's amendments to ss. 627.6474, 636.035, and 641.315, F.S., apply to contracts entered into or renewed on or after July 1, 2013.

Section 22 provides appropriations of:

- $1,258,054,808 from the Medical Care Trust Fund beginning in the 2013-2014 fiscal year to provide coverage for individuals who enroll in Healthy Florida;
- $254,151 from the General Revenue Fund and $18,235,833 from the Medical Care Trust Fund beginning in the 2013-2014 fiscal year to comply with federal regulations to compensate insurers and managed care organizations that contract with the Healthy Florida program for the imposition of the annual fee on health insurance providers under the PPACA; and
- $10,676,377 from the General Revenue Fund and $10,676,377 from the Medical Care Trust Fund beginning in the 2013-2014 fiscal year to fund administrative costs necessary for the FHKC to implement and operate the Healthy Florida program.

Section 23 provides that the act takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

The bill explicitly requires the FHKC to conduct its activities and those of any committees formed by the FHKC, in accordance with chapters 119 and 286, F.S. The FHKC currently provides notice of meetings of its board and committees on its website at www.healthykids.org and posts materials for board meetings on the same site within timeframes set through board policy.

The FHKC also responds to requests for public records, within the additional exemptions and limitations of s. 409.821, F.S. and federal law which protect certain individual and identifying information of applicants and enrollees to the Florida Kidcare program.

The provisions of this bill would expressly require compliance with state public records and open meetings requirements.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Florida's Social Services Estimating Conference (SSEC) estimates that 438,113 individuals would become newly eligible and would enroll in Florida Medicaid during the 2013-2014 state fiscal year if the program's eligibility threshold were expanded to 138 percent of FPL beginning January 1, 2014. An estimated 377,813 of those newly eligible enrollees are currently uninsured while the remaining 60,300 are likely to terminate their existing individual coverage in favor of Medicaid after becoming eligible. The Healthy Florida program would expect roughly the same estimated enrollment if implemented.

The bill contemplates the FHKC contracting with insurers and managed care organizations to deliver comprehensive health insurance coverage to uninsured individuals who may or may not be seeking health care services now. Physicians, hospitals, and other health care providers may be impacted by a potentially higher demand for their services after Healthy Florida is implemented.

The bill may have a negative fiscal impact on health insurer, HMO, and PLHSO policyholders and subscribers who may pay higher costs for dental care if the Legislature prohibits these entities from contracting with dentists to provide services that are not covered at a negotiated fee.

The fiscal impact of the bill's provisions relating to a patient's voluntary contribution of a fee to cover costs of dental laboratory work is expected to be minimal since many areas in the state already allow voluntary contributions.[81]

C. Government Sector Impact:

The bill directs the AHCA to seek the PPACA's enhanced federal match for the Healthy Florida program, which would result in 100 percent federal funding for newly eligible enrollees until January 1, 2017. To cover the estimated 438,113 new enrollees in Fiscal Year 2013-2014, $1.26 billion would be expended, according to the SSEC.

Additionally, under eligibility expansion, the SSEC estimates that 70,647 Kidcare enrollees would become newly eligible for Medicaid and could transfer out of Kidcare. In such a transfer, the federal match would be the same as the Kidcare matching rate, which is 71.03 percent for the 2013-2014 state fiscal year. The state and federal expenditures to cover those children would be the same between the two programs.

[81] *See* Department of Health Bill Analysis for SB 1016 (dated March 11, 2013) on file with the Senate Health Policy Committee and notes from telephone call with staff on March 12, 2013.

The PPACA also imposes a federal health insurance tax (HIT) on health insurance providers beginning January 1, 2014, to be divided among insurers according to a formula based on each insurer's net premiums, including those contracted under Medicaid or Healthy Florida. Federal guidance indicates that states must account for the HIT to be incurred by managed care plans when calculating rates paid by a state Medicaid program to the plans. For the newly eligible population, the federal match for the HIT mirrors the match provided in the PPACA, which means a 100 percent federal match for the HIT during the 2013-2014 state fiscal year. For Kidcare transfers, however, the federal match will mirror the Kidcare matching rate. If all 70,647 children described above were to transfer from Kidcare to Healthy Florida, an estimated $254,151 GR would be required to compensate insurers and managed care plans for the HIT in the 2013-2014 state fiscal year.

The FHKC will need additional resources to adapt its existing eligibility and enrollment systems to accommodate a new program. Also, the FHKC will need to adjust and expand its administrative structure and professional staff to manage new contracts for the Healthy Florida program. Additionally, these needs will vary somewhat depending on the number of persons who enroll in the Healthy Florida program. Based on existing enrollment projections, the fiscal impact of the FHKC's additional resource needs is estimated to be a total of $21.2 million for the 2013-2014 state fiscal year, half of which would be state funds, or $10.6 million GR.

VI. Technical Deficiencies:

None.

VII. Related Issues:

In December 2012, Florida Senate President Don Gaetz formed the Select Committee on the PPACA to launch a comprehensive assessment on the impact of the law on Florida, evaluate the state's options under the law, and to make recommendations to the full Senate membership on any actions necessary to mitigate cost increases, preserve a competitive insurance market, and protect Florida's consumers.[82] The Select Committee received public testimony, expert presentations, and staff reports over nine meetings before it developed three specific recommendations relating to the development of a health care exchange, coverage for certain state employees, and the expansion of Medicaid. On the question of Medicaid expansion, the Select Committee voted 7-4 to recommend to the full Senate to not expand the existing Medicaid program under the current state plan or pending waivers.[83]

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[82] *See* Florida Senate, *Patient Protection and Affordable Care Act*, http://www.flsenate.gov/topics/ppaca (last visited: April 1, 2013).

[83] Florida Senate Select Committee on Patient Protection and Affordable Care Act, *Letter to Senate President Don Gaetz on Medicaid Recommendation* http://www.flsenate.gov/usercontent/topics/ppaca/03-12-13MedicaidRecommendation.pdf (last visited: April 1, 2013).

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS by Appropriations on April 23, 2013:

The committee substitute revises the membership of the board of directors of the FHKC; provides that the Healthy Florida program may contract with prepaid provider service networks in addition to insurers licensed under ch. 627, F.S., and managed care organizations authorized under ch. 641, F.S.; provides that the Healthy Florida program may require nominal copayments specifically from enrollees with family incomes above the FPL; and appropriates general revenue and trust fund dollars for the Healthy Florida program beginning in the 2013-2014 fiscal year.

Sections 17-21 were added to the bill, providing requirements for contracts between dentists and insurers, HMOs, or PLHSOs, and authorizing a dentist who is a government-contracted health care provider under the Access to Health Care Act, to allow a patient, or a parent or guardian of a patient, to voluntarily contribute a fee to cover costs of dental laboratory work.

B. Amendments:

None.

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