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LEGISLATIVE ACTION

Senate	.	House
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04/29/2013 02:35 PM	.	
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Senator Negron moved the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Section 409.811, Florida Statutes, is amended to read:

409.811 Definitions relating to Florida Kidcare Act.—As used in ss. 409.810-409.821, the term:

(1) "Actuarially equivalent" means that:

(a) The aggregate value of the benefits included in health benefits coverage is equal to the value of the benefits in the benchmark benefit plan; and

(b) The benefits included in health benefits coverage are

substantially similar to the benefits included in the benchmark benefit plan, except that preventive health services must be the same as in the benchmark benefit plan.

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

(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. 409.810-409.821.

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

(5) "Child" means any person younger than ~~under~~ 19 years of age.

(6) "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 adjusted for chronological age, and such a child often needs complex care requiring multiple providers, rehabilitation services, and specialized equipment in a number of different settings.

(7) "Children's Medical Services Network" or "network" means a statewide managed care service system as defined in s. 391.021(1).

(8) "CHIP" means the Children's Health Insurance Program as authorized under Title XXI of the Social Security Act, and its regulations, ss. 409.810-409.820, and as administered in this state by the agency, the department, and the Florida Healthy

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Kids Corporation, as appropriate to their respective responsibilities.

(9) "Combined eligibility notice" means an eligibility notice that informs an applicant, an enrollee, or multiple family members of a household, when feasible, of eligibility for each of the insurance affordability programs and enrollment into a program or exchange plan. A combined eligibility form must be issued by the last agency or department to make an eligibility, renewal or denial determination. The form must meet all of the federal and state law and regulatory requirements no later than January 1, 2014.

~~(8) "Community rate" means a method used to develop premiums for a health insurance plan that spreads financial risk across a large population and allows adjustments only for age, gender, family composition, and geographic area.~~

(10)~~(9)~~ "Department" means the Department of Health.

(11)~~(10)~~ "Enrollee" means a child who has been determined eligible for and is receiving coverage under ss. 409.810-409.821.

~~(11) "Family" means the group or the individuals whose income is considered in determining eligibility for the Florida Kidcare program. The family includes a child with a 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 743, the child. The family may also include other 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~~

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~~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 Aid to Families with Dependent Children (AFDC) state plan in effect prior to August 22, 1996.~~

(12) ~~(13)~~ "Florida Kidcare program," "Kidcare program," or "program" means the health benefits program administered through ss. 409.810-409.821.

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

(14) ~~(15)~~ "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) ~~(16)~~ "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

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benefits established under the Employee Retirement Income Security Act of 1974, as amended.

(16) "Household income" means the group or the individual whose income is considered in determining eligibility for the Florida Kidcare program. The term "household" has the same meaning as provided in s. 36B(d)(2) of the Internal Revenue Code of 1986.

(17) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and ss. 409.901-409.920, as administered in this state by the agency.

(18) "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.

(19) "Medikids" means a component of the Florida Kidcare

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program of medical assistance authorized by Title XXI of the Social Security Act, and regulations thereunder, and s. 409.8132, as administered in the state by the agency.

(20) "Modified adjusted gross income" means the individual's or household's annual adjusted gross income as defined in s. 36B(d)(2) of the Internal Revenue Code of 1986 which is used to determine eligibility under the Florida Kidcare program.

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

(22) ~~(20)~~ "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.

(23) ~~(21)~~ "Premium" means the entire cost of a health insurance plan, including the administration fee or the risk assumption charge.

(24) ~~(22)~~ "Premium assistance payment" means the monthly consideration paid by the agency per enrollee in the Florida Kidcare program towards health insurance premiums.

(25) ~~(23)~~ "Qualified alien" means an alien as defined in 8 U.S.C. s. 1641 (b) and (c) ~~s. 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, Pub. L. No. 104-193~~.

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

(27)~~(25)~~ "Rural county" means a county having a population density of less than 100 persons per square mile, or a county defined by the most recent United States Census as rural, in which there is no prepaid health plan participating in the Medicaid program as of July 1, 1998.

~~(26) "Substantially similar" means that, with respect to additional services as defined in s. 2103(c)(2) of Title XXI of the Social Security Act, these services must have an actuarial value equal to at least 75 percent of the actuarial value of the coverage for that service in the benchmark benefit plan and, with respect to the basic services as defined in s. 2103(c)(1) of Title XXI of the Social Security Act, these services must be the same as the services in the benchmark benefit plan.~~

Section 2. Section 409.813, Florida Statutes, is amended to read:

409.813 Health benefits coverage; program components; entitlement and nonentitlement.—

(1) The Florida Kidcare program includes health benefits coverage provided to children through the following program components, which shall be marketed as the Florida Kidcare program:

(a) Medicaid;

(b) Medikids as created in s. 409.8132;

(c) The Florida Healthy Kids Corporation as created in s. 624.91; and

~~(d) Employer-sponsored group health insurance plans approved under ss. 409.810-409.821; and~~

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(d) ~~(c)~~ The Children's Medical Services network established in chapter 391.

(2) Except for Title XIX-funded Florida Kidcare program coverage under the Medicaid program, coverage under the Florida Kidcare program is not an entitlement. No cause of action shall arise against the state, the department, the Department of Children and Families ~~Family Services~~, ~~or~~ the agency, or the Florida Healthy Kids Corporation for failure to make health services available to any person under ss. 409.810-409.821.

Section 3. Subsections (6) and (7) of section 409.8132, Florida Statutes, are amended to read:

409.8132 Medikids program component.—

(6) ELIGIBILITY.—

(a) A child who has attained the age of 1 year but who is under the age of 5 years is eligible to enroll in the Medikids program component of the Florida Kidcare program, if the child is a member of a family that has a family income which exceeds the Medicaid applicable income level as specified in s. 409.903, but which is equal to or below 200 percent of the current federal poverty level. In determining the eligibility of such a child, an assets test is not required. ~~A child who is eligible for Medikids may elect to enroll in Florida Healthy Kids coverage or employer-sponsored group coverage. However, a child who is eligible for Medikids may participate in the Florida Healthy Kids program only if the child has a sibling participating in the Florida Healthy Kids program and the child's county of residence permits such enrollment.~~

(b) The provisions of s. 409.814 apply to the Medikids program.

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(7) ENROLLMENT.—Enrollment in the Medikids program component may occur at any time throughout the year. A child may not receive services under the Medikids program until the child is enrolled in a managed care plan or MediPass. Once determined eligible, an applicant may receive choice counseling and select a managed care plan or MediPass. The agency may initiate mandatory assignment for a Medikids applicant who has not chosen a managed care plan or MediPass provider after the applicant's voluntary choice period ends. An applicant may select MediPass under the Medikids program component only in counties that have fewer than two managed care plans available to serve Medicaid recipients ~~and only if the federal Health Care Financing Administration determines that MediPass constitutes "health insurance coverage" as defined in Title XXI of the Social Security Act~~.

Section 4. Subsection (2) of section 409.8134, Florida Statutes, is amended to read:

409.8134 Program expenditure ceiling; enrollment.—

(2) The Florida Kidcare program may conduct enrollment continuously throughout the year.

(a) Children eligible for coverage under the Title XXI-funded Florida Kidcare program shall be enrolled on a first-come, first-served basis using the date the enrollment application is received. Enrollment shall immediately cease when the expenditure ceiling is reached. Year-round enrollment shall only be held if the Social Services Estimating Conference determines that sufficient federal and state funds will be available to finance the increased enrollment.

(b) The application for the Florida Kidcare program is

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valid for a period of 120 days after the date it was received. At the end of the 120-day period, if the applicant has not been enrolled in the program, the application is invalid and the applicant shall be notified of the action. The applicant may reactivate the application after notification of the action taken by the program.

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

Section 5. Section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.—A child who has not reached 19 years of age whose household ~~family~~ income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. If an enrolled individual is determined to be ineligible for coverage, he or she must be immediately disenrolled from the respective Florida Kidcare program component and referred to another insurance affordability program, if appropriate, through a combined eligibility notice.

(1) A child who is eligible for Medicaid coverage under s. 409.903 or s. 409.904 must be offered the opportunity to enroll ~~enrolled~~ in Medicaid ~~and is not eligible to receive health benefits under any other health benefits coverage authorized under the Florida Kidcare program~~. A child who is eligible for

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Medicaid and opts to enroll in CHIP may disenroll from CHIP at any time and transition to Medicaid. This transition must occur without any break in coverage.

(2) A child who is not eligible for Medicaid, but who is eligible for the Florida Kidcare program, may obtain health benefits coverage under any of the other components listed in s. 409.813 if such coverage is approved and available in the county in which the child resides.

(3) A Title XXI-funded child who is eligible for the Florida Kidcare program who is a child with special health care needs, as determined through a medical or behavioral screening instrument, is eligible for health benefits coverage from and shall be assigned to and may opt out of the Children's Medical Services Network.

(4) The following children are not eligible to receive Title XXI-funded premium assistance for health benefits coverage under the Florida Kidcare program, 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 covered under a family member's group health benefit plan or under other private or employer health insurance coverage, if the cost of the child's participation is not greater than 5 percent of the household's ~~family's~~ income. If a child is otherwise eligible for a subsidy under the Florida Kidcare program and the cost of the child's participation in the family member's health insurance benefit plan is greater than 5 percent of the household's ~~family's~~ income, the child may enroll in the appropriate subsidized Kidcare program.

~~(b) A child who is seeking premium assistance for the~~

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~~Florida Kidcare program through employer-sponsored group coverage, if the child has been covered by the same employer's group coverage during the 60 days before the family submitted an application for determination of eligibility under the program.~~

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

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

(d) ~~(e)~~ A child who is otherwise eligible for premium assistance for the Florida Kidcare program and has had his or her coverage in an employer-sponsored or private health benefit plan voluntarily canceled in the last 60 days, except those children whose coverage was voluntarily canceled for good cause, including, but not limited to, the following circumstances:

1. The cost of participation in an employer-sponsored health benefit plan is greater than 5 percent of the household's modified adjusted gross ~~family's~~ income;

2. The parent lost a job that provided an employer-sponsored health benefit plan for children;

3. The parent who had health benefits coverage for the child is deceased;

4. The child has a medical condition that, without medical care, would cause serious disability, loss of function, or death;

5. The employer of the parent canceled health benefits coverage for children;

6. The child's health benefits coverage ended because the child reached the maximum lifetime coverage amount;

7. The child has exhausted coverage under a COBRA

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continuation provision;

8. The health benefits coverage does not cover the child's health care needs; or

9. Domestic violence led to loss of coverage.

~~(5) A child who is otherwise eligible for the Florida Kidcare program and who has a preexisting condition that prevents coverage under another insurance plan as described in paragraph (4)(a) which would have disqualified the child for the Florida Kidcare program if the child were able to enroll in the plan is eligible for Florida Kidcare coverage when enrollment is possible.~~

(5) ~~(6)~~ A child whose household's modified adjusted gross ~~family~~ income is above 200 percent of the federal poverty level or a child who is excluded under the provisions of subsection (4) may participate in the Florida Kidcare program as provided in s. 409.8132 or, if the child is ineligible for Medikids by reason of age, in the Florida Healthy Kids program, subject to the following:

(a) The family is not eligible for premium assistance payments and must pay the full cost of the premium, including any administrative costs.

(b) The board of directors of the Florida Healthy Kids Corporation may offer a reduced benefit package to these children in order to limit program costs for such families.

(c) By August 15, 2013, the Florida Healthy Kids Corporation shall notify all current full-pay enrollees of the availability of the exchange and how to access other insurance affordability options. New applications for full-pay coverage may not be accepted after September 30, 2013.

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(6) ~~(7)~~ Once a child is enrolled in the Florida Kidcare program, the child is eligible for coverage for 12 months without a redetermination or reverification of eligibility, if the family continues to pay the applicable premium. Eligibility for program components funded through Title XXI of the Social Security Act terminates when a child attains the age of 19. A child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility.

(7) ~~(8)~~ When determining or reviewing a child's eligibility under the Florida Kidcare program, the applicant shall be provided with reasonable notice of changes in eligibility which may affect enrollment in one or more of the program components. If a transition from one program component to another is authorized, there shall be cooperation between the program components and the affected family which promotes continuity of health care coverage. Any authorized transfers must be managed within the program's overall appropriated or authorized levels of funding. Each component of the program shall establish a reserve to ensure that transfers between components will be accomplished within current year appropriations. These reserves shall be reviewed by each convening of the Social Services Estimating Conference to determine the adequacy of such reserves to meet actual experience.

(8) ~~(9)~~ In determining the eligibility of a child, an assets test is not required. Each applicant shall provide documentation during the application process and the redetermination process, including, but not limited to, the following:


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(a) Proof of household ~~family~~ income, which must be verified electronically to determine financial eligibility for the Florida Kidcare program. Written documentation, which may include wages and earnings statements or pay stubs, W-2 forms, or a copy of the applicant's most recent federal income tax return, is required only if the electronic verification is not available or does not substantiate the applicant's income. This paragraph expires December 31, 2013.

(b) A statement from all applicable, employed household ~~family~~ members that:

1. Their employers do not sponsor health benefit plans for employees;

2. The potential enrollee is not covered by an employer-sponsored health benefit plan; or

3. The potential enrollee is covered by an employer-sponsored health benefit plan and the cost of the employer-sponsored health benefit plan is more than 5 percent of the household's modified adjusted gross ~~family's~~ income.

(c) To enroll in the Children's Medical Services Network, a completed application, including a clinical screening.

(d) Effective January 1, 2014, eligibility shall be determined through electronic matching using the federally managed data services hub and other resources. Written documentation from the applicant may be accepted if the electronic verification does not substantiate the applicant's income or if there has been a change in circumstances.

(9) ~~(10)~~ Subject to paragraph (4)(a), the Florida Kidcare program shall withhold benefits from an enrollee if the program obtains evidence that the enrollee is no longer eligible,

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submitted incorrect or fraudulent information in order to establish eligibility, or failed to provide verification of eligibility. The applicant or enrollee shall be notified that because of such evidence program benefits will be withheld unless the applicant or enrollee contacts a designated representative of the program by a specified date, which must be within 10 working days after the date of notice, to discuss and resolve the matter. The program shall make every effort to resolve the matter within a timeframe that will not cause benefits to be withheld from an eligible enrollee.

(10) ~~(11)~~ The following individuals may be subject to prosecution in accordance with s. 414.39:

(a) An applicant obtaining or attempting to obtain benefits for a potential enrollee under the Florida Kidcare program when the applicant knows or should have known the potential enrollee does not qualify for the Florida Kidcare program.

(b) An individual who assists an applicant in obtaining or attempting to obtain benefits for a potential enrollee under the Florida Kidcare program when the individual knows or should have known the potential enrollee does not qualify for the Florida Kidcare program.

Section 6. Paragraphs (g), (k), (q), and (w) of subsection (2) of section 409.815, Florida Statutes, are amended to read:

409.815 Health benefits coverage; limitations.—

(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

(g) *Behavioral health services.*—

1. Mental health benefits include:

a. Inpatient services~~, limited to 30 inpatient days per contract year~~ for psychiatric admissions, or residential services in facilities licensed under s. 394.875(6) or s. 395.003 in lieu of inpatient psychiatric admissions~~; however, a minimum of 10 of the 30 days shall be available only for inpatient psychiatric services~~ if authorized by a physician; and

b. Outpatient services, including outpatient visits for psychological or psychiatric evaluation, diagnosis, and treatment by a licensed mental health professional~~, limited to 40 outpatient visits each contract year~~.

2. Substance abuse services include:

a. Inpatient services~~, limited to 7 inpatient days per contract year~~ for medical detoxification only and ~~30 days of~~ residential services; and

b. Outpatient services, including evaluation, diagnosis, and treatment by a licensed practitioner~~, limited to 40 outpatient visits per contract year~~.

~~Effective October 1, 2009,~~ Covered services include inpatient and outpatient services for mental and nervous disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Such benefits include psychological or psychiatric evaluation, diagnosis, and treatment by a licensed mental health professional and inpatient, outpatient, and residential treatment of substance abuse disorders. Any benefit limitations, including duration of services, number of visits,

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or number of days for hospitalization or residential services, shall not be any less favorable than those for physical illnesses generally. The program may also implement appropriate financial incentives, peer review, utilization requirements, and other methods used for the management of benefits provided for other medical conditions in order to reduce service costs and utilization without compromising quality of care.

(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~~.

(q) *Dental services.* ~~Effective October 1, 2009,~~ Dental services shall be covered as required under federal law and may also include those dental benefits provided to children by the Florida Medicaid program under s. 409.906(6).

(w) *Reimbursement of federally qualified health centers and rural health clinics.* ~~Effective October 1, 2009,~~ Payments for services provided to enrollees by federally qualified health centers and rural health clinics under this section shall be reimbursed using the Medicaid Prospective Payment System as provided for under s. 2107(e)(1)(D) of the Social Security Act. If such services are paid for by health insurers or health care providers under contract with the Florida Healthy Kids Corporation, such entities are responsible for this payment. The

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agency may seek any available federal grants to assist with this transition.

Section 7. Section 409.816, Florida Statutes, is amended 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 households that have ~~families with~~ a modified adjusted gross ~~family~~ income equal to or below 150 percent of the federal poverty level, 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 households that have ~~families with~~ a modified adjusted gross ~~family~~ income above 150 percent of the federal poverty level who are not receiving coverage under the

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Medicaid program or who are not eligible under s. 409.814(5) ~~s. 409.814(6)~~ 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 household ~~family~~ may not exceed 5 percent of the household's modified adjusted ~~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 8. Section 409.817, Florida Statutes, is repealed.

Section 9. Section 409.8175, Florida Statutes, is repealed.

Section 10. Paragraph (c) of subsection (1) of section 409.8177, Florida Statutes, is amended to read:

409.8177 Program evaluation.—

(1) The agency, in consultation with the Department of Health, the Department of Children and Families ~~Family Services~~, and the Florida Healthy Kids Corporation, shall contract for an evaluation of the Florida Kidcare program and shall by January 1 of each year submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of the program. In addition to the items specified under s. 2108 of Title XXI of the Social Security Act, the report shall include an assessment of crowd-out and access to health care, as well as the following:

(c) The characteristics of the children and families assisted under the program, including ages of the children, household ~~family~~ income, and access to or coverage by other

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health insurance prior to the program and after disenrollment from the program.

Section 11. Section 409.818, Florida Statutes, is amended to read:

409.818 Administration.—In order to implement ss. 409.810-409.821, the following agencies shall have the following duties:

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

(a) Maintain ~~Develop~~ a simplified eligibility determination and renewal process ~~application mail-in form to be used for determining the eligibility of children for coverage~~ under the Florida Kidcare program, in consultation with the agency, the Department of Health, and the Florida Healthy Kids Corporation. The simplified eligibility process ~~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. Families applying for children's Medicaid coverage must also be able to use the simplified application process ~~form~~ without having to pay a premium.

(b) Establish and maintain the eligibility determination process under the program except as specified in subsection (3), which includes the following: ~~(5).~~

1. 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 be used solely for determining eligibility of applicants for health benefits coverage under the program. The eligibility determination process must include an initial

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determination of eligibility for any coverage offered under the program, as well as a redetermination or reverification of eligibility each subsequent 6 months. ~~Effective January 1, 1999,~~ A child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility. In conducting an eligibility determination, the department shall determine if the child has special health care needs.

2. The department, in consultation with the Agency for Health Care Administration and the Florida Healthy Kids Corporation, shall develop procedures for redetermining eligibility which enable applicants and enrollees ~~a family~~ to easily update any change in circumstances which could affect eligibility.

3. The department may accept changes in ~~a family's~~ status as reported to the department by the Florida Healthy Kids Corporation or the exchange without requiring a new application ~~from the family~~. Redetermination of a child's eligibility for Medicaid may not be linked to a child's eligibility determination for other programs.

4. The department, in consultation with the agency and the Florida Healthy Kids Corporation, shall develop a combined eligibility notice to inform applicants and enrollees of their application or renewal status, as appropriate. The content must be coordinated to meet all federal and state requirements under the federal Patient Protection and Affordable Care Act.

(c) Inform program applicants about eligibility determinations and provide information about eligibility of

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applicants to the Florida Kidcare program and to insurers and their agents~~, 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 for the program, in coordination with the Department of Children and Family Services, the agency, and the Florida Healthy Kids Corporation. 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) Chair a state-level Florida Kidcare coordinating council to review and make recommendations concerning the implementation and operation of the program. The coordinating council shall include representatives from the department, the Department of Children and Family Services, the agency, the Florida Healthy Kids Corporation, the Office of Insurance Regulation of the Financial Services Commission, local government, health insurers, health maintenance organizations, health care providers, families participating in the program, and organizations representing low-income families.~~

~~(c) In consultation with the Florida Healthy Kids Corporation and the Department of Children and Family Services, establish a toll-free telephone line to assist families with questions about the program.~~

~~(d) Adopt rules necessary to implement outreach activities.~~

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

(a) Calculate the premium assistance payment necessary to

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comply with the premium and cost-sharing limitations specified in s. 409.816 and the federal Patient Protection and Affordable Care Act. The premium assistance payment for each enrollee in a health insurance plan participating in the Florida Healthy Kids Corporation shall equal the premium approved by the Florida Healthy Kids Corporation ~~and the Office of Insurance Regulation of the Financial Services Commission pursuant to ss. 627.410 and 641.31,~~ less any enrollee's share of the premium established within the limitations specified in s. 409.816. ~~The premium assistance payment for each enrollee in an employer-sponsored health insurance plan approved under ss. 409.810-409.821 shall equal the premium for the plan adjusted for any benchmark benefit plan actuarial equivalent benefit rider approved by the Office of Insurance Regulation pursuant to ss. 627.410 and 641.31, less any enrollee's share of the premium established within the 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.~~

(b) Make premium assistance payments to health insurance plans on a periodic basis. The agency may use its Medicaid fiscal agent or a contracted third-party administrator in making these payments. The agency may require health insurance plans that participate in the Medikids program ~~or employer-sponsored group health insurance~~ to collect premium payments from an enrollee's family. Participating health insurance plans shall report premium payments collected on behalf of enrollees in the program to the agency in accordance with a schedule established

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by the agency.

(c) Monitor compliance with quality assurance and access standards developed under s. 409.820 and in accordance with s. 2103(f) of the Social Security Act, 42 U.S.C. s. 1397cc(f).

(d) 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 managed care ~~health maintenance~~ organization, the agency must use the provisions of s. 641.511 to address grievance reporting and resolution requirements.

~~(e) Approve health benefits coverage for participation in the program, following certification by the Office of Insurance Regulation under subsection (4).~~

(e) ~~(f)~~ Adopt rules necessary for ~~calculating premium assistance payment levels, making premium assistance payments,~~ monitoring access and quality assurance standards and~~,~~ investigating and resolving complaints and grievances~~, administering the Medikids program, and approving health benefits coverage~~.

(f) Contract with the Florida Healthy Kids Corporation for the administration of the Florida Kidcare program and the Healthy Florida program and to facilitate the release of any federal and state funds.

The agency is designated the lead state agency for Title XXI of the Social Security Act for purposes of receipt of federal funds, for reporting purposes, and for ensuring compliance with federal and state regulations and rules.

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~~(4) The Office of Insurance Regulation shall certify that health benefits coverage plans that seek to provide services under the Florida Kidcare program, except those offered through the Florida Healthy Kids Corporation or the Children's Medical Services Network, meet, exceed, or are actuarially equivalent to the benchmark benefit plan and that health insurance plans will be offered at an approved rate. In determining actuarial equivalence of benefits coverage, the Office of Insurance Regulation and health insurance plans must comply with the requirements of s. 2103 of Title XXI of the Social Security Act. The department shall adopt rules necessary for certifying health benefits coverage plans.~~

(3)~~(5)~~ The Florida Healthy Kids Corporation shall retain its functions as authorized in s. 624.91, including eligibility determination for participation in the Healthy Kids program.

(4)~~(6)~~ The agency, the Department of Health, the Department of Children and Families ~~Family Services~~, and the Florida Healthy Kids Corporation, ~~and the Office of Insurance Regulation,~~ after consultation with and approval of the Speaker of the House of Representatives and the President of the Senate, may ~~are authorized to~~ make program modifications that are necessary to overcome any objections of the United States Department of Health and Human Services to obtain approval of the state's child health insurance plan under Title XXI of the Social Security Act.

Section 12. Section 409.820, Florida Statutes, is amended to read:

409.820 Quality assurance and access standards.—Except for Medicaid, the Department of Health, in consultation with the

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agency and the Florida Healthy Kids Corporation, shall develop a minimum set of pediatric and adolescent 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. These standards shall comply with the provisions of this chapter and chapter 641 and Title XXI of the Social Security Act.

Section 13. Section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

(1) SHORT TITLE.—This section may be cited as the "William G. 'Doc' Myers Healthy Kids Corporation Act."

(2) LEGISLATIVE INTENT.—

(a) The Legislature finds that increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in this state. Many children do not have comprehensive, affordable health care services available. It is the intent of the Legislature that the Florida Healthy Kids Corporation provide comprehensive health insurance coverage to such children. The corporation is encouraged to cooperate with any existing health service programs funded by the public or the private sector.

(b) It is the intent of the Legislature that the Florida Healthy Kids Corporation serve as one of several providers of services to children eligible for medical assistance under Title XXI of the Social Security Act. Although the corporation may

serve other children, the Legislature intends the primary recipients of services provided through the corporation be school-age children with a family income below 200 percent of the federal poverty level, who do not qualify for Medicaid. It is also the intent of the Legislature that state and local government Florida Healthy Kids funds be used to continue coverage, subject to specific appropriations in the General Appropriations Act, to children not eligible for federal matching funds under Title XXI.

(c) It is further the intent of the Legislature that the Florida Healthy Kids Corporation administer and manage services for Healthy Florida, a health care program for uninsured adults using a unique network of providers and contracts. Enrollees in Healthy Florida will receive comprehensive health care services from private, licensed health insurers who meet standards established by the corporation. It is further the intent of the Legislature that these enrollees participate in their own health care decisionmaking and contribute financially toward their medical costs. The Legislature intends to provide an alternative benefit package that includes a full range of services that meet the needs of residents of this state. As a new program, the Legislature shall also ensure that a comprehensive evaluation is conducted to measure the overall impact of the program and identify whether to renew the program after an initial 3-year term.

(3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only the following individuals are eligible for state-funded assistance in paying premiums for Healthy Florida or Florida Healthy Kids ~~premiums~~:

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(a) Residents of this state who are eligible for the Florida Kidcare program pursuant to s. 409.814 or the Healthy Florida program pursuant to s. 624.917.

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

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

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

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

(b) The Florida Healthy Kids Corporation shall:

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

2. Arrange for the collection of any voluntary contributions to provide for payment of premiums for enrollees in the Florida Kidcare program or Healthy Florida ~~premiums for children who are not eligible for medical assistance under Title XIX or Title XXI of the Social Security Act~~.

3. Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply

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with the requirements of Title XXI of the Social Security Act for the purpose of providing additional Florida Kidcare coverage in contributing counties under Title XXI.

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

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

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

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

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

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

10. Contract with authorized insurers or any provider of

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

a. Health plans shall be selected through a competitive bid process.

b. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For all health care contracts, the minimum medical loss ratio is ~~for a Florida Healthy Kids Corporation contract shall be~~ 85 percent. The calculations must use uniform financial data collected from all plans in a format established by the corporation and shall be computed for each insurer on a statewide basis. Funds shall be classified in a manner consistent with 45 C.F.R. part 158 ~~For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail~~.

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

11. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.

12. Develop and implement a plan to publicize the Florida

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Kidcare program and Healthy Florida, the eligibility requirements of the programs ~~program~~, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the programs ~~program~~.

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

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

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

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

b. The costs and utilization by service of the full-pay enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population. This subparagraph is repealed effective December 31, 2013.

~~By February 1, 2010, the Florida Healthy Kids Corporation shall~~

~~provide a study to the Legislature and the Governor on premium impacts to the subsidized portion of the program from the inclusion of the full-pay program, which shall include recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.~~

16. By August 15, 2013, the corporation shall notify all current full-pay enrollees of the availability of the exchange, as defined in the federal Patient Protection and Affordable Care Act, and how to access other insurance affordability options. New applications for full-pay coverage may not be accepted after September 30, 2013.

17.~~16.~~ Establish benefit packages that conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.821.

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

(d) The Florida Healthy Kids Corporation shall be a private corporation not for profit, registered, incorporated, and organized pursuant to chapter 617, and shall have all powers necessary to carry out the purposes of this act, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of this act. The corporation and

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any committees it forms shall act in compliance with part III of chapter 112, and chapters 119 and 286.

(6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors chaired by an appointee designated by the Governor ~~Chief Financial Officer or her or his designee,~~ and composed of 15 ~~12~~ other members. The Senate shall confirm the designated chair and other board appointees ~~selected~~ for 3-year terms of office as follows:

1. The Secretary of Health Care Administration, or his or her designee, as an ex officio member.

2. The State Surgeon General, or his or her designee, as an ex officio member ~~One member appointed by the Commissioner of Education from the Office of School Health Programs of the Florida Department of Education~~.

3. The Secretary of Children and Families, or his or her designee, as an ex officio member ~~One member appointed by the Chief Financial Officer from among three members nominated by the Florida Pediatric Society~~.

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

5. Two members ~~One member~~ appointed by the President of the Senate ~~Chief Financial Officer from among three members nominated by the Florida Hospital Association~~.

6. Two members ~~One member,~~ appointed by the Senate Minority Leader ~~Governor, who is an expert on child health policy~~.

7. Two members ~~One member,~~ appointed by the Speaker of the House of Representatives ~~Chief Financial Officer, from among~~

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~~three members nominated by the Florida Academy of Family Physicians~~.

8. Two members ~~One member,~~ appointed by the House Minority Leader ~~Governor, who represents the state Medicaid program~~.

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

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

~~11. The Secretary of Children and Family Services, or his or her designee.~~

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

(b) A member of the board of directors may be removed by the official who appointed that member. The board shall appoint an executive director, who is responsible for other staff authorized by the board.

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

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

(e) Board members who are serving on or before the date of enactment of this act or similar legislation may remain until July 1, 2013.

(f) An executive steering committee is created to provide management direction and support and to make recommendations to the board on the programs. The steering committee is composed of

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the Secretary of Health Care Administration, the Secretary of Children and Families, and the State Surgeon General. Committee members may not delegate their membership or attendance.

(7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

(a) The corporation shall not be deemed an insurer. The officers, directors, and employees of the corporation shall not be deemed to be agents of an insurer. Neither the corporation nor any officer, director, or employee of the corporation is subject to the licensing requirements of the insurance code or the rules of the Department of Financial Services or Office of Insurance Regulation. However, any marketing representative utilized and compensated by the corporation must be appointed as a representative of the insurers or health services providers with which the corporation contracts.

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

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

Section 14. Section 624.915, Florida Statutes, is repealed.

Section 15. Section 624.917, Florida Statutes, is created to read:

624.917 Healthy Florida program.—

(1) PROGRAM CREATION.—There is created Healthy Florida, a health care program for lower income, uninsured adults who meet the eligibility guidelines established under s. 624.91. The Florida Healthy Kids Corporation shall administer the program under its existing corporate governance and structure.

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

(a) "Actuarially equivalent" means:

1. The aggregate value of the benefits included in health benefits coverage is equal to the value of the benefits in the child benchmark benefit plan as defined in s. 409.811; and

2. The benefits included in health benefits coverage are substantially similar to the benefits included in the child benchmark benefit plan, except that preventive health services do not include dental services.

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

(c) "Applicant" means the individual who applies for determination of eligibility for health benefits coverage under this section.

(d) "Child" means any person younger than 19 years of age.

(e) "Child benchmark benefit plan" means the form and level of health benefits coverage established in s. 409.815.

(f) "Corporation" means the Florida Healthy Kids Corporation.

(g) "Enrollee" means an individual who has been determined eligible for and is receiving coverage under this section.

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

(i) "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.

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(j) "Healthy Florida" means the program created by this section which is administered by the Florida Healthy Kids Corporation.

(k) "Healthy Kids" means the Florida Kidcare program component created under s. 624.91 for children who are 5 through 18 years of age.

(l) "Household income" means the group or the individual whose income is considered in determining eligibility for the Healthy Florida program. The term "household" has the same meaning as provided in s. 36B(d)(2) of the Internal Revenue Code of 1986.

(m) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and ss. 409.901-409.920, as administered in this state by the agency.

(n) "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:

1. Consistent with the symptom, diagnosis, and treatment of the enrollee's condition;

2. Provided in accordance with generally accepted standards of medical practice;

3. Not primarily intended for the convenience of the enrollee, the enrollee's family, or the health care provider;

4. The most appropriate level of supply or service for the diagnosis and treatment of the enrollee's condition; and

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5. 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.

(o) "Modified adjusted gross income" means the individual or household's annual adjusted gross income as defined in s. 36B(d)(2) of the Internal Revenue Code of 1986 which is used to determine eligibility under the Florida Kidcare program.

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

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

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

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

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

(3) ELIGIBILITY.—To be eligible and remain eligible for the Healthy Florida program, an individual must be a resident of this state and meet the following additional criteria:

(a) Be identified as newly eligible, as defined in s. 1902(a)(10)(A)(i)(VIII) of the Social Security Act or s. 2001 of the federal Patient Protection and Affordable Care Act, and as may be further defined by federal regulation.

(b) Maintain eligibility with the corporation and meet all renewal requirements as established by the corporation.

(c) Renew eligibility on at least an annual basis.

(4) ENROLLMENT.—The corporation may begin the enrollment of applicants in the Healthy Florida program on October 1, 2013. Enrollment may occur directly, through the services of a third-party administrator, referrals from the Department of Children and Families, and the exchange as defined by the federal Patient Protection and Affordable Care Act. As an enrollee disenrolls, the corporation must also provide the enrollee with information about other insurance affordability programs and electronically refer the enrollee to the exchange or other programs, as appropriate. The earliest coverage effective date under the program shall be January 1, 2014.

(5) DELIVERY OF SERVICES.—The corporation shall contract with authorized insurers licensed under chapter 627; managed care organizations authorized under chapter 641; and provider service networks authorized under ss. 409.912(4)(d) and 409.962(13) which are prepaid plans. These insurers, managed care organizations, and provider service networks must meet standards established by the corporation to provide comprehensive health care services to enrollees who qualify for services under this section. The corporation may contract for such services on a statewide or regional basis. To encourage continuity of care among enrollees who may transition across multiple insurance affordability programs, the corporation is encouraged to contract with those insurers and managed care organizations that participate in more than one such program.

(a) The corporation shall establish access and network

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standards for such contracts and ensure that contracted providers have sufficient providers to meet enrollee needs. Quality standards must be developed by the corporation, specific to the adult population, which take into consideration recommendations from the National Committee on Quality Assurance, stakeholders, and other existing performance indicators from both public and commercial populations. The corporation and its contracted health plans shall develop policies that minimize the disruption of enrollee medical homes when enrollees transition between insurance affordability plans.

(b) The corporation shall provide an enrollee a choice of plans. The corporation may select a plan if no selection has been received before the coverage start date. Once enrolled, an enrollee has an initial 90-day free-look period before a lock-in period of not more than 12 months is applied. Exceptions to the lock-in period must be offered to an enrollee for reasons based upon good cause or qualifying events.

(c) The corporation may consider contracts that provide family plans that would allow members from multiple state and federally funded programs to remain together under the same plan.

(d) All contracts must meet the medical loss ratio requirements under s. 624.91.

(6) BENEFITS.—The corporation shall establish a benefits package that is actuarially equivalent to the benchmark benefit plan offered under s. 409.815(2), excluding dental, and meets the alternative benefits package requirements under s. 1937 of the Social Security Act. Benefits must be offered as an integrated, single package.

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(a) In addition to benchmark benefits, health reimbursement accounts or a comparable health savings account for each enrollee must be established through the corporation or the contracts managed by the corporation. Enrollees must be rewarded for healthy behaviors, wellness program adherence, and other activities established by the corporation which demonstrate compliance with preventive care or disease management guidelines. Funds deposited into these accounts may be used to pay cost-sharing obligations or to purchase over-the-counter health-related items to the extent allowed under federal law or regulation.

(b) Enhanced services may be offered if the cost of such additional services provides savings to the overall plan.

(c) The corporation shall establish a process for the payment of wrap-around services not covered by the benchmark benefit plan through a separate subcapitation process to its contracted providers if it is determined that such services are required by federal law. Such services would be covered when deemed medically necessary on an individual basis. The subcapitation pool is subject to a separate reconciliation process under the medical loss ratio provisions in s. 624.91.

(d) A prior authorization process and other utilization controls may be established by the plan for any benefit if approved by the corporation.

(7) COST SHARING.—The corporation may collect premiums and copayments from enrollees in accordance with federal law. Amounts to be collected for the Healthy Florida program must be established annually in the General Appropriations Act.

(a) Payment of a monthly premium may be required before the

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establishment of an enrollee's coverage start date and to retain monthly coverage.

(b) An enrollee who has a family income above the federal poverty level may be required to make nominal copayments, in accordance with federal rule, as a condition of receiving a health care service.

(c) A provider is responsible for the collection of point-of-service cost-sharing obligations. The enrollee's cost-sharing contribution is considered part of the provider's total reimbursement. Failure to collect an enrollee's cost sharing reduces the provider's share of the reimbursement.

(8) PROGRAM MANAGEMENT.—The corporation is responsible for the oversight of the Healthy Florida program. The agency shall seek a state plan amendment or other appropriate federal approval to implement the Healthy Florida program. The agency shall consult with the corporation in the amendment's development and submit by June 14, 2013, the state plan amendment to the federal Department of Health and Human Services. The agency shall contract with the corporation for the administration of the Healthy Florida program and for the timely release of federal and state funds. The agency retains its authorities as provided in ss. 409.902 and 409.963.

(a) The corporation shall establish a process by which grievances can be resolved and Healthy Florida recipients can be informed of their rights under the Medicaid Fair Hearing Process, as appropriate, or any alternative resolution process adopted by the corporation.

(b) The corporation shall establish a program integrity process to ensure compliance with program guidelines. At a

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minimum, the corporation shall withhold benefits from an applicant or enrollee if the corporation obtains evidence that the applicant or enrollee is no longer eligible, submitted incorrect or fraudulent information in order to establish eligibility, or failed to provide verification of eligibility. The corporation shall notify the applicant or enrollee that, because of such evidence, program benefits must be withheld unless the applicant or enrollee contacts a designated representative of the corporation by a specified date, which must be within 10 working days after the date of notice, to discuss and resolve the matter. The corporation shall make every effort to resolve the matter within a timeframe that will not cause benefits to be withheld from an eligible enrollee. The following individuals may be subject to specific prosecution in accordance with s. 414.39:

1. An applicant who obtains or attempts to obtain benefits for a potential enrollee under the Healthy Florida program when the applicant knows or should have known that the potential enrollee does not qualify for the Healthy Florida program.

2. An individual who assists an applicant in obtaining or attempting to obtain benefits for a potential enrollee under the Healthy Florida program when the individual knows or should have known that the potential enrollee does not qualify for the Healthy Florida program.

(9) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The provisions of ss. 409.902, 409.9128, and 409.920 apply to the administration of the Healthy Florida program.

(10) PROGRAM EVALUATION.—The corporation shall collect both eligibility and enrollment data from program applicants and

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enrollees as well as encounter and utilization data from all contracted entities during the program term. The corporation shall submit monthly enrollment reports to the President of the Senate, the Speaker of the House of Representative, and the Minority Leaders of the Senate and the House of Representatives. The corporation shall submit an interim independent evaluation of the Healthy Florida program to the presiding officers no later than July 1, 2015, with annual evaluations due July 1 each year thereafter. The evaluations must address, at a minimum, application and enrollment trends and issues, utilization and cost data, and customer satisfaction.

(11) PROGRAM EXPIRATION.—The Healthy Florida program shall expire at the end of the state fiscal year in which any of these conditions occur, whichever occurs first:

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

(b) The federal match contribution falls below the increased FMAP for medical assistance for newly eligible mandatory individuals as specified in the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

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

Section 16. The Florida Healthy Kids Corporation may make changes to comply with the objections of the federal Department of Health and Human Services to gain approval of the Healthy

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Florida program in compliance with the federal Patient Protection and Affordable Care Act, upon giving notice to the Senate and the House of Representatives of the proposed changes. If there is a conflict between a provision in this section and the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, the provision must be interpreted and applied so as to comply with the requirement of the federal law.

Section 17. Section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.—

(1) A health insurer may ~~shall~~ not require a contracted health care practitioner as defined in s. 456.001(4) to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or health maintenance organization, under common management and control with the insurer, including Medicare and Medicaid practitioner contracts and those authorized by s. 627.6471, s. 627.6472, s. 636.035, or s. 641.315, except for a practitioner in a group practice as defined in s. 456.053 who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this section is void. A violation of this subsection ~~section~~ is not subject to the criminal penalty specified in s. 624.15.

(2)(a) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not contain any provision that requires the dentist

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to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract.

(b) Covered services are those services that are listed as a benefit that the insured is entitled to receive under the contract. An insurer may not provide merely de minimis reimbursement or coverage in order to avoid the requirements of this section. Fees for covered services shall be set in good faith and must not be nominal.

(c) A health insurer may not require as a condition of the contract that the dentist participate in a discount medical plan under part II of chapter 636.

Section 18. Subsection (13) is added to section 636.035, Florida Statutes, to read:

636.035 Provider arrangements.—

(13)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the prepaid limited health service organization may not contain any provision that requires the dentist to provide services to the subscriber of the prepaid limited health service organization at a fee set by the prepaid limited health service organization unless such services are covered services under the applicable contract.

(b) Covered services are those services that are listed as a benefit that the subscriber is entitled to receive under the contract. A prepaid limited health service organization may not provide merely de minimis reimbursement or coverage in order to avoid the requirements of this section. Fees for covered services shall be set in good faith and must not be nominal.

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(c) A prepaid limited health service organization may not require as a condition of the contract that the dentist participate in a discount medical plan under part II of this chapter.

Section 19. Subsection (11) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.—

(11)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not contain any provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract.

(b) Covered services are those services that are listed as a benefit that the subscriber is entitled to receive under the contract. A health maintenance organization may not provide merely de minimis reimbursement or coverage in order to avoid the requirements of this section. Fees for covered services shall be set in good faith and must not be nominal.

(c) A health maintenance organization may not require as a condition of the contract that the dentist participate in a discount medical plan under part II of chapter 636.

Section 20. Paragraph (a) of subsection (3) of section 766.1115, Florida Statutes, is amended, and paragraph (h) is added to subsection (4) of that section, to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

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

(a) "Contract" means an agreement executed in compliance with this section between a health care provider and a governmental contractor which allows~~. This contract shall allow~~ the health care provider to deliver health care services to low-income recipients as an agent of the governmental contractor. The contract must be for volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services under this section, the health care provider must receive no compensation from the governmental contractor for ~~any~~ services provided under the contract and must not bill or accept compensation from the recipient, or a ~~any~~ public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract.

(4) CONTRACT REQUIREMENTS.—A health care provider that executes a contract with a governmental contractor to deliver health care services on or after April 17, 1992, as an agent of the governmental contractor is an agent for purposes of s. 768.28(9), while acting within the scope of duties under the contract, if the contract complies with the requirements of this section and regardless of whether the individual treated is later found to be ineligible. A health care provider under contract with the state may not be named as a defendant in any action arising out of medical care or treatment provided on or after April 17, 1992, under contracts entered into under this section. The contract must provide that:

(h) As an agent of the governmental contractor for purposes of s. 768.28(9), while acting within the scope of duties under the contract, a health care provider licensed under chapter 466

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may allow a patient or a parent or guardian of the patient to voluntarily contribute a fee to cover costs of dental laboratory work related to the services provided to the patient. This contribution may not exceed the actual cost of the dental laboratory charges and is deemed in compliance with this section.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

Section 21. The amendments to ss. 627.6474, 636.035, and 641.315, Florida Statutes, apply to contracts entered into or renewed on or after July 1, 2013.

Section 22. (1) The sum of $1,258,054,808 from the Medical Care Trust Fund is appropriated to the Agency for Health Care Administration beginning in the 2013-2014 fiscal year to provide coverage for individuals who enroll in the Healthy Florida program.

(2) The sum of $254,151 from the General Revenue Fund and $18,235,833 from the Medical Care Trust Fund is appropriated to the Agency for Health Care Administration 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 section 9010 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

(3) The sum of $10,676,377 from the General Revenue Fund

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and $10,676,377 from the Medical Care Trust Fund is appropriated beginning in the 2013-2014 fiscal year to the Agency for Health Care Administration to contract with the Florida Healthy Kids Corporation under s. 409.818(2)(f), Florida Statutes, to fund administrative costs necessary for implementing and operating the Healthy Florida program.

(4) The Agency for Health Care Administration may submit budget amendments to the Legislative Budget Commission pursuant to chapter 216, Florida Statutes, to fund the Healthy Florida program for the coverage of children who transfer from the Florida Kidcare Program to the Healthy Florida program, or to provide additional spending authority from the Medical Care Trust Fund under subsection (1) for the coverage of individuals who enroll in the Healthy Florida program, during the 2013-2014 fiscal year.

Section 23. This act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health care; amending s. 409.811, F.S.; revising and providing definitions; amending s. 409.813, F.S.; revising the components of the Florida Kidcare program; prohibiting a cause of action from arising against the Florida Healthy Kids Corporation for failure to make health services available; amending s. 409.8132, F.S.; revising the eligibility

of the Medikids program component; revising the enrollment requirements of the Medikids program component; amending s. 409.8134, F.S.; conforming provisions to changes made by the act; amending s. 409.814, F.S.; revising eligibility requirements for the Florida Kidcare program; amending s. 409.815, F.S.; revising the minimum health benefits coverage under the Florida Kidcare Act; deleting obsolete provisions; amending ss. 409.816 and 409.8177, F.S.; conforming provisions to changes made by the act; repealing s. 409.817, F.S., relating to the approval of health benefits coverage and financial assistance; repealing s. 409.8175, F.S., relating to delivery of services in rural counties; amending s. 409.818, F.S.; revising the duties of the Department of Children and Families and the Agency for Health Care Administration with regard to the Florida Kidcare Act; deleting the duties of the Department of Health and the Office of Insurance Regulation with regard to the Florida Kidcare Act; amending s. 409.820, F.S.; requiring the Department of Health, in consultation with the agency and the Florida Healthy Kids Corporation, to develop a minimum set of pediatric and adolescent quality assurance and access standards for all program components; amending s. 624.91, F.S.; revising the legislative intent of the Florida Healthy Kids Corporation Act to include the Healthy Florida program; revising participation guidelines for nonsubsidized enrollees in the Healthy Florida

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program; revising the medical loss ratio requirements for the contracts for the Florida Healthy Kids Corporation; modifying the membership of the Florida Healthy Kids Corporation's board of directors; creating an executive steering committee; requiring additional corporate compliance requirements for the Florida Healthy Kids Corporation; repealing s. 624.915, F.S., relating to the operating fund of the Florida Healthy Kids Corporation; creating s. 624.917, F.S.; creating the Healthy Florida program; providing definitions; providing eligibility and enrollment requirements; authorizing the Florida Healthy Kids Corporation to contract with certain insurers, managed care organizations, and provider service networks; encouraging the corporation to contract with insurers and managed care organizations that participate in more than one insurance affordability program under certain circumstances; requiring the corporation to establish a benefits package and a process for payment of services; authorizing the corporation to collect premiums and copayments; requiring the corporation to oversee the Healthy Florida program and to establish a grievance process and integrity process; providing applicability of certain state laws for administration of the Healthy Florida program; requiring the corporation to collect certain data and to submit enrollment reports and interim independent evaluations to the Legislature; providing for expiration of the program; providing an implementation and

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interpretation clause; amending s. 627.6474, F.S.; prohibiting a contract between a health insurer and a dentist from requiring the dentist to provide services at a fee set by the insurer under certain circumstances; providing that covered services are those services listed as a benefit that the insured is entitled to receive under a contract; prohibiting an insurer from providing merely de minimis reimbursement or coverage; requiring that fees for covered services be set in good faith and not be nominal; prohibiting a health insurer from requiring as a condition of a contract that a dentist participate in a discount medical plan; amending s. 636.035, F.S.; prohibiting a contract between a prepaid limited health service organization and a dentist from requiring the dentist to provide services at a fee set by the organization under certain circumstances; providing that covered services are those services listed as a benefit that a subscriber of a prepaid limited health service organization is entitled to receive under a contract; prohibiting a prepaid limited health service organization from providing merely de minimis reimbursement or coverage; requiring that fees for covered services be set in good faith and not be nominal; prohibiting the prepaid limited health service organization from requiring as a condition of a contract that a dentist participate in a discount medical plan; amending s. 641.315, F.S.; prohibiting a contract between a health maintenance organization and

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a dentist from requiring the dentist to provide services at a fee set by the organization under certain circumstances; providing that covered services are those services listed as a benefit that a subscriber of a health maintenance organization is entitled to receive under a contract; prohibiting a health maintenance organization from providing merely de minimis reimbursement or coverage; requiring that fees for covered services be set in good faith and not be nominal; prohibiting the health maintenance organization from requiring as a condition of a contract that a dentist participate in a discount medical plan; amending s. 766.1115, F.S.; revising a definition; requiring a contract with a governmental contractor for health care services to include a provision for a health care provider licensed under ch. 466, F.S., as an agent of the governmental contractor, to allow a patient or a parent or guardian of the patient to voluntarily contribute a fee to cover costs of dental laboratory work related to the services provided to the patient without forfeiting sovereign immunity; prohibiting the contribution from exceeding the actual amount of the dental laboratory charges; providing that the contribution complies with the requirements of s. 766.1115, F.S.; providing for applicability; providing appropriations; providing an effective date.