By the Committee on Appropriations

576-02872-15 20152512__

A bill to be entitled

An act relating to Medicaid; amending s. 395.602, F.S.; revising the term "rural hospital"; amending s. 409.908, F.S.; deleting provisions that authorized the agency to receive funds from certain state entities, local governments, and other political subdivisions for a specific purpose; providing that the Agency for Health Care Administration is authorized to receive intergovernmental transfers of funds from governmental entities for specified purposes; requiring the agency to seek Medicaid waiver authority for the use of local intergovernmental transfers under certain parameters; revising the list of provider types that are subject to certain statutory provisions relating to the establishment of rates; amending s. 409.909, F.S.; revising definitions; altering the annual allocation cap for hospitals participating in the Statewide Medicaid Residency Program; creating the Graduate Medical Education Startup Bonus Program; providing allocations for the program; amending s. 409.911, F.S.; updating references to data used for calculating disproportionate share program payments to certain hospitals for the 2015-2016 fiscal year; repealing s. 409.97, F.S, relating to state and local Medicaid partnerships; amending s. 409.983, F.S.; providing parameters for the reconciliation of managed care plan payments in the long-term care managed care program; amending s. 408.07, F.S.; conforming a cross-reference; creating s. 409.720, F.S.; providing a

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

duties for the corporation to perform; requiring an annual report to the Governor and the Legislature; amending s. 409.904, F.S.; establishing a date when new enrollment in the Medically Needy program is suspended; providing an expiration date for the program; amending s. 624.91, F.S.; revising eligibility requirements for state-funded assistance; revising the duties and powers of the Florida Healthy Kids Corporation; revising provisions for the appointment of members of the board of the Florida Healthy Kids Corporation; requiring transition plans; repealing s. 624.915, F.S., relating to the operating fund of the Florida Healthy Kids Corporation; providing effective dates.

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

Section 1. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

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

(e) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under

normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;

~~4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92 which has up to 340 licensed beds;~~

4.~~5.~~ A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the agency; or

5.~~6.~~ A hospital designated as a critical access hospital, as defined in s. 408.07.

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021 ~~2015~~, if the hospital continues to have up to 100 licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during

the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2021 ~~2015~~, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 2. Effective upon this act becoming a law, subsection (1) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent

or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided in s. 409.905(5), except as otherwise provided in this subsection.

1. If authorized by the General Appropriations Act, the agency may modify reimbursement for specific types of services or diagnoses, recipient ages, and hospital provider types.

2. The agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for:

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency has established a global fee.

d. Recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62.

3. The agency shall modify reimbursement according to other methodologies recognized in the General Appropriations Act.

~~The agency may receive funds from state entities, including, but~~

~~not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under this paragraph, paragraph (b), or the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature annually by January 1.~~

(b) Reimbursement for hospital outpatient care is limited to $1,500 per state fiscal year per recipient, except for:

1. Such care provided to a Medicaid recipient under age 21,

in which case the only limitation is medical necessity.

2. Renal dialysis services.

3. Other exceptions made by the agency.

~~The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, the Board of Governors of the State University System, local governments, and other local political subdivisions, for the purpose of making payments, including federal matching funds, through the Medicaid outpatient reimbursement methodologies. Funds received from state entities and local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.~~

(c)1. The agency may receive intergovernmental transfers of funds from governmental entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments or to enhance provider reimbursement, including federal matching funds, through the Medicaid inpatient or outpatient reimbursement methodologies. Funds received by intergovernmental transfer for these purposes shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local intergovernmental transfers used as state match under Title XIX of the Social Security Act to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local intergovernmental transfers, a local governmental entity

must submit a final, executed letter of agreement to the agency which must be received by October 1 of each fiscal year and provide the total amount of intergovernmental transfers authorized by the entity for that fiscal year under this paragraph or the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified.

2. The agency shall seek Medicaid waiver authority to use local intergovernmental transfers for the advancement of the Medicaid program and for enhancing or supplementing provider reimbursement under this part and part IV in ways that incent donations of local intergovernmental transfers and prevent providers from being penalized in the calculations of Medicaid cost limits by virtue of having donated intergovernmental transfers under waiver authority granted under this paragraph. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature annually by January 1.

(d) ~~(c)~~ Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the General Appropriations Act. The computation of these payments must be made in compliance with all federal regulations and the

methodologies described in ss. 409.911 and 409.9113.

(e) ~~(d)~~ The agency is authorized to limit inflationary increases for outpatient hospital services as directed by the General Appropriations Act.

Section 3. Paragraph (c) of subsection (23) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates,

lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(23)

(c) This subsection applies to the following provider types:

1. Inpatient hospitals.

2. Outpatient hospitals.

3. Nursing homes.

4. County health departments.

~~5. Community intermediate care facilities for the developmentally disabled.~~

5.~~6.~~ Prepaid health plans.

Section 4. Section 409.909, Florida Statutes, is amended to read:

409.909 Statewide Medicaid Residency Program.—

(1) The Statewide Medicaid Residency Program is established to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide. The agency shall make payments to hospitals licensed under part I of chapter 395 for graduate medical education associated with the Medicaid program. This system of payments is designed to generate federal matching funds under Medicaid and distribute the resulting funds to participating hospitals on a quarterly basis in each fiscal year for which an appropriation is made.

(2) On or before September 15 of each year, the agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals. On or before the final business day of each quarter of a state fiscal year, the agency shall distribute to each participating hospital one-fourth of that hospital's annual allocation calculated under subsection (4). The allocation fraction for each participating hospital is based on the hospital's number of full-time equivalent residents and the amount of its Medicaid payments. As used in this section, the term:

(a) "Full-time equivalent," or "FTE," means a resident who is in his or her residency period, with the initial residency period~~, which is~~ defined as the minimum number of years of training required before the resident may become eligible for board certification by the American Osteopathic Association Bureau of Osteopathic Specialists or the American Board of Medical Specialties in the specialty in which he or she first began training, not to exceed 5 years. The residency specialty is defined as reported using the current resident code in the Intern and Resident Information System (IRIS), required by Medicare. A resident training beyond the initial residency period is counted as 0.5 FTE, unless his or her chosen specialty is in ~~general surgery or~~ primary care, in which case the resident is counted as 1.0 FTE. For the purposes of this section, primary care specialties include:

1. Family medicine;

2. General internal medicine;

3. General pediatrics;

4. Preventive medicine;

5. Geriatric medicine;

6. Osteopathic general practice;

7. Obstetrics and gynecology; ~~and~~

8. Emergency medicine; and

9. General surgery.

(b) "Medicaid payments" means the estimated total payments for reimbursing a hospital for direct inpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and the parameters for the inpatient diagnosis-related group base rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency.

(c) "Resident" means a medical intern, fellow, or resident enrolled in a program accredited by the Accreditation Council for Graduate Medical Education, the American Association of Colleges of Osteopathic Medicine, or the American Osteopathic Association at the beginning of the state fiscal year during which the allocation fraction is calculated, as reported by the hospital to the agency.

(3) The agency shall use the following formula to calculate a participating hospital's allocation fraction:

$$HAF=[0.9 \times (HFTE/TFTE)] + [0.1 \times (HMP/TMP)]$$

Where:

HAF=A hospital's allocation fraction.

HFTE=A hospital's total number of FTE residents.

TFTE=The total FTE residents for all participating hospitals.

HMP=A hospital's Medicaid payments.

TMP=The total Medicaid payments for all participating hospitals.

(4) A hospital's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's allocation fraction. If the calculation results in an annual allocation that exceeds 2 times the average ~~$50,000~~ per FTE resident amount for all hospitals, the hospital's annual allocation shall be reduced to a sum equaling no more than 2 times the average ~~$50,000~~ per FTE resident. The funds calculated for that hospital in excess of 2 times the average ~~$50,000~~ per FTE resident amount for all hospitals shall be redistributed to participating hospitals whose annual allocation does not exceed 2 times the average ~~$50,000~~ per FTE resident amount for all hospitals, using the same methodology and payment schedule specified in this section.

(5) Graduate Medical Education Startup Bonus Program—Hospitals eligible for participation in subsection (1) are eligible to participate in the graduate medical education startup bonus program established under this subsection. Notwithstanding subsection (4) or an FTE's residency period, and in any state fiscal year in which funds are appropriated for the startup bonus program, the agency shall allocate a $100,000 startup bonus for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a

physician specialty in statewide supply/demand deficit. In any year in which funding is not sufficient to provide $100,000 for each newly created resident position, funding shall be reduced pro rata across all newly created resident positions in physician specialties in statewide supply/demand deficit.

(a) Hospitals applying for a startup bonus must submit to the agency by March 1 their Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval validating the new resident positions approved in physician specialties in statewide supply/demand deficit in the current fiscal year. An applicant hospital may validate a change in the number of residents by comparing the prior period Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval to the current year.

(b) Any unobligated startup bonus funds on April 15 of each fiscal year shall be proportionally allocated to hospitals participating under subsection (3) for existing FTE residents in the physician specialties in statewide supply/demand deficit. This nonrecurring allocation shall be in addition to the funds allocated in subsection (4). Notwithstanding subsection (4), the allocation under this subsection shall not exceed $100,000 per FTE resident.

(c) For purposes of this subsection, physician specialties and subspecialties, both adult and pediatric, in statewide supply/demand deficit are those identified in the General Appropriations Act.

(d) The agency shall distribute all funds authorized under the Graduate Medical Education Startup Bonus program on or

before the final business day of the fourth quarter of a state fiscal year.

(6)~~(5)~~ Beginning in the 2015-2016 state fiscal year, the agency shall reconcile each participating hospital's total number of FTE residents calculated for the state fiscal year 2 years prior with its most recently available Medicare cost reports covering the same time period. Reconciled FTE counts shall be prorated according to the portion of the state fiscal year covered by a Medicare cost report. Using the same definitions, methodology, and payment schedule specified in this section, the reconciliation shall apply any differences in annual allocations calculated under subsection (4) to the current year's annual allocations.

(7)~~(6)~~ The agency may adopt rules to administer this section.

Section 5. Paragraph (a) of subsection (2) of section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and

charity care to be used in calculating the disproportionate share payment:

(a) The average of the ~~2005, 2006, and~~ 2007, 2008, and 2009 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2015-2016 ~~2014-2015~~ state fiscal year.

Section 6. Section 409.97, Florida Statutes, is repealed.

Section 7. Subsection (6) of section 409.983, Florida Statutes, is amended to read:

409.983 Long-term care managed care plan payment.—In addition to the payment provisions of s. 409.968, the agency shall provide payment to plans in the long-term care managed care program pursuant to this section.

(6) The agency shall establish nursing-facility-specific payment rates for each licensed nursing home based on facility costs adjusted for inflation and other factors as authorized in the General Appropriations Act. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to nursing facilities resulting from changes in nursing home per diem rates but may not be reconciled to actual days experienced by the long-term care managed care plans.

Section 8. Subsection (43) of section 408.07, Florida Statutes, is amended to read:

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(43) "Rural hospital" means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:

(a) The sole provider within a county with a population

density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county;

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

(e) A critical access hospital.

Population densities used in this subsection must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room~~, or meets the criteria of s. 395.602(2)(e)4~~. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this subsection shall be granted such designation upon

application, including supporting documentation, to the Agency for Health Care Administration.

Section 9. Effective upon this act becoming a law, the Division of Law Revision and Information is directed to rename part II of chapter 409, Florida Statutes, as "Insurance Affordability Programs" and to incorporate ss. 409.720-409.731, Florida Statutes, under this part.

Section 10. Effective upon this act becoming a law, section 409.720, Florida Statutes, is created to read:

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

Section 11. Effective upon this act becoming a law, section 409.721, Florida Statutes, is created to read:

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

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

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

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

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

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

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

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

Section 12. Effective upon this act becoming a law, section 409.722, Florida Statutes, is created to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) "Premium credit" means the monthly amount paid by the agency per enrollee in the Florida Health Insurance

Affordability Exchange Program toward health benefits coverage.

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

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

Section 13. Effective upon this act becoming a law, section 409.723, Florida Statutes, is created to read:

409.723 Participation.—

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

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

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

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

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

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

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

(c) The department shall review a participant's eligibility

every 12 months.

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

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

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

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

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

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

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

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

(a) Complete an initial application for health benefits coverage and an annual renewal process;

(b) Annually provide evidence of participation in one of the following activities at the levels required under paragraph (c):

1. Proof of employment.

2. On-the-job training or job placement activities.

3. Pursuit of educational opportunities.

(c) Engage in the activities required under paragraph (b) at the following minimum levels:

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

2. For a childless adult, a minimum of 30 hours weekly.

A participant who is a disabled adult or a caregiver of a disabled child or adult may submit a request for an exception to these requirements to the corporation and, thereafter, shall annually submit to the department a request to renew the exception to the hourly level requirements.

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

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

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

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

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

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

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

(h) Timely make monthly premium and any other cost-sharing payments.

(i) Meet minimum coverage requirements by selecting a high-

deductible health plan combined with a health savings or health reimbursement account if not selecting a plan offering more extensive coverage.

(5) COST SHARING.—

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

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

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

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

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

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

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

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

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

(e) If, after a 30-day grace period, a full premium payment has not been received, the enrollee shall be transitioned from

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

Section 14. Effective upon this act becoming a law, section 409.724, Florida Statutes, is created to read:

409.724 Available assistance.—

(1) PREMIUM CREDITS.—

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

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

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

(d) Enrollee contributions.—The enrollee may make deposits to his or her account at any time to supplement the premium

credit, to purchase additional FHIX products, or to offset other cost-sharing obligations.

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

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

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

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

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

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

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

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

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

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

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

Section 15. Effective upon this act becoming a law, section 409.725, Florida Statutes, is created to read:

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

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

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

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

(4) Employer-sponsored plans.

Section 16. Effective upon this act becoming a law, section 409.726, Florida Statutes, is created to read:

409.726 Program accountability.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Enrollment and application trends and issues.

(b) Utilization and cost data.

(c) Customer satisfaction.

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

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

(f) Types of products and plans purchased.

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

(h) Recommendations for program improvement.

Section 17. Effective upon this act becoming a law, section 409.727, Florida Statutes, is created to read:

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

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

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

(b) Plan availability and presence of plan choice.

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

(d) Availability of customer support.

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

(2) PHASE ONE.—

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

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

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

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

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

(3) PHASE TWO.—

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

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

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

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

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

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

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

(4) PHASE THREE.—

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

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

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

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

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

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

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

Section 18. Effective upon this act becoming a law, section

409.728, Florida Statutes, is created to read:

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

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

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

(b) Administer Phase One of FHIX.

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

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

(e) Timely transmit enrollee information to the corporation.

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

(g) Transfer to the corporation such funds as approved in

the General Appropriations Act for the premium credits.

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

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

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

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

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

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

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

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

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

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

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

(c) Offer health benefits coverage packages on the FHIX

marketplace, including plans compliant with the Affordable Care Act.

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

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

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

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

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

(i) Encourage insurance agents licensed under chapter 626 to identify and assist enrollees. This act does not prohibit these agents from receiving usual and customary commissions from insurers and health maintenance organizations that offer plans in the FHIX marketplace.

Section 19. Effective upon this act becoming a law, section 409.729, Florida Statutes, is created to read:

409.729 Long-term reorganization.—The FHIX Workgroup is created to facilitate the implementation of FHIX and to plan for a multiyear reorganization of the state's insurance affordability programs. The FHIX Workgroup consists of two representatives each from the agency, the department, the Florida Healthy Kids Corporation, and the corporation. An

additional representative of the agency serves as chair. The FHIX Workgroup must hold its organizational meeting no later than 30 days after the effective date of this act and must meet at least bimonthly. The role of the FHIX Workgroup is to make recommendations to the agency. The responsibilities of the workgroup include, but are not limited to:

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

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

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

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

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

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

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

(8) Determine staff requirements for Phase Three.

(9) Develop and present a final transition plan that

incorporates all elements under this section no later than December 1, 2015, in a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 20. Effective upon this act becoming a law, section 409.730, Florida Statutes, is created to read:

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

Section 21. Effective upon this act becoming a law, section 409.731, Florida Statutes, is created to read:

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

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

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

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

Section 22. Effective upon this act becoming a law, section 408.70, Florida Statutes, is repealed.

Section 23. Effective upon this act becoming a law, section 408.910, Florida Statutes, is amended to read:

408.910 Florida Health Choices Program.—

(1) LEGISLATIVE INTENT.—The Legislature finds that a

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

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

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

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

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

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

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

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

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

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

(c) "Florida Health Insurance Affordability Exchange Program" or "FHIX" is the program created under ss. 409.720-

409.731 for low-income, uninsured residents of this state.

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

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

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

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

(3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health Choices Program is created as a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care. These products include, but are not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. The components of the program include:

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

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

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

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

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

4. Services that promote healthy behaviors.

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

6. Consumer assistance and enrollment services for the Florida Health Insurance Affordability Exchange Program, or FHIX.

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

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

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

(g) Information services for individuals and employers.

(h) Program evaluation.

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

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

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

1. Individual employees of enrolled employers.

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

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

1. Submission of required information.

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

has a premium payment and flexible spending arrangements.

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

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

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

6. Identification of eligible employees.

7. Arrangement for periodic payments.

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

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

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

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

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

4. Prepaid health clinic service providers licensed under

part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

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

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

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

A vendor described in subparagraphs 3.-7. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation and is authorized to provide coverage in the relevant geographic area. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

(e) Eligible individuals may participate in the program voluntarily. Individuals who join the program may participate by

complying with the procedures established by the corporation. These procedures must include, but are not limited to:

1. Submission of required information.

2. Authorization for payroll deduction, if applicable.

3. Compliance with federal tax requirements.

4. Arrangements for payment.

5. Selection of products and services.

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

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

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

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

4. Establishment of product prices based on applicable criteria.

5. Arrangements for receiving payment for enrolled participants.

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

7. Compliance with grievance procedures established by the corporation.

(g) Health insurance agents licensed under part IV of

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

1. Completion of training requirements.

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

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

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

(5) PRODUCTS.—

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

1. Health insurance policies.

2. Health maintenance contracts.

3. Limited benefit plans.

4. Prepaid clinic services.

5. Service contracts.

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

7. Flexible spending accounts.

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

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

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

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

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

(7) THE MARKETPLACE PROCESS.—The program shall provide a single, centralized market for purchase of health insurance, health maintenance contracts, and other health products and

services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive Internet website.

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

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

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

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

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

5.~~(e)~~ The limits established in subparagraphs 2., 3., and 4. ~~paragraphs (b)-(d)~~ apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of

flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(b) FHIX marketplace purchasing.—

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

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

(8) CONSUMER INFORMATION.—The corporation shall:

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

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

(9) RISK POOLING.—The program may use methods for pooling the risk of individual participants and preventing selection bias. These methods may include, but are not limited to, a postenrollment risk adjustment of the premium payments to the vendors. The corporation may establish a methodology for assessing the risk of enrolled individual participants based on data reported annually by the vendors about their enrollees. Distribution of payments to the vendors may be adjusted based on the assessed relative risk profile of the enrollees in each

risk-bearing product for the most recent period for which data is available.

(10) EXEMPTIONS.—

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

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

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

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

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

1. Three ex officio, nonvoting members to include:

a. The Secretary of Health Care Administration or a

designee with expertise in health care services.

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

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

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

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

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

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

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

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

(d) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061. No other compensation is authorized.

(e) There is no liability on the part of, and no cause of action shall arise against, any member of the board or its employees or agents for any action taken by them in the

performance of their powers and duties under this section.

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

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

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

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

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

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

regulation, and insurers.

(i) The corporation shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—

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

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

2. "Enrollee" means an employer who is eligible to enroll

in the program pursuant to paragraph (4)(a).

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

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

a. Business plans.

b. Internal auditing controls and reports of internal auditors.

c. Reports of external auditors for privately held companies.

d. Client and customer lists.

e. Potentially patentable material.

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

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

(b) *Public record exemptions.*—

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

2. Client and customer lists of a buyer's representative

held by the corporation are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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

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

(d) *Authorized release.*—

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

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

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

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

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

(e) *Penalty.*—A person who knowingly and willfully violates this subsection commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

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

Section 24. Effective upon this act becoming a law, subsection (2) of section 409.904, Florida Statutes, is amended to read:

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

(2) A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled. Effective October 1, 2015, persons eligible under "medically needy" shall be limited to children under the age of 21 and pregnant women. This subsection expires October 1, 2019.

Section 25. Effective upon this act becoming a law, section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

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

(2) LEGISLATIVE INTENT.—

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

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

(3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only <u>residents of this state are eligible</u> ~~the following individuals are eligible~~ for state-funded assistance in paying Florida Healthy

Kids premiums pursuant to s. 409.814.~~÷~~

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

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

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

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

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

(b) The Florida Healthy Kids Corporation shall:

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

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

3. ~~Subject to the provisions of s. 409.8134, accept~~

~~voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional Florida Kidcare coverage in contributing counties under Title XXI.~~

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

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

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

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

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

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

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

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

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

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

d. Effective July 1, 2016, health and dental services contracts of the corporation must transition to the FHIX

marketplace under s. 409.722. Qualifying plans may enroll as vendors with the FHIX marketplace to maintain continuity of care for participants.

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

11.~~12.~~ Develop and implement a plan to publicize the Florida Kidcare program, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.

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

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

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

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

b. The costs and utilization by service of the full-pay

enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population.

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

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

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

a. Administrative functions.

b. Contracting with vendors.

c. Customer service.

d. Enrollee education.

e. Financial services.

f. Program integrity.

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

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

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

(6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

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

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

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

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

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

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

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

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

~~8. One member, appointed by the Governor, who represents~~

~~the state Medicaid program.~~

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

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

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

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

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

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

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

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

(7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

(a) The corporation shall not be deemed an insurer. The officers, directors, and employees of the corporation shall not be deemed to be agents of an insurer. Neither the corporation nor any officer, director, or employee of the corporation is subject to the licensing requirements of the insurance code or

the rules of the Department of Financial Services. However, any marketing representative utilized and compensated by the corporation must be appointed as a representative of the insurers or health services providers with which the corporation contracts.

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

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

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

Section 26. Effective upon this act becoming a law, section 624.915, Florida Statutes, is repealed.

Section 27. Effective upon this act becoming a law, the Division of Law Revision and Information is directed to replace the phrase "the effective date of this act" wherever it occurs in this act with the date the act becomes a law.

Section 28. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2015.