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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/17/2015	.	
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Appropriations Subcommittee on Health and Human Services (Sobel) recommended the following:

Senate Amendment (with title amendment)

Delete lines 92 - 1410

and insert:

(3) "Corporation" means the Florida Healthy Kids Corporation, as established under s. 624.91.

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

(5) "FHIX marketplace" or "marketplace" means the single,

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

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

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

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

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

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

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

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

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

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

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

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

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

409.723 Participation.—

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

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

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

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

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

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determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) COST SHARING.—

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

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

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

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

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

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

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

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

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

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

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

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

409.724 Available assistance.—

(1) PREMIUM CREDITS.—

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

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

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

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

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

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

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

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

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

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

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

(d) Information about health benefits coverage, provider

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

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

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

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

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

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

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

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

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

(3) Authorized products under the corporation pursuant to s. 624.91.

(4) Employer-sponsored plans.

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

409.726 Program accountability.—

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

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

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

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

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

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

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(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 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 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.

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

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

(f) Types of products and plans purchased.

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

(h) Recommendations for program improvement.

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

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

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

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

(b) Plan availability and presence of plan choice.

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

(d) Availability of customer support.

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

(2) PHASE I.—

(a) Phase I begins on July 1, 2015. The agency, the

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corporation, and Florida Health Choices, Inc., 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 II.—

(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 I 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


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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 III.—

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

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

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

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

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

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

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

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

409.728 Program operation and management.—In order to

implement ss. 409.720-409.731:

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

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

(b) Administer Phase One of FHIX.

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

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

(e) Timely transmit enrollee information to the corporation.

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

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

(h) Encourage Medicaid managed care plans to apply as


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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 Florida Health Choices, Inc., 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 corporation shall do all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(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 Florida Health Choices, Inc., currently and under FHIX's proposed Phase Three program.

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

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

(8) Determine staff requirements for Phase Three.

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

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

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

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

409.731 Program expiration.—The Florida Health Insurance

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Affordability Exchange Program expires at the end of Phase One if the state does not receive federal approval for Phase Two or at the end of the state fiscal year in which any of these conditions occurs:

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

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

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

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

Section 15. 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~~

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~~these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.~~

Section 16. 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 the health of adults and reduce the incidence and costs of childhood and adult illness and disabilities ~~among children~~ in this state. Many children and adults 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 and adults. 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 and adults eligible for medical assistance under Title XXI of the Social Security Act. Although the corporation may serve other children and adults, the Legislature intends the primary recipients of services provided through the


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corporation be school-age children and adults 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 and adults not eligible for federal matching funds under Title XXI.

(3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only residents of this state are eligible ~~the following individuals are eligible~~ for state-funded assistance in paying Florida Healthy Kids premiums pursuant to s. 409.814.~~:~~

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

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

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

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

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

(b) The Florida Healthy Kids Corporation shall:

1. Arrange for the collection of any individual, family,

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~~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 and adults 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~~

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

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


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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

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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.


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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.~~


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~~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


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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


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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.

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

And the title is amended as follows:

Delete lines 27 - 34

and insert:

regarding access to affordable health care;