The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SPB 7044
INTRODUCER:	For consideration by the Health Policy Committee
SUBJECT:	Health Insurance Affordability Exchange
DATE:	March 5, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall		**Pre-meeting**

I. Summary:

SPB 7044 creates the "Florida Health Insurance Affordability Exchange Program" or FHIX under ss. 409.710 - 409.731, F.S., as a multi-phased, consumer-driven approach to providing access to high-quality, affordable health care coverage to low-income, uninsured Floridians. Implementation of the program will begin upon the effective date of the act.

The bill extends health care coverage to an estimated 800,000 uninsured, low-income Floridians who are individuals earning less than 138 percent of the federal poverty level and who are not currently eligible under the current Medicaid program, s. 409.902, F.S. To be eligible, an individual must be a U.S. citizen and a Florida resident.

Under FHIX, enrollees may access all Florida Health Choices products and services, Medicaid managed care plans, products offered by the Florida Healthy Kids Corporation, and employer sponsored plans.

Every enrollee must be provided with a health reimbursement or health savings account. The bill provides for how funds may roll-over into the account, who may contribute to the account, and how the enrollee may earn additional credits. An enrollee may only withdraw a refund from the account those funds that he or she has contributed to the account.

The bill outlines participant rights and responsibilities under the program to delineate the roles that both the participant and the state agencies and organizations have under FHIX.

FHIX participants may begin accessing coverage through the Medicaid managed care delivery system in Phase One beginning July 1, 2015, with statewide implementation completed by January 1, 2016. Applicants will use the Medicaid eligibility determination process through the Department of Children and Families (department) and the choice counseling and consumer support services of the Agency for Health Care Administration (AHCA) during this phase. The Florida Health Choices, Inc., (corporation) and the Florida Healthy Kids Corporation (FHKC) will coordinate the implementation of FHIX and other program phases as Phase One is started.

Phase Two's implementation is contingent upon the approval of the federal Centers for Medicare and Medicaid Services. Beginning with Phase Two on January 1, 2016, participants are required to provide proof at application and renewal of employment, on-the-job training or placement activities, or pursuit of educational opportunities at minimal weekly hourly levels based on their classification as either a parent with children (20 hours) or childless adult (30 hours). An exception process is established through the Medicaid Fair Hearing Process and for those who are disabled or are a parent or caregiver of a disabled child.

Under Phase Two enrollees are also required to make monthly premium payments to remain in active status. Premiums range from $3 to $25. After a 30-day grace period, individuals who have not made a payment will not be disenrolled, but will be moved to inactive status and retain access to funds in their health reimbursement or health savings accounts. Accounts may not be reinstated to active status for 6 months.

Delivery of services and benefits under Phase Two will occur through the FHIX marketplace administered by the corporation. Phase One enrollees will be required to transition coverage to FHIX by April 1, 2016 and may be able to keep their Medicaid managed care plan if that plan participates in the FHIX. Enrollees will receive a premium credit based on a risk adjusted rate amount to shop for plans, services, and products on the FHIX marketplace.

Phase Three of the program folds the enrollees of the Healthy Kids program into the FHIX marketplace starting July 1, 2016.

Enrollees may be charged for inappropriate use of the emergency room. For the first visit, an $8 copayment may be assessed and subsequent visits may be $25, depending on the plan selected by the enrollee.

A Transition Workgroup will oversee the process and make recommendations to the agency regarding implementation. The agency, as the single state agency for Medicaid, will make the final decision on whether to move forward on each region or phase of the program.

SPB 7044 provides the agency, department, corporation, and FHKC with specific administrative duties and functions for the implementation of the FHIX program. The agency has the administrative lead for Phase One of the program and the corporation for Phases II and III. The department shall continue its function of determining Medicaid eligibility. The FHKC retains its functions and responsibilities until Phase Three when its enrollees are transitioned to FHIX.

The bill provides the agency with authority to seek federal approval to implement the FHIX program. Triggers for ending the program are also included should the Phase II not be approved or if the federal match rate falls below certain thresholds.

The Florida Health Choices Program statute, s. 409.910, F.S., is modified to recognize the FHIX marketplace and to authorize the corporation to administer FHIX.

The Florida Healthy Kids Corporation, s. 624.91, F.S., is modified to remove obsolete provisions, recognize the FHIX program and changes made in this act, and to reconfigure its board of directors.

The bill also repeals two statutes: the FHKC Operating Fund statute, s. 624.915, F.S., and the Medically Needy program, s. 409.904, F.S., under Medicaid.

The bill is effective upon becoming a law.

II. Present Situation:

In 2013, the American Community Survey (ACS) of the federal Census Bureau, estimated that 4 million Floridians were uninsured.[1] Of that number, 594,000 had been projected to be children.[2] Approximately 900,000 adults in Florida were estimated to have incomes under 100 percent of the federal poverty level (FPL), according to statistics for 2013.[3]

Beginning January 1, 2014, health insurance coverage in Florida became available through the federal Marketplace[4] to persons with incomes above 100 percent of the FPL. Also, on January 1, 2014, Florida Medicaid coverage to children up to age 18 was extended to 133 percent of the FPL.

The Census Bureau's March 2014 Supplement to the Current Population Survey showed that Florida's overall uninsured number had dropped to 3.6 million and the children's number to 504,900.[5,6] The survey had been conducted from January through April 2014.[7]

Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income children and disabled persons. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

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[1] Office of Economic and Demographic Research, Florida Legislature, *Economic Analysis of PPACA and Medicaid Expansion*, Presentation to Senate Select Committee on Patient Protection and Affordable Care Act (Mar. 4, 2013), http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2071.pdf (last visited Mar. 8, 2015).
[2] Ibid.
[3] Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of the Non-Elderly (0-64) with Income Below 100% Federal Poverty Level (FPL)* *http://kff.org/other/state-indicator/nonelderly-up-to-139-fpl/* (Mar. 7, 2015).
[4] President Obama signed the Affordable Care Act into law on March 23, 2010. The first open enrollment was held starting on October 1, 2013 and a second one was held from November 15, 2014 through February 15, 2015. Florida does not operate its own exchange, so Floridians purchase coverage through the federal marketplace on www.healthcare.gov.
[5] Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of the Total Population (2013),* *http://kff.org/other/state-indicator/total-population/* (last visited: Mar. 7, 2015).
[6] Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of Children 0-18,* *http://kff.org/other/state-indicator/children-0-18/* (last visited: Mar. 7, 2015).
[7] More current, reliable estimates of the number of uninsured Floridians is not available at this time.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds. The Department of Children and Families (DCF) determines eligibility for the Medicaid program and transmits that information to the AHCA. The AHCA is designated as the single state Medicaid agency and has the lead responsibility for the overall program.[8]

Over 3.7 million Floridians are currently enrolled in Medicaid[9] and the program's estimated expenditures for the 2014-2015 fiscal year are 23.4 billion.[10] The current traditional federal share is 60.51 percent with the state paying 39.49 percent for Medicaid enrollees.[11] Florida has the fourth largest Medicaid program in the country.[12]

Medicaid currently covers:

- 20% of Florida's population;
- 27% of Florida's children;
- 62.2% of Florida's births;
- 69% of Florida's nursing homes days.[13]

The structure for each state's Medicaid program is different and what states pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law and regulation sets the minimum amount, scope, and duration of services offered in the program among other requirements. Eligibility for the Medicaid program is based on a number of factors, including age, household or individual income, and assets. State Medicaid benefits are provided in statute under s. 409.903, F.S. (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.[14] Applicants must also agree to cooperate with Child Support Enforcement during the application process and then be completed after the eligibility process.[15]

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[8] *See* s. 409.963, F.S.

[9] Agency for Health Care Administration, *Report of Medicaid Eligibles - January 31, 2015,* http://ahca.myflorida.com/medicaid/about/pdf/age_assistance_category_2015-01-31.pdf (last visited: Mar. 9, 2015).

[10] Office of Economic and Demographic Research, *Social Services Estimating Conference Medicaid Expenditures* (December 12, 2014) http://edr.state.fl.us/Content/conferences/medicaid/medhistory.pdf (last visited: Mar. 6, 2015).

[11] Office of Economic and Demographic Research, *Social Services Estimating Conference - Official FMAP Estimate (November 2014),* http://edr.state.fl.us/Content/conferences/medicaid/fmap.pdf (last viewed: Mar. 8, 2015). The SSEC has also created a "real time" FMAP blend" for the Statewide Medicaid Managed Care Program which is 60.43% for SFY 2015-16.

[12] Agency for Health Care Administration, Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - An Overview (Jan. 22, 2015),* Slide 9, http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2759.pdf (last visited: Mar. 6, 2015).

[13] Id at 10.

[14] Florida Department of Children and Families, *Family-Related Medicaid Programs Fact Sheet, (January 2015),* p.3, http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last visited: Mar. 8, 2015).

[15] Id.

Florida's Current Medicaid and CHIP Eligibility Levels in Florida[16] (With Income Disregards and Modified Adjusted Gross Income)						
Children's Medicaid			**CHIP (Kidcare)**	**Pregnant Women**	**Parents**	**Childless Adults**
Age 0-1	Age 1-5	Age 6-18	Ages 0-18	Medicaid		
206% FPL	140% FPL	133% FPL	210% FPL	191% FPL	30% FPL	0% FPL

Federal poverty guidelines are updated every year by the Census Bureau. The guidelines are used to adopt the threshold for eligibility for financial assistance under a number of different social and human service programs, including Medicaid and the Children's Health Insurance Program.

Federal Poverty Guidelines for 2015[17] Annual Income (rounded)				
Family Size	**100%**	**133%**	**150%**	**200%**
1	$11,770	$15,654	$17,655	$23,540
2	$15,930	$21,187	$23,895	$31,860
3	$20,090	$26,720	$30,135	$40,180
4	$24,250	$32,252	$36,375	$48,500
5	$28,410	$37,785	$42,615	$56,820
	Add $4,160 each additional person after 5			

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.[18] States can add benefits, with federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.[19] For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services which are those health care and diagnostic services and treatment and measures that may be needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services consistent with federal law.[20]

Medicaid Managed Care

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) Program as part IV of ch. 409, F.S.[21] The SMMC has two components: the Long Term Care Managed Care (LTC) program and the Managed Medical Assistance (MMA) program. The SMMC is an integrated managed care program for Medicaid enrollees that incorporates all of the covered services, for the delivery of primary and acute care in 11 regions.

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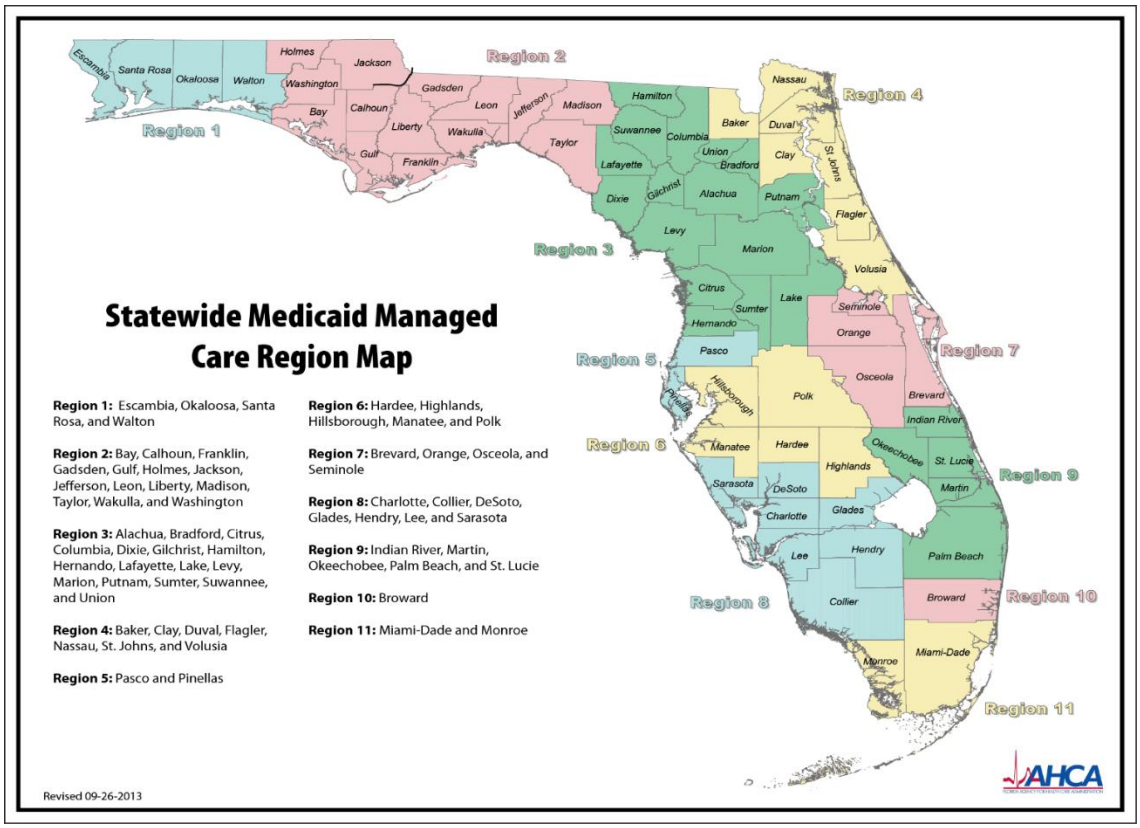
[16] U.S. Centers for Medicare and Medicaid Services, Medicaid.gov, *Florida*, *http://www.medicaid.gov/medicaid-chip-program-information/by-state/florida.html* (last visited: Mar. 7, 2015).
[17] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid and CHIP Program Information - 2015 Federal Poverty Level Charts* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf (last visited: Mar. 7, 2015.
[18] Section 409.905, F.S.
[19] Section 409.906, F.S.
[20] *See* Section 1905 9(r) of the Social Security Act.
[21] *See* Chapter Laws, 2011-134 and 2011-135.



To implement the two components and receive federal Medicaid funding, the AHCA received federal authorization through two different Medicaid waivers from the CMS. The first component authorized was the LTC's 1915(b) and (c) waivers on February 1, 2013. These two waivers for the LTC program are effective July 1, 2013 through June 30, 2015 and operate concurrently.[22]

Long Term Care Managed Care Program (LTC)

For the LTC program, individuals must meet these eligibility requirements or participate in one of these existing waivers to enroll in the program:

- Age 65 years or older and need nursing facility level of care;
- Age 18 years of age or older and are eligible for Medicaid by reason of a disability and need nursing facility level of care;
- Aged and Disabled Adult (A/DA) waiver;
- Consumer Directed Care Plus for individuals in the A/DA waiver;
- Assisted Living waiver;
- Nursing Home Diversion waiver;
- Frail Elder Option; or

[22] Department of Health and Human Services, Disabled & Elderly Health Programs Group, *Approval Letter to Agency for Health Care Administration*, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (last visited: Mar. 6, 2015).

- Channeling Services waiver.[23]

Individuals who are enrolled in these programs may enroll in the LTC, but are not required to:
- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Injury waiver;
- Project AIDS Care waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver; or
- Model waiver.[24]

The AHCA engaged in a competitive procurement to select providers in each of the 11 regions. Contracts were awarded to health maintenance organizations and provider service networks. Seven non-specialty plans are currently contracted, including one provider service network that is available in all eleven regions and one health maintenance organization that is in 10 regions.[25]

Choice counselors are available via a toll-free number or the internet to assist Medicaid recipients with plan selection. An in-person visit may also be requested.

Enrollment into the LTC Managed Care program began in August 1, 2013, and finished March 1, 2014. As of December 1, 2014, 85,169 were enrolled in the LTC program.[26]

Managed Medical Assistance Program (MMA)

For the MMA component, health care services were also bid competitively using the same 11 regions. Thirteen non-specialty managed care plans contract with AHCA across the different regions. Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure or cardiovascular disease may also select from specialized plans.

Most plans supplemented the required benefits and offered enhanced options, such as adult dental, hearing and vision coverage, outpatient hospital coverage and physician services. The minimum and maximum number of plans selected by region is prescribed under s. 409.974, F.S.

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[23] Agency for Health Care Administration, *A Snapshot of the Florida Medicaid Long-term Care Program*, *http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf* (last visited Mar. 6, 2015).
[24] Id.
[25] Id.
[26] Agency for Health Care Administration, Presentation to Senate Health and Human Services Appropriations Committee, *Implementation and Status of Statewide Medicaid Managed Care (Jan. 7, 2015)*, Slide 4, http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2729.pdf (last visited Mar. 6, 2015).

Eligible Number of Non-Specialty Managed Care Plans[27]			
Region	**Minimum**	**Maximum**	**Current MMA**
1	2	NA	2
2	2	NA	2
3	3	5	4
4	3	5	4
5	2	4	4
6	4	7	7
7	3	6	6
8	2	4	4
9	2	4	4
10	2	4	4
11	5	10	10

Under s. 409.967, F.S., accountability provisions for the managed care plans specify several conditions or requirements including emergency care and physician reimbursement standards, access and credentialing requirements, encounter data submission guidelines, grievance and resolutions, and medical loss ratio calculations.

Statewide implementation of SMMC started May 1, 2014 and was completed by August 1, 2014. Similar to the LTC component, enrollees receive choice counseling service via a toll-free number or online. In-person visits are available for those enrollees with special needs.

Most Medicaid recipients must be enrolled in the MMA program. Those individuals who are not required to enroll, but may choose to do so are:

- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities under s. 394.455(32), F.S.;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.[28]

Other Medicaid enrollees are exempt from the MMA program and are served in the Medicaid fee-for-service program. Exempt enrollees are:

- Women who are eligible for family planning services only;
- Women who are eligible only for breast and cervical cancer services; and
- Persons eligible for emergency Medicaid for aliens.

[27] Agency for Health Care Administration, *A Snapshot of the Florida Medicaid Medical Assistance Program*, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_MMA_Snapshot.pdf (last visited Mar. 6, 2015).
[28] Section 409.972, F.S.

The MMA program is authorized by a section 1115 demonstration waiver by federal CMS. It was approved in 2005 as an expansion of the managed care pilot program and renewed for an second additional 3-year period on July 31, 2014 through June 30, 2017.[29]

A part of the original waiver approval included the Low Income Pool supplemental payment authority (LIP). The LIP program was extended through June 30, 2015.[30] LIP funds are used to assist safety net providers in providing health care services to Medicaid, underinsured, and uninsured populations. The total computable funds under LIP for the 2014-2015 fiscal year are not to exceed $2.1 billion under the extension.[31] Additionally, the state was directed by federal CMS to develop a plan to reform Medicaid provider payments and funding mechanisms with the goal of identifying a mechanism that that would ensure the delivery of quality medical services to Medicaid recipients without reliance on LIP funds.[32]

Florida Kidcare Program

The Florida Kidcare Program (Program) was created in 1998 by the Florida Legislature in response to the federal enactment of the Children's Health Insurance Program (CHIP) in 1997. The CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who have family incomes under 200 percent of the FPL and meet other eligibility criteria. The state statutory authority for the Program is found under part II of ch. 409, F.S., specifically in ss. 409.810 through 409.821, F.S.

The Program includes four operating components:

- Medicaid administered by AHCA with eligibility determined by the Department of Children and Families;
- Medikids administered by AHCA;
- Children's Medical Services Network administered by the Department of Health; and
- Healthy Kids administered by the Florida Healthy Kids Corporation.[33]

A fifth component under the statute, the employer sponsored group health insurance plan, has never been implemented. The AHCA submitted State Plan Amendment #7 in December 1998 for implementation of that component; however, the plan amendment withdrawn from further consideration.[34]

The Title XXI-funded or CHIP-funded components of Florida Kidcare serve distinct populations under the program:

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[29] Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid 1115 Demonstration Fact Sheet* (July 31, 2014), *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf* (last visited Mar. 8, 2015).
[30] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Approval Letter to the Agency for Health Care Administration* (July 31, 2014), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/July312014ApprovalLetter.pdf (last visited Mar. 5, 2015).
[31] Id at 3.
[32] Id at 3.
[33] Section 409.813, F.S.
[34] *See* U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services, Florida State Plan Amendment #22, Plan Amendment History, p.8, http://www.medicaid.gov/CHIP/Downloads/FL/FL-CSPA-22-FINAL.pdf (last visited Mar. 8, 2015).

- Medicaid for Children: Children from birth until age 1 for family incomes between 185 percent and 200 percent of the FPL.
- Medikids: Children from age 1 until age 5 for family incomes between 133 percent and 200 percent of the FPL. Those enrollees above 200 percent FPL may enroll at a non-subsidized rate established by the AHCA.
- Healthy Kids: Children from age 5 through age 18 for family incomes between 133 and 200 percent of the FPL. Those above 200 percent FPL may enroll at a non-subsidized rate established by the FHKC.
- Children's Medical Services Network: Title XXI and Title XIX funds are available from birth until age 19 for family incomes up to 200 percent of the FPL for children with special health care needs. The Department of Health assesses whether children meet the clinical requirements.

The Program is funded by Medicaid funds under Title XIX of the Social Security Act, state funds from General Revenue and the Tobacco Settlement Trust Fund, and family contributions.[35] CHIP has an enhanced federal matching rate that is more favorable than Medicaid. For the period of October 2014 through June 2015, the federal match rate is 71.80 percent.[36]

Family contributions are based on family size, household income, and other eligibility factors. Families above the income limits for premium assistance or who are not otherwise eligible for premium assistance are offered the opportunity to participate in the Program at a non-subsidized rate (full-pay). The non-subsidized rates are established by the individual program and are based on the actual costs of the program, both premiums and an administrative fee. The income limit for premium assistance is 200 percent of the FPL.

CHIP was re-authorized by Congress in 2009 until federal Fiscal Year 2019, but federal funding was only re-authorized until September 30, 2015. Re-authorization bills are pending in Congress, including a bipartisan discussion draft led by the House Energy and Commerce Chair Fred Upton, House Health Subcommittee Chair Joe Pitts and the Senate Finance Committee Chair and original CHIP bill sponsor, Orrin Hatch.[37] The discussion draft does not provide an extension period but extends funding for at least 1 year while seeking stakeholder feedback.

Another proposal, *Protecting & Retaining Our Children's Health Insurance Program Act of 2015 (PRO-CHIP)* has also been introduced and would extend CHIP funding through 2019 and the other components of the program. The proposal, Senate Bill 522, is sponsored by Senator

[35] Florida Kidcare Coordinating Council, *2014 Annual Report and Recommendations,* p. 14, http://www.floridakidcare.org/council/wp-content/uploads/2014/08/2014_Annual_Report.pdf (last reviewed: Mar. 8, 2015).
[36] Office of Economic and Demographic Research, *Social Services Estimating Conference - Kidcare Program (November 21, 2014 Conference Results)* http://edr.state.fl.us/Content/conferences/kidcare/kidcaredetail.pdf (last viewed: Mar. 8, 2015).
[37] U.S. House Energy and Commerce Committee, *Extending Funding for the State's Children Health Insurance Program*, (Feb. 24, 2015), http://energycommerce.house.gov/fact-sheet/extending-funding-state-children%E2%80%99s-health-insurance-program (last visited: Mar. 5, 2015).

Sherrod Brown with Senators Stabenow, Wyden, Casey and Minority Leader Reid and more than 40 other Senators. [38,39]

Florida Healthy Kids Corporation

The Florida Healthy Kids Program is authorized under s. 624.91, F.S., which is also known as the "William G. 'Doc' Myers Healthy Kids Corporation Act." The FHKC was created as a private, not-for-profit corporation by the 1990 Florida Legislature in an effort to increase access to health insurance for school-aged children.[40]

Eligibility for the state-funded assistance is prescribed under s. 624.91(3), F.S., and provides cross references to the Florida Kidcare Act. The Healthy Kids program is also identified as a non-entitlement program.[41]

The FHKC is managed by an executive director selected by the board with the number of staff determined by the board. The FHKC is authorized to:

- Collect contributions from families, local sources or employer based premiums;
- Establish administrative and accounting procedures;
- Establish preventive health standards for children that do not limit participation to pediatricians in rural areas with consultation from appropriate experts;
- Determine eligibility for children seeking enrollment in Title XXI funded and non-Title XXI components;
- Establish grievance processes;
- Establish participation criteria for administrative services for the FHKC;
- Establish enrollment criteria that include penalties or waiting periods for non-payment of premiums of 30 days;
- Contract with authorized insurers and other health care providers meeting standards established by the FHKC for the delivery of services and select health plans through a competitive bid process;
- Purchase goods and services in a cost effective manner with a minimum medical loss ratio of 85 percent for health plan contracts;
- Establish disenrollment criteria for insufficient funding levels;
- Develop a plan to publicize the program;
- Secure staff and the necessary funds to administer the program;
- Provide an annual Kidcare report, in consultation with partner agencies, to the governor, chief financial officer, commissioner of education, President of the Senate, Speaker of the House of Representatives, and minority leaders of the Senate and House of Representatives;

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[38] U.S. Senate Committee on Finance, *Wyden Joins Sens. Brown, Casey and Stabenow on Legislation to Extend the Children's Health Insurance Program*, (February 12, 2015) http://www.finance.senate.gov/newsroom/ranking/release/?id=20c6ac77-77af-424f-bb3e-dc84a92af22d (last visited: Mar. 5, 2015).
[39] S. 522, 114th Congress (2015).
[40] Florida Healthy Kids Corporation, *History*, https://www.healthykids.org/healthykids/history/ (last visited Mar. 7, 2015).
[41] A non-entitlement program means that funding may be limited. If more applicants or enrollees apply or enroll for the program than funding allows, an enrollee is not entitled to enrollment, even if eligible.

- Provide quarterly enrollment information on the full pay population; and
- Establish benefit packages that conform to the Florida Kidcare benchmark benefit.

Limits on premiums and cost sharing in the Healthy Kids must conform to existing federal law and regulation for Title XIX and XXI. All Title XXI funded enrollees pay monthly premiums of $15 or $20 per family per month based on their family size and income. For those families at or below 150 percent of the FPL, the cost is $15 per family per month. For those between 150 percent of the FPL and 200 percent of the FPL, the cost is $20 per family per month.

Enrollees also have copayments for non-preventive services that range from $5 per prescription to $10 for an inappropriate use of the emergency room visit. There are no copayments for visits related to well-child, preventive health, or dental care.[42]

Benefits for the program must also meet the benchmark benefit plan under the Kidcare Act.[43] FHKC is under discussions with CMS regarding its benefits package for its non-subsidized enrollees. CMS had notified FHKC that the benefit package for these enrollees must be compliant with the Affordable Care Act minimum benefit requirements and have identified a few benefits that do not meet those standards: removal of annual or lifetime limits on benefits, addition of applied behavioral analysis benefits, and removal of an overall lifetime limit.[44]

The FHKC is governed by a 13-member board of directors, chaired by Florida's chief financial officer or his or her designee.[45] The 12 other board members are:

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

[42] *See* State of Florida, Florida KidCare Program, Title XXI State Child Health Insurance Plan, Amendment #22, July 1, 2012, pp.98-101., http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/CHIP-SPAs/FL-CSPA-22-FINAL.pdf (last visited: Mar. 17, 2013).
[43] A benchmark benefit plan under Kidcare, excluding Medicaid and Medikids coverage, must include the minimum benefits listed under s. 409.815(2), F.S. The plan includes preventive health services, inpatient hospital services, emergency services, maternity services, organ transplantation services, outpatient services, behavioral health services, durable medical equipment, health practitioner services, home health services, hospice services, laboratory and x-ray services, nursing facility services, prescribed drugs, therapy services, transportation services, dental services, and a lifetime maximum.
[44] E-Mail Correspondence from Fred Knapp, Interim Executive Director, Florida Healthy Kids Corporation (Sept. 2, 2014) (on file in the Senate Health Policy Committee).
[45] *See* s. 624.91(6), F.S.

- One member, appointed by the chief financial officer, from among three members nominated by the Florida Association of Counties;
- The state health officer or his or her designee;
- The secretary of the DCF, or his or her designee; and
- One member, appointed by the governor, from among three members nominated by the Florida Dental Association.

Board members do not receive compensation for their service but may receive reimbursement for per diem and travel expenses in accordance with s. 112.061, F.S.[46]

The FHKC is not an insurer and is not subject to the licensing requirements of the Department of Financial Services. In addition, the FHKC board is also granted complete fiscal control over the FHKC and responsibility for all fiscal operations. Any liquidation of the FHKC would be supervised by the Department of Financial Services.[47]

Cover Florida and Florida Health Choices

In 2008, the Florida Legislature created two programs simultaneously to address the issue of Florida's uninsured: the Cover Florida Health Access Program and the Florida Health Choices Program.[48] The two programs offered two unique methods of addressing Florida's uninsured population.

Cover Florida Health Access Program

Cover Florida is designed to provide affordable health care options for uninsured residents between the ages of 19 and 64 and who met other criteria under s. 408.9091, F.S. The AHCA and the Office of Insurance Regulation (OIR) have joint responsibility for the program and were directed to issue an Invitation to Negotiate (ITN) to secure plans for the delivery of services by July 1 2008. An ITN was released July 2, 2008, and as a result of that ITN, 2-year contracts were executed with two statewide plans and four regional plans.[49]

The Cover Florida plans were not subject to the Florida Insurance Code and ch. 641, F.S., relating to HMOs. Two plan options were required for development: plans with catastrophic coverage and plans without catastrophic coverage. Plans without catastrophic coverage are required to include other benefit options such as:[50]

- Incentives for routine preventive care;
- Office visits for diagnosis and treatment of illness or injury;
- Behavioral health services;
- Durable medical equipment and prosthetics; and
- Diabetic supplies.

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[46] *See* s. 624.91(5), F.S.
[47] *See* s. 624.91(7), F.S.
[48] *See* Chapter Law 2008-32.
[49] Agency for Health Care Administration, *Cover Florida Health Care Access Program Annual Report*, p. 1 (March 2013), *http://ahca.myflorida.com/MCHQ/Managed_Health_Care/CHMO/docs/CoverFLReport-Mar2013.pdf* (last visited Mar. 22, 2013).
[50] *See* s. 409.9091(4)(6)(a).

Plans that did include catastrophic coverage were required to include all of the benefits above, plus have options for these additional benefits:[51]

- Inpatient hospital stays;
- Hospital emergency care services;
- Urgent care services; and,
- Outpatient facility services, outpatient surgery, and outpatient diagnostic services.

All plans are guaranteed-issue policies[52] and are required to include prescription drug benefits. Plans can also place limits on services and cap benefits and copayments.

To be eligible, the enrollee must be:

- A resident of Florida;
- Between 19 and 64 years old;
- Not covered by private insurance or eligible for public insurance, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements; and
- Uninsured for at least the prior 6 months, with exceptions for persons who lose coverage within the past 6 months under certain conditions.

No insurers or HMOs currently offer any new policies under Cover Florida due to lack of participation by both applicants and other insurers.[53] Only one insurer has enrollment and that carrier has 633 enrollees as of December 31, 2014.[54]

Florida Health Choices Corporation, Inc. (Corporation)

The corporation is a private, non-profit, corporation under s. 408.910, F.S., and operates in compliance with part III of chapter 112 (Public Officers and Employees) and chapter 119 (Public Records), 286 (Public Business), and 617 (Corporations Not for Profit).

The corporation is led by a 15-member board of directors and three ex-officio, non-voting board members for 3-year terms to include:

- Three non-voting ex-officio members:
  - Secretary of the Agency for Health Care Administration or a designee with expertise in health care services;
  - Secretary of the Department of Management Services or a designee with expertise in health care services; and
  - Commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.
- Four members appointed by and serving at the pleasure of the Governor;
- Four members appointed by and serving at the pleasure of the President of the Senate; and

[51] *See* s. 409.9091(4)(a)(7).
[52] Guaranteed issue policies means a policy where the health plan must permit an individual to enroll regardless of health status, age, gender, or other factors that might predict the use of health services.
[53] Florida Office of Insurance Regulation, *Cover Florida Health Care Access Program Annual Report (March 2015)*, (last visited Mar. 7, 2015).
[54] Id.

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

No board members may include insurers, health insurance agents or brokers, health care providers, health maintenance organizations (HMOs), prepaid service providers, or any other entity or affiliate or subsidiary of eligible vendors. Board members may not serve for more than 9 years and members must disclose any conflicts of interest that would prohibit him or her from participating in any decision that would inure to the member's benefit or the member's organization. The board selects a chief executive officer for the corporation who is responsible for the selection of other staff, as authorized by an operating budget.

The corporation is designed as a single, centralized marketplace for the purchase of health products including, but not limited to, health insurance plans, HMO plans, prepaid services, and flexible spending accounts. Policies sold as part of the program are exempt from regulation under the Insurance Code and laws governing HMOs. The following entities are authorized to be eligible vendors:

- Insurers authorized under ch. 624, of the Insurance Code, such as self-insurers, indemnity plans, life and health insurers, church benefit plans, disability, and multi-employer welfare arrangements, and Florida Healthy Kids Corporation;
- HMOs authorized under part I of ch. 641, F.S., relating to Health Service Programs, including health maintenance organization contracts, limited benefit policies, and other risk bearing coverage, benefits, and products;
- Prepaid limited health service organizations and discount medical plans under ch. 636, F.S.;
- Prepaid health clinics licensed under ch. 641, part II, F.S.;
- Health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers;
- Provider organizations, including service networks, group practices, and professional associations; and
- Corporate entities providing specific health services.

The corporation is authorized to collect premiums and other payments from employers. The law further specifies who may participate as either an employer or an individual. Employers eligible to enroll include employers that meet criteria established by the corporation and their individual employees and other individuals meeting criteria established by the corporation.[55]

The corporation is required to:

- Determine eligibility of employers, vendors, individuals and agents;
- Establish procedures for the operation of the program;
- Arrange for the collection of contributions from employers and participants;
- Establish criteria for disenrollment for failure to pay the individual's share of any contribution required to maintain enrollment in any product;
- Establish criteria for exclusion of vendors;
- Develop and implement a plan for public awareness and program promotion;
- Secure staff and consultant services, as necessary;

[55] *See* s. 408.910(4)(a), F.S.

- Establish policies and procedures as necessary;
- Operate a toll-free hotline to respond to requests for assistance;
- Provide for initial, open and special enrollment periods; and
- Evaluate options for employer participation which may conform with common insurance practices.

Florida Health Choices' marketplace currently includes individual health plans, discount plans, and limited benefit plans. The marketplace offers options that are PPACA-compliant[56] across the different metal ranges, dental-only plans, vision and hearing plans, telemedicine plans, discount plans, and prescription drug plans.[57] Additional marketplace platforms for group health plans for small employers and associations are planned.

Pricing for products on Florida's Marketplace must be transparent to the participants and established by the vendors. The marketplace will assess a surcharge annually of not more than 2.5% of the price. The surcharge shall be used to support the administrative services provided by corporation and for payments to buyers' representatives.

During its most recent open enrollment, January 5, 2015 through February 15, 2015, FHCC reported 51 total individual product enrollments covering 56 adults and children with 66 applications started. Of those that purchased coverage, 85 percent purchased individual coverage and 15 percent purchased spouse or family coverage.[58] Florida's Health Insurance Marketplace recorded 4,800 visits during their January open enrollment.[59]

The corporation offers a minimum of 20 plans per county from two different companies with a maximum of 46 plans in a county from six different companies as of March 2015.[60]

The Patient Protection and Affordable Care Act of 2010

In March 2010, the Congress passed and the President signed two pieces of legislation: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 that are together called PPACA.[61] Under PPACA, one of the key components required the states to expand Medicaid to a minimum national eligibility threshold of 133 percent of the FPL, or, as it is sometimes expressed, 138 percent of the FPL with application of an

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[56] To be compliant with PPACA, plans must eliminate any pre-existing condition exclusions, annual or lifetime dollar limits on the essential benefits, prohibit recissions, provide preventive services without cost sharing, include emergency services without prior authorization, establish an appeals process, provide access to pediatricians and OB\GYNs, extend dependent coverage to age 26 and provide the essential health benefits. For a checklist, see Nat'l Assn. of Insurance Commissioners Compliance Summary: http://www.naic.org/documents/index_health_reform_ppaca_uniform_compliance_summary.pdf (last visited: Mar. 9, 2015).

[57] Florida Office of Insurance Regulation, *Cover Florida Health Care Access Program Annual Report (March 2015)*, (last visited Mar. 7, 2015).

[58] Florida Health Choices Corporation, *Florida Health Choices Reports Zero Glitches with New Online Marketplace Launched in January* (February 20, 2015) http://www.myfloridachoices.org/florida-health-choices-reports-zero-glitches-with-new-online-marketplace-launched-in-january/ (last visited Mar. 7, 2015).

[59] Id.

[60] Conversation with Rose Naff, CEO, Florida Health Choices, Inc.,(Mar. 9, 2015).

[61] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010) and (Pub. Law No. 111-152, 111th Cong. (Mar. 30, 2010).

automatic 5 percent income disregard, effective January 1, 2014.[62] While the funding for the newly eligible under this expansion would be initially funded at 100 percent federal funds for the first three calendar years (2014, 2015, and 2016), the states would gradually be required to pay a share of the costs, starting at 5 percent in calendar year 2017 before leveling off at 10 percent in 2020.[63] As enacted, PPACA provided that states refusing to expand to the new national eligibility threshold faced the loss of *all* of their federal Medicaid funding.[64]

Enhanced Medicaid Match Rate for Newly Eligibles Only: CY 2014 and Beyond[65]							
CY	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020+**
FMAP	100%	100%	100%	95%	94%	93%	90%

Florida, along with 25 other states challenged the constitutionality of the law. In *NFIB v. Sebelius*, the Supreme Court found the enforcement provisions of the Medicaid expansion unconstitutional.[66] As a result, states can voluntarily expand their Medicaid eligibility thresholds to PPACA standards and receive the enhanced federal match for the expansion population, but states cannot be penalized for not doing so.[67]

Since the decision in *NFIB v. Sebelius*, federal guidance has emphasized state flexibility in how states expand coverage to those defined as the newly eligible population. In a letter to the National Governors Association January 14, 2013, then-Health and Human Services Secretary Kathleen Sebelius reminded states of their ability to design flexible benefit packages without the need for waivers and the alternative benefit plans that are available.[68] This letter was preceded by the Frequently Asked Questions document on Exchange, Market Reforms and Medicaid, issued on December 10, 2012, that discussed promotion of personal responsibility, wellness benefits, and state flexibility to design benefits.[69]

Individual and Employer Mandates

A state Medicaid director letter on November 20, 2012 (ACA #21) further addressed state options for the adult Medicaid expansion group and the alternative benefit plans available under Section 1937 of the Social Security Act.[70] Under Section 1937, state Medicaid programs have the

[62] 42 U.S.C. s. 1396a(1).
[63] 42 U.S.C. s. 1396d(y)(1).
[64] 42 U.S.C. s. 1396c
[65] *Supra* at Note 63.
[66] *National Federal of Independent Business (NFIB) v. Sebelius, Secretary of Health and Human Services*, 648 F. 3d 1235, affirmed in part, reversed in part.

[67] Department of Health and Human Services, *Secretary Sebelius Letter to Governors*, (July 10, 2012), http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf (last visited Mar. 7, 2015).
[68] *Letter to National Governor's Association from Secretary Sebelius*, January 14, 2013 (copy on file with Senate Health Policy Committee).
[69] Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, pp. 15-16, (December 10, 2012), http://cciio.cms.gov/resources/factsheets/index.html, (last visited Mar. 17, 2013).
[70] Centers for Medicare and Medicaid Services, *State Medicaid Director Letter: Essential Health Benefits in the Medicaid Program* (November 20, 2012), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf (last visited Mar. 17, 2013).

option of providing certain groups with benchmark or benchmark equivalent coverage based on four products: (1) the standard Blue Cross/Blue Shield Preferred Provider option offered to federal employees; (2) state employee coverage that is generally offered to all state employees; (3) the commercial HMO with the largest insured, non-Medicaid enrollment in the state or (4) Secretary-approved coverage.[71] For children under the age of 21, the coverage must include the Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT). Other aspects of the essential health benefit requirements of PPACA, as discussed further below, may also be applicable, depending on the benefit package utilized.

In addition to the Medicaid expansion component, the PPACA imposes a mandate on individuals to acquire health insurance or pay a penalty when they file their tax returns. Currently, many uninsured individuals are eligible for Medicaid or Kidcare coverage but are not enrolled. The existence of the federal mandate to purchase insurance may result in an unknown number of currently eligible individuals coming forward and enrolling in Medicaid who had not previously chosen to enroll. Their participation – to the extent it occurs – will result in increased costs that the state would not likely have incurred without the catalyst of the federal legislation.

Under the provisions, employers with more than 50 full-time employees that do not offer coverage meeting the essential benefits coverage standard and who does not offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and at least one employee receive a premium tax credit through the federal Marketplace, the employer will be assessed a fee of $2,000 per full time employee, with the first 30 employees, including those who have minimum essential coverage.[72] Or, if an employer does offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and at least one employee receives a premium tax credit through the federal marketplace because the employer's coverage was not affordable, did not provide minimum value, or because the employee was not one of the 95 percent of the employees offered coverage, the employer is assessed the lesser of $3,000 per employee receiving the credit.[73] The large employer can only be assessed under one of the scenarios, not both.

Like individuals, certain employers also have a shared responsibility under PPACA beginning January 1, 2015. This responsibility was slated to start in 2014 under PPACA; however, the Department of Treasurer and the Internal Revenue Service have provided transition relief in 2014 for:

- Information reporting requirements applicable to insurers, self-insuring employers and certain other providers of minimum essential coverage;
- Information reporting requirements applicable to large employers; and
- Employer shared responsibilities.[74]

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[71] Id.
[72] Internal Revenue Service, Employer Shared Responsibilities, http://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions (last visited Mar. 7, 2015).
[73] Id.
[74] Internal Revenue Service, Not-129718-13, *Transition Relief for 2014 Under §§6055 (§6055 Information Reporting), §6056 information Reporting) and 4980H (Employer Responsibility Provisions), http://www.irs.gov/pub/irs-drop/n-13-45.pdf (last visited: Mar. 7, 2015).*

The notice indicates the delay is intended to give additional time to provide input by employers and other reporting entities and to allow all parties to adapt their reporting systems. The transition relief states that it has no impact on other PPACA provisions.[75]

Individuals may be exempt from the purchase of minimum essential coverage if the minimum amount the individual must pay for that coverage is more than 8 percent of their household income or they may qualify to receive a hardship exemption.[76] Some of the reasons that may qualify an individual for a hardship exemption include, but are not limited to:

- Being ineligible for Medicaid because the individual lives in a state that decided not to expand Medicaid under the PPACA;
- Spending less than three consecutive months without minimum essential health coverage;
- Buying coverage would pose a hardship or go against religious beliefs;
- Having gross income below the applicable return filing threshold;
- Finding no affordable coverage on the Marketplace that meets the minimum value standard; and
- Being eligible for services through Indian Health Care Services.[77]

The Internal Revenue Service releases a rule every year setting the tax penalty for the lack of minimum essential coverage. For 2014, the annual payment amount is the greater of:

- One percent of your household income that is above the tax return filing threshold for your filing status, or
- Your family's flat dollar amount, which is $95 per adult and $47.50 per adult, limited to a family maximum of $285.[78]

The amount is calculated based on the national average for a premium payment for a bronze level health plan in the marketplace for 2014. For 2014, the annual national average premium for a bronze level health plan was $2,448 per individual, but $12,240 for a family with five or more members.[79]

Exchanges

A health insurance exchange is intended to create an organized and competitive market for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the health care options available to them.[80] To facilitate coverage, PPACA authorized the state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP)

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[75] Id.
[76] Internal Revenue Service, *Individual Shared Responsibility Provision*, *http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision* (last visited Mar. 7, 2015).
[77] Internal Revenue Service, *Shared Responsibility Provision*, http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision (last visited Mar. 7, 2015).
[78] Internal Revenue Service, *Individual Shared Responsibility Provision - Reporting and Calculating the Payment*, http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment (last visited Mar. 7, 2015).
[79] Id.
[80] Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Exchanges* (April 2010) https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7908-02.pdf (last visited Mar. 7, 2015).

Exchanges. These exchanges can be administered by governmental agencies or non-profit organizations. The exchanges, at a minimum, must:[81]

- Certify, re-certify and de-certify plans participating on the exchange;
- Operate a toll-free hotline;
- Maintain a website;
- Provide plan information and plan benefit options;
- Interact with the state's Medicaid and CHIP programs and provide information on eligibility and determination of eligibility for these programs;
- Certify individuals that gain exemptions from the individual responsibility requirement; and,
- Establish a navigator program.

On November 16, 2012, Florida Governor Rick Scott notified then-HHS Secretary Sebelius that Florida had too many unanswered questions to commit to a state-based exchange under PPACA for the first enrollment period on January 1, 2014.[82] Florida has since opted to use the federal marketplace.

Qualifying coverage may be obtained through an employer, the federal Marketplace, or private individual or group coverage outside of the federal Marketplace meeting the minimum essential benefits coverage standard.

Exchange Benefits

Each plan sold in an exchange or the federal marketplace must include the "essential health benefits" as defined by PPACA and as compared to an existing benchmark plan set in each state. The essential health benefits are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Qualified Health Plans

In order to receive a health care tax credit, an individual must be enrolled in a qualified health plan.[83] Qualified health plans are certified by the marketplace and meet specific requirements:

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[81] Centers for Medicare and Medicaid Services, *Initial Guidance to States on Exchanges*, (November 18, 2010), http://www.cms.gov/CCIIO/Resources/Files/guidance_to_states_on_exchanges.html (last visited Mar. 7, 2015).
[82] *Letter from Governor Rick Scott to Health and Human Services Secretary Kathleen Sebelius,* (November 16, 2012) http://www.flgov.com/2012/11/16/letter-from-governor-rick-scott-to-u-s-secretary-of-health-and-human-services-kathleen-sebelius/ (last visited Mar. 6, 2015).
[83] Internal Revenue Service, *Health Care Tax Credits: Qualified Health Plan Requirements*, http://www.irs.gov/Individuals/HCTC:-Qualified-Health-Plan-Requirements (last viewed Mar. 8, 2015).

- Provide essential health benefits;
- Follow the established limits on cost sharing; and
- Meet all other requirements.[84]

These plans are available on the federal marketplace or may also be available directly from an insurance company or one of the state's qualified health plans.[85]

Each plan sold must also be one of the following actuarial values[86] or "metal levels:"
- Bronze: 60 percent actuarial value;
- Silver: 70 percent actuarial value;
- Gold: 80 percent actuarial value; and
- Platinum: 90 percent actuarial value.

Premium Tax Credits and Cost Sharing Subsidies

Premium credits and other cost sharing subsidies are available to United States citizens and legal immigrants within certain income limits for coverage purchased through the exchanges. Legal immigrants with incomes at or below 100 percent of the FPL who are not eligible for Medicaid during their first 5 years are eligible for premium credits.[87] Premium credits are set on a sliding scale based on the percent of FPL for the household and reduce the out-of-pocket costs incurred by individuals and families.

The amount for premium tax credits, as a percentage of income, are set in section 36B of the Internal Revenue Code follows:[88]

Premium Tax Credits	
Income Range	**Premium Percentage Range** (% of income)
Up to 133% FPL	2%
133% to 150%	3% - 4%
150% to 200%	4% - 6.3%
200% to 250%	6.3% - 8.05%
250% to 300%	8.05% - 9.5%
300% to 400%	9.5%

In addition to subsidies for the costs of health insurance premiums, individuals may also qualify to offset other out of pocket costs through cost sharing credits. Subsidies for cost sharing are

[84] U.S. Department of Health and Human Services, Healthcare.gov, *Qualified Health Plan*, *https://www.healthcare.gov/glossary/qualified-health-plan/* (last viewed Mar. 8, 2015).
[85] Id.
[86] Actuarial value is calculated by computing the ratio of total expected payments by the plan for essential health benefits and costing sharing rules with the total costs of the essential health benefits the standard population is expected to incur. For example, a health plan with an actuarial value of 70 percent would be expected to pay an average of 70 percent of the standard population's expected medical expenses for the essential health benefits. Individuals covered by the plan would then be expected to pay the remaining 30 percent, on average through cost sharing such as deductibles, co-pays and co-insurance.
[87] 26 U.S.C. s. 36B(c).
[88] 26 U.S.C. s. 36B(b).

available for those individuals between 100 percent of the FPL and 400 percent of the FPL. The cost sharing credits reduce the out-of-pocket amounts incurred by individuals on essential health benefits and will also impact the actuarial value of a health plan. Actuarial value reflects the average share of covered benefits paid by the insurer or health plan. For example, if the actuarial value of a plan is 90 percent, the health plan is paying 90 percent of the costs and the enrollee 10 percent.

The maximum amount of cost sharing is 94 percent for those individuals between 100 percent and 150 percent FPL and individuals with incomes up to 400 percent FPL who may qualify for a 70 percent subsidy as the table below illustrates.

Cost Sharing Subsidies[89]	
FPL Level	**Cost Sharing Subsidy**
100% - 150%	94%
150% - 200%	87%
200% - 250%	73%
250% - 400%	70%

Cost sharing limitations are based on the limits placed on Health Savings Accounts under the Internal Revenue Code.[90] The maximum out of pocket costs for any federal Marketplace plan in 2015 are $6,600 for an individual and $13,200 for a family plan, even with a catastrophic plan.[91]

In addition to enrolling individuals into qualified health plans, an exchange may also determine eligibility for Medicaid and CHIP. The exchange also determines if an individual is eligible for advance premium tax credits and cost sharing reductions.

Supreme Court Action - King v. Burwell

On March 4, 2015, the U.S. Supreme Court heard oral arguments in *King v. Burwell*, a collection of cases that challenge the availability of federal premium tax subsidies for individuals who purchase health insurance coverage on the federal marketplace.[92] The argument centers on Section 1311(b)(1) of the PPACA and the direction that each state shall establish an exchange. Thirty-six states have since declined to develop their own state exchanges and their residents rely on the federal marketplace. If those residents would no longer be eligible for subsidies on the federal marketplace, it is estimated that the uninsured would increase by 8.2 million and that $28.8 billion in tax credits would be eliminated.[93] For Florida, over 1.1 million individuals would

[89] 42 U.S.C. s. 18071(c)(1)(B)
[90] CFR 45 §126.130; *See also* Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended for self only coverage for 2014; or for other than self-only coverage, the annual dollar amount in section 223(c)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended, for non-self only coverage that is in effect for 2014.
[91] U.S. Department of Health and Human Services, healthcare.gov, *Out of pocket costs*, *https://www.healthcare.gov/choose-a-plan/out-of-pocket-costs/* (last visit Mar. 7, 2015).
[92] King v. Burwell, ___F.2d ___ (Fed. Cir. 2014). 2014 U.S. App. LEXIS 13902.
[93] Linda J. Blumberg et al., *The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums*, ROBERT WOOD JOHNSON FOUNDATION AND URBAN INSTITUTE (Jan. 2015) http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf (last visited Mar. 7, 2015).

lose tax credits resulting in over 1 million people becoming uninsured and a loss of $3.8 billion in tax credits and cost sharing reductions,[94]

High Deductible Plans

High-deductible plans are paired with health savings accounts.[95] To qualify as a high deductible plan, the annual deductible must be at least $1,250 for single plans and $2,500 for family coverage. The employer and the employee make annual contributions[96] to a limit of $3,250 for single coverage and $6,250 for family coverage. For 2014, total out of pocket spending is capped at $6,350 for individual and $12,700 for family.[97] Both the employer and the employee contributions are not subject to federal income tax on the employee's income. Unused funds roll over automatically every year. A health savings account is owned by the employee and is portable.

Alternative Medicaid Expansion in Other States

Arkansas

Arkansas received approval for a Medicaid Section 1115 demonstration waiver to implement its Medicaid expansion in September 2013. Under its waiver, Arkansas uses Medicaid funds as premium assistance to purchase coverage in the federal Marketplace for its newly eligible adults up to 138 percent FPL. All newly eligible adults will primarily purchase coverage and enroll in a plan through the federal Marketplace to receive their coverage. Any services not covered through their plan are provided through the state's fee-for-service Medicaid delivery system.[98]

Individuals excluded from enrolling in the federal Marketplace include the medically frail, who may opt out and receive services directly through the state, and American Indians or Alaskan Natives. For all other enrollees affected by the demonstration, enrollment in a QHP is a condition of receiving benefits.[99]

Arkansas' Approved Monthly Premiums - Medicaid Expansion Waiver[100]		
Less than 50%	**50% - 100%**	**100 - 138% FPL**
None	$5 to IA	$10-$25 to IA

[94] Id at 5.
[95] Internal Revenue Code, 26 U.S.C. sec. 223.
[96] The IRS annually sets the contribution limit as adjusted by inflation.
[97] Internal Revenue Services, *Health Savings Accounts and Other Tax-Favored Health Plans (Pub. 969)(2013)* *http://www.irs.gov/publications/p969/index.html* (last visited Mar. 7, 2015).
[98] Centers for Medicare and Medicaid Services, *Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration Fact Sheet*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-fs.pdf (last visited Mar. 7, 2015).
[99] Centers for Medicare and Medicaid Services, Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration, pp.14-15, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (last visited Mar. 7, 2015).
[100] Centers for Medicare and Medicaid Services, Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration, pp.7 & 21, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (last visited Mar. 7, 2015).

All beneficiaries with incomes between 50 percent and 133 percent of the FPL will be assigned an Independence Account (IA). The individual will receive a credit or debit card to access the amounts in that account to cover copayments and coinsurance. Both the state and the participant are required to make contributions to this account.[101]

The state pays the managed care plans selected by the beneficiaries directly and identification cards are sent by the plan directly to their new enrollee. Individuals who do not make a selection are auto-assigned to a silver-level plan and are given 30-days to change plans.

Enrollees under 50 percent of the FPL have no additional cost sharing. Those enrollees above 50 percent of the FPL have cost sharing consistent with Medicaid requirements and does exceed more than 5 percent of family monthly or quarterly income.[102]

Iowa

In December 2013, Iowa received approval for two Medicaid waivers for implementation of its Medicaid expansion under PPACA. The waivers cover all newly eligible adults statewide up to 138 percent of the FPL, but does so under two delivery systems:

- Expands Medicaid for those at or below 100 percent FPL through Medicaid managed care; and
- Expands Medicaid for those from 101 percent FPL - 138 percent FPL by purchasing silver-level qualified health plan coverage in the marketplace.

Premiums were not imposed during the first year of the program but will be in the second year of the demonstration for enrollees above 50 percent of the FPL. Enrollees have the opportunity to have these waived if they complete healthy behaviors and can continue to be waived in subsequent years for meeting those incentives. At the state's option, the non-payment of a premium can result in a collectible debt, but not a loss of coverage.[103]

Iowa's Approved Monthly Premiums - Medicaid Expansion Waiver		
Less than 50% FPL	**50% - 100% FPL**	**100 - 133% FPL**
None	$5/household	$10/household
90 day premium grace period		

Individuals in the Wellness Plan (Medicaid Managed Care) receive a Medicaid alternative benefits plan that is at least equivalent to the state employee benefit plan, except for an enhanced dental plan with access to additional dental benefits with prior authorization.[104] While those in the Marketplace plan, receive an essential health benefit plan that is at least equivalent to those

[101] Centers for Medicare and Medicaid Services, Special Terms and Conditions - Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration, p.7, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (last visited Mar. 7, 2015).
[102] Id at 16.
[103] Centers for Medicare and Medicaid Services, Special Terms and Conditions with Iowa Department of Human Services - Iowa Wellness Plan (11-W-00289/5) http://dhs.iowa.gov/sites/default/files/WellnessSTCsTechnicalCorrections_020215.pdf (last visited Mar. 7, 2015).
[104] Iowa Department of Human Services, Medicaid 1115 Waiver Application, Iowa Wellness Plan, p.5, http://dhs.iowa.gov/sites/default/files/IAWellnessPlan1115_Final.pdf (last visited Mar. 7, 2015).

provided on the commercial essential health benefits benchmark.[105] Wrap-around services are provided by the Medicaid agency for family planning services at non-network providers and for EPSDT services for 19 and 20 year old enrollees. Iowa is not required to provide non-emergency transportation. The waiver was initially granted in year one of the demonstration and continued through July 31, 2015.[106]

Indiana

An amendment to Indiana's existing Medicaid demonstration, Healthy Indiana Plan 1.0 (HIP) was approved on January 27, 2015, and renamed the Healthy Indiana Plan 2.0. HIP 2.0 extends Medicaid to adults through 133 of the FPL beginning February 1, 2015. Under HIP 2.0, Indiana will offer three different pathways to coverage:

- HIP Basic - an ABP for individuals that includes all of the essential health benefits and does not require a premium payment;
- HIP Plus - a comprehensive ABP for individuals who contribute to a POWER account with additional benefits not available in HIP Basic; and
- HIP Link Program - a voluntary premium assistance program for individuals above age 21 with access to cost effective employer sponsored insurance that meets qualification criteria.[107]

Indiana does not offer non-emergency transportation for the first year of the demonstration.

In addition to health benefits coverage, individuals who contribute to a Personal Wellness and Responsibility (POWER) account access additional benefits, contributions to a POWER account are a condition of eligibility for those with incomes above 100 percent of the FPL.[108] Funds in the POWER accounts are used to pay for some of beneficiaries' health care expenses. With the exception of inappropriate use of the emergency room fee, no other cost sharing is charged under the HIP Plus component.

Those enrolled in HIP Basic are subject to copayments. These copayments are consistent with the Medicaid cost sharing rule and must include the automated tracking of the 5 percent monthly or quarterly aggregate cap. Indiana had the following co-payments approved:

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[105] Iowa Department of Human Services, Medicaid 1115 Waiver, Iowa Marketplace Choice Plan, p.5, http://dhs.iowa.gov/sites/default/files/IAMktplaceChoice1115_Final.pdf (last visited Mar. 7, 2015)

[106] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Iowa Marketplace Choice Plan - Section 1115 Demonstration Fact Sheet*, *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-fs.pdf* (last visited: Mar. 9, 2015).

[107] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Healthy Indiana Plan 2.0 Section 1115 Medicaid Demonstration Fact Sheet (January 27, 2015)*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-fs.pdf (last visited: Mar. 7, 2015).

[108] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Approval Letter and Special Terms and Conditions (January 27, 2015) http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf (last visited Mar. 7, 2015).

Indiana HIP Basic Co-Pay Schedule[109]	
Service	**Per Visit\Service**
Preventive Care Services (including family planning and maternity services)	$0
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-Preferred Drugs	$8
Non-Emergent ER Use (HIP Basic and HIP Plus)	$8 - 1st visit $25 - Recurrent

Enrollees above 100 percent of the FPL who do not make contributions or who cease transition to the HIP Basic program after a 60 day grace period are disqualified from the HIP Plus program for 6 months.[110] There are exceptions to the lock-out period for the medically frail and other special circumstances.

Indiana Maximum Monthly POWER Contributions[111]					
<5% FPL	**<22%**	**22% - 50%**	**51% -75%**	**76%-100%**	**101%-138%**
$1	$4.32	$9.82	$14.72	$19.62	$27.39
- Represents approximately 2% of enrollee's income; - When enrollee leaves the program, the member amount is refunded to the member; and - When enrollee remains in the program, the member portion rolls over at the end of the year; can double if member completes required preventive services.					

The POWER accounts function like a health savings account and hold both beneficiary and state contributions. The POWER account funds pay for the first $2,500 in claims; claims beyond that amount are covered through capitation or other payments made by the state.[112] The funds are not for copayments under the HIP Plus accounts. For HIP Link enrollees, the POWER account funds are used to pay premium and cost sharing amounts.[113]

Employers and other third parties are also permitted to contribute to POWER accounts. It is the managed care organization's responsibility to issue the POWER card to each enrollee upon enrollment and to track all of the contributions.[114]

Outside of this demonstration, Indiana will offer a separate work search and job training program to encourage employment called Gateway to Work for those enrollees who choose to participate. Health coverage under Medicaid will not be affected.[115]

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[109] Id at 35 and 36.
[110] Id.
[111] Healthy Indiana Plan 2.0, Presentation to Senate Health Policy Committee (March 4, 2015), slides 16 & 17 (on file with the Senate Committee on Health Policy).
[112] *Supra* Note 108, at 26.
[113] Id.
[114] *Supra* Note 108, at 30.
[115] *Supra* Note 108, at 3.

III. Effect of Proposed Changes:

Florida Health Insurance Affordability Exchange Program (Sections 1-14)

SPB 7044 directs the Division of Law Revision and Information to rename part II of chapter 409, Florida Statutes as the "Insurance Affordability Programs" which is currently named "Kidcare," to incorporate the newly created sections of ss. 409.720-409.731, F.S., under this part. The "Florida Health Insurance Affordability Exchange Program" or "FHIX" is established under sections 409.720 through 409.731, Florida Statutes, a new program under part II of ch. 409F.S.

The FHIX program is placed within the Agency for Health Care Administration (AHCA) for the purpose of assisting Floridians in purchasing health benefits coverage and gaining access to health services. The FHIX is based on seven principles:

- Fair Value;
- Consumer Choice;
- Simplicity;
- Portability;
- Promotes Employment;
- Consumer Empowerment; and
- Risk Adjustment.

Definitions specific for the FHIX program are:

- "Agency" means the Agency for Health Care Administration;
- "Applicant" means an individual who applies for determination of eligibility for health benefits coverage under this part;
- "Corporation" means Florida Health Choices, Inc.;
- "Enrollee" means an individual who has been determined eligible for and is receiving health benefits coverage under this part;
- "Florida Health Insurance Affordability Exchange" or "FHIX" means the program created under ss. 409.720-409.731, F.S.;
- "Florida Healthy Kids Corporation" means the entity created under s. 624.91, F.S.;
- "Florida Kidcare Program" or "Kidcare" means the program created under ss. 409,810-409.821, F.S.;
- "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 prepaid or per capita basis or a prepaid aggregate fixed sum basis;
- "Inactive status" means the enrollment status of a participant previously enrolled in health benefits coverage in the FHIX marketplace, who lost coverage through non-payment, but maintains access to his or her balance in a health savings account or health reimbursement account;
- "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and part III and IV of ch. 409, F.S., as administered by the agency;
- "Modified adjusted gross income" means the individual's or household's 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;

- "Patient Protection and Affordable Care Act" or "Affordable Care Act" means Public Law No. 111-148, as further amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and amendments to, and regulations or guidance under, those acts;
- "Premium credit" means the monthly amount paid by the agency per enrollee in the FHIX toward health benefits coverage;
- "Qualified alien" means an alien as defined in 8 U.S.C. s. 1641(b) or (c);[116] and
- "Resident" means a United States citizen or qualified alien who is domiciled in this state.

Eligibility

In order to participate in the FHIX, s. 409.723, F.S. establishes that an individual must be a resident and must also meet the following requirements, as applicable:
- Qualify as a newly eligible enrollee 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;
- Meet and maintain the responsibilities under participant responsibilities; and
- Qualify as a participant in the Florida Healthy Kids program under s. 624.91, F.S., subject to the implementation of Phase Three under s. 409.727, F.S.

A "newly eligible enrollee" as described above is an adult between the ages of 19 and 64 whose income is at or below 133 percent of the FPL based on a modified adjusted gross income or MAGI. This includes parents and childless adults who may not have previously qualified for Medicaid.

Enrollment

To enroll in FHIX, applicants will apply using the same process used today for Medicaid eligibility through the Department of Children and Families (department). The department is responsible for processing applications, determining eligibility and transmitting information to the agency or the corporation, depending on the phase on each applicant's eligibility status. An application is only deemed complete when it has met all of the requirements under participant responsibilities.

The department will also be responsible for corresponding with the participant on an ongoing basis regarding the participant's status and shall review the eligibility status at least every 12 months.

Participant Rights

A participant has certain rights under FHIX:
- Access to the FHIX marketplace to select the scope, amount, and type of health care coverage and services to purchase;

[116] "Qualified alien" means an alien as defined in s. 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.

- Continuity and portability of coverage to avoid disruption of coverage and other health care services when the participant's economic circumstances change;
- Retention of unspent credits in the participant's health savings or health reimbursement account following a change in the participant's eligibility status. Credits are maintained for an inactive status participant for up to 5 years after the participant enters inactive status;
- Ability to select more than one product or plan on the FHIX marketplace; and
- Choice of at least 2 health benefits products that meet the requirements of the Affordable Care Act.

Participant Responsibilities

A participant under the FHIX program also has certain responsibilities to remain enrolled or in an active status:

- Complete an initial application for health benefits coverage and annual renewal process which includes proof of employment, on-the-job training or placement activities, or pursuit of educational opportunities at certain hourly levels based on status;
- Learn and remain informed about the choices available on the FHIX marketplace and the uses of credit in the individual accounts;
- Execute a contract with the department that acknowledges that FHIX is not an entitlement, state and federal funding may end at any time, failure to pay cost sharing may result in a transition to inactive status, and noncompliance with other requirements may also result in a transition to inactive status;
- Select plans and other products in a timely manner;
- Comply with program rules and prohibitions against fraud;
- Make monthly premium payments and other cost sharing by the deadline; and
- 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.

Beginning with Phase Two, employment, on-the-job training, or pursuit of educational opportunities requirements will be implemented. Minimum hourly rates will vary by a participant's individual status in order to maintain an active status on the FHIX marketplace. For a parent of a child younger than 18, the minimum hourly requirements for pursuit of these activities or employment is 20 hours weekly. For a childless adult, the minimum weekly hourly requirement is 30. A disabled adult or the caregiver of a disabled child or adult may seek an exception to these requirements through the corporation on an annual basis.

Cost Sharing

Enrollees are required to make monthly premium payments to maintain their health benefits coverage on the FHIX marketplace. Premiums are assessed based on the enrollee's modified adjusted gross income and the maximum monthly premiums are set as follows:

FPL	**<22**	**22% - 50%**	**>50%-75%**	**>75%-100%**	**>100%**
Amount	$3	$8	$15	$20	$25

Depending on the products and services selected by the enrollee, he or she may incur additional cost sharing, such as copayments, deductibles, or other out of pocket costs. An enrollee may also be charged an inappropriate emergency room fee of $8 for the first visit and up to $25 for any subsequent visit, based on the plan selected by the enrollee. Cumulative annual cost sharing, however, may not exceed 5 percent of the enrollee's annual modified adjusted gross income.

If after a 30-day grace period, a full premium payment has not been received, the enrollee will be transitioned to an inactive status and may not re-enroll to active status for 6 months, unless a hardship exemption has been granted under the Medicaid Fair Hearing Process.

Available Assistance

Under s. 409.724, F.S., participants under FHIX receive a standard credit amount equivalent to the applicable risk-adjusted capitation rate paid to Medicaid managed care plans. Subject to federal approval, additional resources could be made available to supplement the standard credit amount and be made available to FHIX enrollees in the future and incorporated into FHIX.

In addition to the standard health benefits provided, the corporation must also offer each enrollee access to an individual account that qualifies as a health reimbursement or health savings account. Unexpended funds from the monthly premium credit must be placed in the account as well as credits earned from healthy behaviors, adherence to wellness plans, or compliance with disease management plans. Funds in these accounts may be used to pay cost sharing obligations or to purchase other health-related items, as permitted under federal law. This account may be retained for up to 5 years after a participant moves into inactive status.

The enrollee or other third parties may also make contributions to the enrollee's account to supplement the premium credit or other earned credits. The enrollee may not withdraw as a refund any funds except those funds the enrollee has deposited into his or her own account.

Choice counseling will be coordinated by the agency and the corporation for the FHIX. The choice counseling program must ensure the enrollees have information about the FHIX marketplace program, the products and services, who to call for questions or to make plan selections. The program will also provide culturally sensitive materials that take into consideration the projected population.

An ongoing education campaign coordinated by the agency, the corporation, and the Florida Healthy Kids Corporation must include:

- How the transition process to the FHIX marketplace will occur and the timeline for the enrollee's specific transition;
- What plans are available and how to research information about available plans;
- Information about other available insurance affordability programs for the individual and his or her family;
- Information about health benefits coverage, provider networks, and cost sharing for available plans in each region;
- Information on how to complete the required annual renewal process, including renewal dates and deadlines; and

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

Beginning in Phase Two (January 1, 2016), the Florida Healthy Kids Corporation will provide customer support for the FHIX marketplace. Customer support will include:
- Having a toll-free number;
- Maintaining a web site in multiple languages;
- Providing general program information;
- Handling financial information, including enrollee premiums; and
- Providing customer service and status reports on enrollee premiums;

The corporation is required to inform participants who transition to inactive status about other insurance affordability options and to electronically refer such enrollees to the federal exchange or other programs, as appropriate.

Available Products and Services

Section 409.725, F.S., requires the FHIX marketplace to offer the following products and services:
- Authorized products and services that are offered on the Florida Health Choices, Inc. marketplace (409.910, F.S.);
- Medicaid managed care plans under part IV of this chapter, that qualify to participate;
- Authorized products under the Florida Healthy Kids Corporation; and
- Employer sponsored plans.

Program Accountability

The plans and products that participate in FHIX will be required to meet certain accountability standards under s. 409.726, F.S. All managed care plans must collect and maintain encounter level data in the same manner as under s. 409.967(2)(d), F.S., the SMMC program and will be subject to the accompanying penalties under s. 409.967(2)(h)2, F.S., for the failure to meet those standards. The agency will be responsible for the collection and maintenance of that data.

The corporation and the agency will work together to develop network and access standards for FHIX contract standards and to develop coverage quality standards for the adult population.

SPB 7044 establishes specific performance standards for the department for the processing of applications, both initial applications and renewals. The agency, department, and the Florida Healthy Kids Corporation must conduct an annual satisfaction survey for the FHIX marketplace which may be incorporated into the annual report. Enrollment reports must be posted online monthly.

An annual report is due by July 1 to the Governor, the President of the Senate and the Speaker of the House of Representatives. The minimum components of the report include enrollment and application data, customer satisfaction, utilization and cost data, enrollee use of funds in reimbursement accounts, types of plans and products purchased and recommendations for program improvement.

Implementation Schedule

The implementation schedule for FHIX is based on each phase passing a readiness review and before implementation under s. 409.727, F.S. The agency is identified as the lead agency for FHIX, as the state's designated Medicaid agency. The agency, the corporation, the department, and the Florida Healthy Kids Corporation are directed to begin implementation upon SPB 7044 becoming law, with statewide implementation of the FHIX marketplace by January 1, 2016.

Implementation Activities			
Phase	**Start Date**	**Activities**	**Enrollee Requirements**
Readiness	Effective Date - Ongoing Based on Phase\Region	Implementation Activities	None
One	July 1, 2015	-Enroll newly eligible, low-income, uninsured into Medicaid managed care plans -Corporation readies for implementation of FHIX marketplace for Phase Two -Healthy Kids prepares for customer service, financial support and choice counseling in Phase Two and Three	-Complete application -Select MMA plan -Utilize health savings or health reimbursement account
Two	January 1, 2016*	1. Enroll newly eligible, low-income, uninsured into FHIX 2. Transition Phase One enrollees from MMA plans to FHIX by April 1, 2016 3. Renew existing enrollees at annual enrollment date 3. Healthy Kids prepares to transition enrollees to FHIX under Phase Three	-Complete application -Meet work or educational requirements or seek an exemption -Pay required premium or transition to inactive status -Select plans products, or services from FHIX -Execute contract -Comply with program rules -Meet minimum coverage requirements -Utilize health savings or health reimbursement account
Three	July 1, 2016*	1. Enroll newly eligible, low-income, uninsured into FHIX 2. Renew existing enrollees at annual enrollment date 3. Healthy Kids transitions enrollees to FHIX under Phase Three	-Complete application -Meet work or educational requirements or seek an exemption -Pay required premium or transition to inactive status -Select plans products, or services from FHIX -Execute contract -Comply with program rules

			-Meet minimum coverage requirements -Utilize health savings or health reimbursement account

**Phase Two implementation is contingent upon federal approval*

Before implementation of any phase, the agency shall conduct a readiness review in consultation with the FHIX Workgroup. The agency must determine that the region has satisfied the following milestones, at a minimum:

- Functional readiness of the service delivery platform for the phase;
- Plan availability and presence of plan choice;
- Provider network capacity and adequacy of the available plans in the region;
- Availability of customer support; and
- Other factors critical to the success of FHIX.

Phase One begins on July 1, 2015 and requires the agency, corporation, and the Florida Healthy Kids Corporation to coordinate activities. To be eligible during this phase, an enrollee must meet the definition of being "newly eligible" only. An enrollee is not be required to meet the work or educational search requirements or make premium payments during this phase.

Responsibilities of Agencies by Implementation Phase			
Activity	**Phase One**	**Phase Two**	**Phase Three**
Eligibility Determination	DCF	DCF	DCF
Benefits\Plan Delivery	Agency	FHIX	FHIX
Choice Counseling	Agency	Healthy Kids	Healthy Kids
Customer Service	Agency	Healthy Kids	Healthy Kids
Financial Service	Agency	Healthy Kids	Healthy Kids
Program Oversight	Agency	Agency	Agency

Enrollees in Phase One receive benefits and services through the Medicaid managed care plans in part IV of this chapter. At least two plans per region will be available to an enrollee to select from during this phase. Choice counseling and customer service will be provided by the agency.

Phase Two's implementation is contingent upon federal approval, but is planned to start no later than January 1, 2016. Participants will enroll or transition from Medicaid managed care plans to services and products on the FHIX marketplace. To be eligible during this phase, an enrollee must be "newly eligible," meet the work or educational search requirements, learn and be informed of the FHIX marketplace choices, execute department contract, select plans in a timely manner, comply with all program rules and prohibitions, make monthly premium payments and any other cost sharing payments, and meet minimum coverage requirements.

Enrollees moving from Phase One coverage must complete the process by April 1, 2016, or they will transition to inactive status. There is no automatic enrollment in the FHIX. Choice counseling during Phase Two will be provided in coordination by the agency and the corporation with customer support by the Florida Healthy Kids Corporation.

Phase Three begins no later than July 1, 2016 with the transition of Healthy Kids enrollees to the FHIX marketplace. Healthy Kids enrollees must meet the eligibility requirements of Phase Two enrollees and be eligible for the Healthy Kids program under s. 624.91, F.S. A Healthy Kids enrollee who selects a FHIX marketplace plan will be provided a premium credit equal to the average capitation rate paid in his or her county of residence in the Healthy Kids program as of June 30, 2016. The enrollee would be responsible for any difference in costs. Any unexpended funds from the premium credit may be used on the FHIX marketplace for supplemental benefits.

The corporation is required is to notify enrollees of their premium credit amounts and how to access the FHIX marketplace selection process. Customer service and choice counseling services will also be provided.

Program Operation and Management

In order to implement the FHIX program, several agencies and two non-profit corporations created by the state have specific responsibilities under new s. 409.728, F.S.:

Specific Program Operations and Management Duties for FHIX			
Agency for Health Care Admin.	**Dept. of Children and Families**	**Florida Health Choices, Inc.**	**Florida Healthy Kids**
Contract with Fla Health Choices for FHIX for implementation, development and administration and release of funds	Coordinate with other agencies and corporations	Begin implementation of FHIX in Phase One	Retain duties in Phase One and Two
Administer Phase One	Determine eligibility and renewals	Implement FHIX for Phase Two and Three	Provide customer service to FHIX
Provide administrative support to FHIX Workgroup	Transmit eligibility determinations to agency and corporation	Offer health benefits coverage compliant with PPACA	Collect and transfer family funds to FHIX
Transition Phase One Enrollees to FHIX no later than April 1, 2016		Offer at least 2 plans at each metal level	Conduct financial reporting
Transmit enrollee information to FHIX		Provide opportunity for MMA plans to participate on FHIX in Phase Three	Coordinate activities with partner agencies
With Phase Two, determine risk adjusted rates annually based on specific statutory criteria		Offer enhanced or customized benefits	

Specific Program Operations and Management Duties for FHIX			
Agency for Health Care Admin.	**Dept. of Children and Families**	**Florida Health Choices, Inc.**	**Florida Healthy Kids**
Transfer funds to FHIX for premium credits		Provide sufficient staff and resources	
Encourage Medicaid Managed Assistance (MMA) plans to participate on FHIX		Provide opportunity for Healthy Kids plans to participate at FHIX	

Long Term Re-Organization

Under s. 409.729, F.S., a FHIX Workgroup is created to facilitate the implementation of the program and to plan for a multi-year reorganization of the state's insurance affordability programs. The Workgroup is chaired by a representative of the agency and includes two additional representatives from the agency, plus two representatives each from the department, the corporation, and the FHKC.

The Workgroup is required to hold its first organizational meeting within 30 days after the effective date of this act and to meet at least bimonthly. The responsibilities of the Workgroup include:

- Recommend a Phase Two implementation plan no later than October 1, 2015;
- Review network and access standards for plans and products;
- 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 non-readiness recommendation, the reasons for such a recommendation, and develop a proposed plan for achieving readiness;
- Recommend any proposed change to Title XIX-funded or Title XXI-funded programs based on the availability of federal funding;
- Identify duplication of services among the corporation, the agency, and the FHKC currently and under FHIX's proposed Phase Three program;
- Evaluate fiscal impacts based on proposed Phase Three transition plan;
- Compile schedule of impacted contracts, leases, and other assets;
- Determine staff requirements for Phase Three; and
- Develop and present a final transition plan no later than December 1, 2015, to the Governor, President of the Senate, and Speaker of the House of Representatives.

Federal Authorities

Section 12 creates under s. 409.730, F.S., to authorize the agency to seek federal approval to implement FHIX. Obtaining federal approval may be a multi-step process.

Section 13 creates s. 409.731, F.S., and establishes triggers for expiration of the FHIX program under certain conditions. FHIX 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 occur:

- Federal match contribution falls below 90 percent;
- Federal match contribution falls below the increased Federal Match Assistance Percentage for medical assistance for newly eligible mandatory individuals as specified in the Affordable Care Act; or
- 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, non-blended federal contributions.

Florida Health Choices Program

Section 15 revises s. 408.910, F.S., to recognize the role the corporation will play in the FHIX marketplace. The bill makes the necessary changes to authorize the corporation to offer the products and services to the newly eligible population under the FHIX.

Definitions are added to include the "Florida Health Insurance Affordability Exchange Program" or "FHIX" and to include the potential availability of Medicaid managed care plans under the existing definition of "Insurer." A definition for the "Patient Protection and Affordable Care Act" or "Affordable Care Act" is also added.

In the list of services to individual participants that the corporation currently provides, two new services have been added:

- Health benefits coverage information about health insurance plans compliant with the Affordable Care Act; and
- Consumer assistance and enrollment services for the FHIX.

SPB 7044 includes a modification that recognizes that not all enrollees may have the option of payroll deduction.

The bill clarifies that surcharges may not be assessed on products or services sold on the FHIX marketplace. A separate reference to the FHIX marketplace has been created within the statute from the existing marketplace to distinguish the process, enrollment periods, and differing limits.

Authority has been granted to the corporation to collect contributions from third parties and governmental entities, to administer the FHIX program, and to coordinate with the agency, the department and FHKC on the transition plan for FHIX and any subsequent transition activities. Participation in the FHIX marketplace may begin at any time and is not limited to an open enrollment period.

Florida Healthy Kids Corporation (Sections 17 and 18)

Section 17 revises s. 624.91, F.S., the "William G. 'Doc' Myers Healthy Kids Corporation Act." Obsolete language referring to local and state subsidized non-Title XXI enrollees who have attritioned out of the program is deleted throughout the act. References to local match or local funds which are no longer collected are also deleted.

Healthy Kids' authorizations, duties and powers are amended to include:

- Collect premiums for the Florida Health Insurance Affordability Exchange program;
- Contract with other insurance affordability programs and FHIX to provide customer service other enrollment-focused services;
- Develop performance metrics annually for administrative functions, contracting with vendors, customer service, enrollee education, financial services, and program integrity; and
- Modify the health plan medical loss ratio to include dental and include calculations consistent with federal regulation.

Under the bill, effective July 1, 2016, health and dental services contracts of Healthy Kids must transition to the FHIX marketplace. Qualifying plans may enroll as vendors on FHIX to maintain continuity of care for Healthy Kids' participants.

Quarterly full-pay enrollment and utilization comparison information is required to be provided online. The current statute is not specific as to how the information may be provided.

The board of directors is re-configured with the chair being an appointee designated by the Governor and composed of 12 other members appointed by the Governor and confirmed by the Senate for 3-year terms. The board members serve at the pleasure of the Governor. Those members who are serving as of the effective date of this act may remain on the board until January 1, 2016.

Healthy Kids is also directed to confer with the agency, the department and the corporation to develop transition plans for FHIX.

Under section 18, s. 624.915, F.S., the Operating Fund of the Florida Healthy Kids Corporation is repealed effective upon the bill becoming law. The Operating Fund of Healthy Kids has never been separately funded.

Other Provisions (Sections 14, 19)

Section 408.70, F.S., which authorizes the Medically Needy program under Medicaid is repealed under section 14 of this bill. The action would be effective upon the bill becoming law.

Section 19 directs the Division of Law Revision and Information to replace the phrase "the effective date of this act" wherever it occurs with the date the act becomes law.

Effective Date (Section 20)

The act shall take effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SPB 7044 may provide cost saving to Floridians and stimulate economic growth. The following two organizations have published estimates:

- The Florida Chamber estimates that Florida's families and business pay $1.4 billion in hidden health care taxes to cover the costs of the uninsured.[117] As an example, the Chamber has estimated that every insured Floridian pays about $2,000 for every hospital stay to cover the cost of the uninsured.[118]
- The Florida Hospital Association (FHA) has also conducted research on the impact of extending health insurance coverage to this population. By covering 1 million or more Floridians, the FHA has projected 121,000 new jobs, savings of more than $2.5 billion in state general revenue, and $541 million a year in local government revenue.[119]

The Affordable Care Act imposes an employer mandate effective in 2015 for businesses that employ 100 or more people. Those employers must provide affordable health insurance coverage or face penalties of $2,000 or $3,000 per person. This may also have an impact on Florida's economy if additional options are not available and more individuals are not covered.[120]

C. Government Sector Impact:

Additional jobs that lead to 1 million additional insured individuals in the state may have an impact on other government services, state and local. Repeal of the Medically Needy program and a shift of those individuals into a more comprehensive medical insurance program at a higher federal match rate may generate savings in General Revenue or Tobacco Settlement funds that could be utilized to offset costs in the program in the long-term.

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[117] Florida Chamber of Commerce, *Smarter Healthcare Coverage in Florida*, p.3, http://www.flchamber.com/wp-content/uploads/FL-Chamber-Plan-for-Smarter-Healthcare-Coverage.pdf (last visited Mar. 8, 2015).
[118] Id.
[119] Florida Hospital Association, *A Healthy Florida Works*, *http://ahealthyfloridaworks.com/v6/wp-content/uploads/2014/10/AHealthyFloridaIGv10.pdf* (last visited Mar. 8, 2015).
[120] Id.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 408.910, 409.904, and 624.91.
This bill creates the following sections of the Florida Statutes: 409.720 - 409.731.
This bill repeals the following sections of the Florida Statutes: 408.70 and 624.915.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

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