By Senator Lee

24-00021-15A 20152508A__

1 A bill to be entitled
2 An act relating to Medicaid; amending s. 395.602,
3 F.S.; revising the term "rural hospital"; amending s.
4 409.908, F.S.; deleting provisions that authorized the
5 agency to receive funds from certain state entities,
6 local governments, and other political subdivisions
7 for a specific purpose; providing that the Agency for
8 Health Care Administration is authorized to receive
9 intergovernmental transfers of funds from governmental
10 entities for specified purposes; requiring the agency
11 to seek Medicaid waiver authority for the use of local
12 intergovernmental transfers under certain parameters;
13 revising the list of provider types that are subject
14 to certain statutory provisions relating to the
15 establishment of rates; amending s. 409.909, F.S.;
16 revising definitions; altering the annual allocation
17 cap for hospitals participating in the Statewide
18 Medicaid Residency Program; creating the Graduate
19 Medical Education Startup Bonus Program; providing
20 allocations for the program; amending s. 409.911,
21 F.S.; updating references to data used for calculating
22 disproportionate share program payments to certain
23 hospitals for the 2015-2016 fiscal year; repealing s.
24 409.97, F.S, relating to state and local Medicaid
25 partnerships; amending s. 409.983, F.S.; providing
26 parameters for the reconciliation of managed care plan
27 payments in the long-term care managed care program;
28 amending s. 408.07, F.S.; conforming a cross-
29 reference; creating s. 409.720, F.S.; providing a

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30 short title; creating s. 409.721, F.S.; creating the
31 Florida Health Insurance Affordability Exchange
32 Program or FHIX in the Agency for Health Care
33 Administration; providing program authority and
34 principles; creating s. 409.722, F.S.; defining terms;
35 creating s. 409.723, F.S.; providing eligibility and
36 enrollment criteria; providing patient rights and
37 responsibilities; providing premium levels; creating
38 s. 409.724, F.S.; providing for premium credits and
39 choice counseling; establishing an education campaign;
40 providing for customer support and disenrollment;
41 creating s. 409.725, F.S.; providing for available
42 products and services; creating s. 409.726, F.S.;
43 providing for program accountability; creating s.
44 409.727, F.S.; providing an implementation schedule;
45 creating s. 409.728, F.S.; providing program operation
46 and management duties; creating s. 409.729, F.S.;
47 providing for the development of a long-term
48 reorganization plan and the formation of the FHIX
49 Workgroup; creating s. 409.730, F.S.; authorizing the
50 agency to seek federal approval; creating s. 409.731,
51 F.S.; providing for program expiration; repealing s.
52 408.70, F.S., relating to legislative findings
53 regarding access to affordable health care; amending
54 s. 408.910, F.S.; revising legislative intent;
55 redefining terms; revising the scope of the Florida
56 Health Choices Program and the pricing of services
57 under the program; providing requirements for
58 operation of the marketplace; providing additional

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59 duties for the corporation to perform; requiring an
60 annual report to the Governor and the Legislature;
61 amending s. 409.904, F.S.; establishing a date when
62 new enrollment in the Medically Needy program is
63 suspended; providing an expiration date for the
64 program; amending s. 624.91, F.S.; revising
65 eligibility requirements for state-funded assistance;
66 revising the duties and powers of the Florida Healthy
67 Kids Corporation; revising provisions for the
68 appointment of members of the board of the Florida
69 Healthy Kids Corporation; requiring transition plans;
70 amending chapter 2012-33, Laws of Florida; requiring a
71 Program of All-Inclusive Care for the Elderly
72 organization in Broward County to serve frail elders
73 in Miami-Dade County; repealing s. 624.915, F.S.,
74 relating to the operating fund of the Florida Healthy
75 Kids Corporation; providing a directive to the
76 Division of Law Revision and Information; providing
77 effective dates.
78
79 Be It Enacted by the Legislature of the State of Florida:
80
81 Section 1. Paragraph (e) of subsection (2) of section
82 395.602, Florida Statutes, is amended to read:
83 395.602 Rural hospitals.—
84 (2) DEFINITIONS.—As used in this part<u>, the term</u>:
85 (e) “Rural hospital” means an acute care hospital licensed
86 under this chapter, having 100 or fewer licensed beds and an
87 emergency room, which is:

88 1. The sole provider within a county with a population
89 density of up to 100 persons per square mile;
90 2. An acute care hospital, in a county with a population
91 density of up to 100 persons per square mile, which is at least
92 30 minutes of travel time, on normally traveled roads under
93 normal traffic conditions, from any other acute care hospital
94 within the same county;
95 3. A hospital supported by a tax district or subdistrict
96 whose boundaries encompass a population of up to 100 persons per
97 square mile;
98 ~~4. A hospital classified as a sole community hospital under~~
99 ~~42 C.F.R. s. 412.92 which has up to 340 licensed beds;~~
100 4.~~5.~~ A hospital with a service area that has a population
101 of up to 100 persons per square mile. As used in this
102 subparagraph, the term “service area” means the fewest number of
103 zip codes that account for 75 percent of the hospital’s
104 discharges for the most recent 5-year period, based on
105 information available from the hospital inpatient discharge
106 database in the Florida Center for Health Information and Policy
107 Analysis at the agency; or
108 5.~~6.~~ A hospital designated as a critical access hospital,
109 as defined in s. 408.07.
110
111 Population densities used in this paragraph must be based upon
112 the most recently completed United States census. A hospital
113 that received funds under s. 409.9116 for a quarter beginning no
114 later than July 1, 2002, is deemed to have been and shall
115 continue to be a rural hospital from that date through June 30,
116 2021 ~~2015~~, if the hospital continues to have up to 100 licensed

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117 beds and an emergency room. An acute care hospital that has not
118 previously been designated as a rural hospital and that meets
119 the criteria of this paragraph shall be granted such designation
120 upon application, including supporting documentation, to the
121 agency. A hospital that was licensed as a rural hospital during
122 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
123 rural hospital from the date of designation through June 30,
124 2021 ~~2015~~, if the hospital continues to have up to 100 licensed
125 beds and an emergency room.
126 Section 2. Effective upon this act becoming a law,
127 subsection (1) of section 409.908, Florida Statutes, is amended
128 to read:
129 409.908 Reimbursement of Medicaid providers.—Subject to
130 specific appropriations, the agency shall reimburse Medicaid
131 providers, in accordance with state and federal law, according
132 to methodologies set forth in the rules of the agency and in
133 policy manuals and handbooks incorporated by reference therein.
134 These methodologies may include fee schedules, reimbursement
135 methods based on cost reporting, negotiated fees, competitive
136 bidding pursuant to s. 287.057, and other mechanisms the agency
137 considers efficient and effective for purchasing services or
138 goods on behalf of recipients. If a provider is reimbursed based
139 on cost reporting and submits a cost report late and that cost
140 report would have been used to set a lower reimbursement rate
141 for a rate semester, then the provider's rate for that semester
142 shall be retroactively calculated using the new cost report, and
143 full payment at the recalculated rate shall be effected
144 retroactively. Medicare-granted extensions for filing cost
145 reports, if applicable, shall also apply to Medicaid cost

146 reports. Payment for Medicaid compensable services made on
147 behalf of Medicaid eligible persons is subject to the
148 availability of moneys and any limitations or directions
149 provided for in the General Appropriations Act or chapter 216.
150 Further, nothing in this section shall be construed to prevent
151 or limit the agency from adjusting fees, reimbursement rates,
152 lengths of stay, number of visits, or number of services, or
153 making any other adjustments necessary to comply with the
154 availability of moneys and any limitations or directions
155 provided for in the General Appropriations Act, provided the
156 adjustment is consistent with legislative intent.
157 (1) Reimbursement to hospitals licensed under part I of
158 chapter 395 must be made prospectively or on the basis of
159 negotiation.
160 (a) Reimbursement for inpatient care is limited as provided
161 in s. 409.905(5), except as otherwise provided in this
162 subsection.
163 1. If authorized by the General Appropriations Act, the
164 agency may modify reimbursement for specific types of services
165 or diagnoses, recipient ages, and hospital provider types.
166 2. The agency may establish an alternative methodology to
167 the DRG-based prospective payment system to set reimbursement
168 rates for:
169 a. State-owned psychiatric hospitals.
170 b. Newborn hearing screening services.
171 c. Transplant services for which the agency has established
172 a global fee.
173 d. Recipients who have tuberculosis that is resistant to
174 therapy who are in need of long-term, hospital-based treatment

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175 pursuant to s. 392.62.
176 3. The agency shall modify reimbursement according to other
177 methodologies recognized in the General Appropriations Act.
178
179 ~~The agency may receive funds from state entities, including, but~~
180 ~~not limited to, the Department of Health, local governments, and~~
181 ~~other local political subdivisions, for the purpose of making~~
182 ~~special exception payments, including federal matching funds,~~
183 ~~through the Medicaid inpatient reimbursement methodologies.~~
184 ~~Funds received for this purpose shall be separately accounted~~
185 ~~for and may not be commingled with other state or local funds in~~
186 ~~any manner. The agency may certify all local governmental funds~~
187 ~~used as state match under Title XIX of the Social Security Act,~~
188 ~~to the extent and in the manner authorized under the General~~
189 ~~Appropriations Act and pursuant to an agreement between the~~
190 ~~agency and the local governmental entity. In order for the~~
191 ~~agency to certify such local governmental funds, a local~~
192 ~~governmental entity must submit a final, executed letter of~~
193 ~~agreement to the agency, which must be received by October 1 of~~
194 ~~each fiscal year and provide the total amount of local~~
195 ~~governmental funds authorized by the entity for that fiscal year~~
196 ~~under this paragraph, paragraph (b), or the General~~
197 ~~Appropriations Act. The local governmental entity shall use a~~
198 ~~certification form prescribed by the agency. At a minimum, the~~
199 ~~certification form must identify the amount being certified and~~
200 ~~describe the relationship between the certifying local~~
201 ~~governmental entity and the local health care provider. The~~
202 ~~agency shall prepare an annual statement of impact which~~
203 ~~documents the specific activities undertaken during the previous~~

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204 ~~fiscal year pursuant to this paragraph, to be submitted to the~~
205 ~~Legislature annually by January 1.~~
206 (b) Reimbursement for hospital outpatient care is limited
207 to $1,500 per state fiscal year per recipient, except for:
208 1. Such care provided to a Medicaid recipient under age 21,
209 in which case the only limitation is medical necessity.
210 2. Renal dialysis services.
211 3. Other exceptions made by the agency.
212
213 ~~The agency is authorized to receive funds from state entities,~~
214 ~~including, but not limited to, the Department of Health, the~~
215 ~~Board of Governors of the State University System, local~~
216 ~~governments, and other local political subdivisions, for the~~
217 ~~purpose of making payments, including federal matching funds,~~
218 ~~through the Medicaid outpatient reimbursement methodologies.~~
219 ~~Funds received from state entities and local governments for~~
220 ~~this purpose shall be separately accounted for and shall not be~~
221 ~~commingled with other state or local funds in any manner.~~
222 <u>(c)1. The agency may receive intergovernmental transfers of</u>
223 <u>funds from governmental entities, including, but not limited to,</u>
224 <u>the Department of Health, local governments, and other local</u>
225 <u>political subdivisions, for the purpose of making special</u>
226 <u>exception payments or to enhance provider reimbursement,</u>
227 <u>including federal matching funds, through the Medicaid inpatient</u>
228 <u>or outpatient reimbursement methodologies. Funds received by</u>
229 <u>intergovernmental transfer for these purposes shall be</u>
230 <u>separately accounted for and may not be commingled with other</u>
231 <u>state or local funds in any manner. The agency may certify all</u>
232 <u>local intergovernmental transfers used as state match under</u>

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233 Title XIX of the Social Security Act to the extent and in the
234 manner authorized under the General Appropriations Act and
235 pursuant to an agreement between the agency and the local
236 governmental entity. In order for the agency to certify such
237 local intergovernmental transfers, a local governmental entity
238 must submit a final, executed letter of agreement to the agency
239 which must be received by October 1 of each fiscal year and
240 provide the total amount of intergovernmental transfers
241 authorized by the entity for that fiscal year under this
242 paragraph or the General Appropriations Act. The local
243 governmental entity shall use a certification form prescribed by
244 the agency. At a minimum, the certification form must identify
245 the amount being certified.
246 2. The agency shall seek Medicaid waiver authority to use
247 local intergovernmental transfers for the advancement of the
248 Medicaid program and for enhancing or supplementing provider
249 reimbursement under this part and part IV in ways that incent
250 donations of local intergovernmental transfers and prevent
251 providers from being penalized in the calculations of Medicaid
252 cost limits by virtue of having donated intergovernmental
253 transfers under waiver authority granted under this paragraph.
254 The agency shall prepare an annual statement of impact which
255 documents the specific activities undertaken during the previous
256 fiscal year pursuant to this paragraph, to be submitted to the
257 Legislature annually by January 1.
258 (d)(c) Hospitals that provide services to a
259 disproportionate share of low-income Medicaid recipients, or
260 that participate in the regional perinatal intensive care center
261 program under chapter 383, or that participate in the statutory

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262 teaching hospital disproportionate share program may receive
263 additional reimbursement. The total amount of payment for
264 disproportionate share hospitals shall be fixed by the General
265 Appropriations Act. The computation of these payments must be
266 made in compliance with all federal regulations and the
267 methodologies described in ss. 409.911 and 409.9113.
268 (e) ~~(d)~~ The agency is authorized to limit inflationary
269 increases for outpatient hospital services as directed by the
270 General Appropriations Act.
271 Section 3. Paragraph (c) of subsection (23) of section
272 409.908, Florida Statutes, is amended to read:
273 409.908 Reimbursement of Medicaid providers.—Subject to
274 specific appropriations, the agency shall reimburse Medicaid
275 providers, in accordance with state and federal law, according
276 to methodologies set forth in the rules of the agency and in
277 policy manuals and handbooks incorporated by reference therein.
278 These methodologies may include fee schedules, reimbursement
279 methods based on cost reporting, negotiated fees, competitive
280 bidding pursuant to s. 287.057, and other mechanisms the agency
281 considers efficient and effective for purchasing services or
282 goods on behalf of recipients. If a provider is reimbursed based
283 on cost reporting and submits a cost report late and that cost
284 report would have been used to set a lower reimbursement rate
285 for a rate semester, then the provider’s rate for that semester
286 shall be retroactively calculated using the new cost report, and
287 full payment at the recalculated rate shall be effected
288 retroactively. Medicare-granted extensions for filing cost
289 reports, if applicable, shall also apply to Medicaid cost
290 reports. Payment for Medicaid compensable services made on

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291 behalf of Medicaid eligible persons is subject to the
292 availability of moneys and any limitations or directions
293 provided for in the General Appropriations Act or chapter 216.
294 Further, nothing in this section shall be construed to prevent
295 or limit the agency from adjusting fees, reimbursement rates,
296 lengths of stay, number of visits, or number of services, or
297 making any other adjustments necessary to comply with the
298 availability of moneys and any limitations or directions
299 provided for in the General Appropriations Act, provided the
300 adjustment is consistent with legislative intent.
301 (23)
302 (c) This subsection applies to the following provider
303 types:
304 1. Inpatient hospitals.
305 2. Outpatient hospitals.
306 3. Nursing homes.
307 4. County health departments.
308 ~~5. Community intermediate care facilities for the~~
309 ~~developmentally disabled.~~
310 5.~~6.~~ Prepaid health plans.
311 Section 4. Section 409.909, Florida Statutes, is amended to
312 read:
313 409.909 Statewide Medicaid Residency Program.—
314 (1) The Statewide Medicaid Residency Program is established
315 to improve the quality of care and access to care for Medicaid
316 recipients, expand graduate medical education on an equitable
317 basis, and increase the supply of highly trained physicians
318 statewide. The agency shall make payments to hospitals licensed
319 under part I of chapter 395 for graduate medical education

320 associated with the Medicaid program. This system of payments is
321 designed to generate federal matching funds under Medicaid and
322 distribute the resulting funds to participating hospitals on a
323 quarterly basis in each fiscal year for which an appropriation
324 is made.
325 (2) On or before September 15 of each year, the agency
326 shall calculate an allocation fraction to be used for
327 distributing funds to participating hospitals. On or before the
328 final business day of each quarter of a state fiscal year, the
329 agency shall distribute to each participating hospital one-
330 fourth of that hospital's annual allocation calculated under
331 subsection (4). The allocation fraction for each participating
332 hospital is based on the hospital's number of full-time
333 equivalent residents and the amount of its Medicaid payments. As
334 used in this section, the term:
335 (a) "Full-time equivalent," or "FTE," means a resident who
336 is in his or her residency period, with the initial residency
337 period, which is defined as the minimum number of years of
338 training required before the resident may become eligible for
339 board certification by the American Osteopathic Association
340 Bureau of Osteopathic Specialists or the American Board of
341 Medical Specialties in the specialty in which he or she first
342 began training, not to exceed 5 years. The residency specialty
343 is defined as reported using the current resident code in the
344 Intern and Resident Information System (IRIS), required by
345 Medicare. A resident training beyond the initial residency
346 period is counted as 0.5 FTE, unless his or her chosen specialty
347 is in general surgery or primary care, in which case the
348 resident is counted as 1.0 FTE. For the purposes of this

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349 section, primary care specialties include:
350 1. Family medicine;
351 2. General internal medicine;
352 3. General pediatrics;
353 4. Preventive medicine;
354 5. Geriatric medicine;
355 6. Osteopathic general practice;
356 7. Obstetrics and gynecology; ~~and~~
357 8. Emergency medicine; and
358 9. General surgery.
359 (b) “Medicaid payments” means the estimated total payments
360 for reimbursing a hospital for direct inpatient services for the
361 fiscal year in which the allocation fraction is calculated based
362 on the hospital inpatient appropriation and the parameters for
363 the inpatient diagnosis-related group base rate, including
364 applicable intergovernmental transfers, specified in the General
365 Appropriations Act, as determined by the agency.
366 (c) “Resident” means a medical intern, fellow, or resident
367 enrolled in a program accredited by the Accreditation Council
368 for Graduate Medical Education, the American Association of
369 Colleges of Osteopathic Medicine, or the American Osteopathic
370 Association at the beginning of the state fiscal year during
371 which the allocation fraction is calculated, as reported by the
372 hospital to the agency.
373 (3) The agency shall use the following formula to calculate
374 a participating hospital’s allocation fraction:
375
376 HAF=[0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]
377

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378 Where:
379 HAF=A hospital’s allocation fraction.
380 HFTE=A hospital’s total number of FTE residents.
381 TFTE=The total FTE residents for all participating
382 hospitals.
383 HMP=A hospital’s Medicaid payments.
384 TMP=The total Medicaid payments for all participating
385 hospitals.
386
387 (4) A hospital’s annual allocation shall be calculated by
388 multiplying the funds appropriated for the Statewide Medicaid
389 Residency Program in the General Appropriations Act by that
390 hospital’s allocation fraction. If the calculation results in an
391 annual allocation that exceeds 2 times the average ~~$50,000~~ per
392 FTE resident amount for all hospitals, the hospital’s annual
393 allocation shall be reduced to a sum equaling no more than 2
394 times the average ~~$50,000~~ per FTE resident. The funds calculated
395 for that hospital in excess of 2 times the average ~~$50,000~~ per
396 FTE resident amount for all hospitals shall be redistributed to
397 participating hospitals whose annual allocation does not exceed
398 2 times the average ~~$50,000~~ per FTE resident amount for all
399 hospitals, using the same methodology and payment schedule
400 specified in this section.
401 (5) Graduate Medical Education Startup Bonus Program—
402 Hospitals eligible for participation in subsection (1) are
403 eligible to participate in the graduate medical education
404 startup bonus program established under this subsection.
405 Notwithstanding subsection (4) or an FTE’s residency period, and
406 in any state fiscal year in which funds are appropriated for the

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407 startup bonus program, the agency shall allocate a $100,000
408 startup bonus for each newly created resident position that is
409 authorized by the Accreditation Council for Graduate Medical
410 Education or Osteopathic Postdoctoral Training Institution in an
411 initial or established accredited training program that is in a
412 physician specialty in statewide supply/demand deficit. In any
413 year in which funding is not sufficient to provide $100,000 for
414 each newly created resident position, funding shall be reduced
415 pro rata across all newly created resident positions in
416 physician specialties in statewide supply/demand deficit.
417 (a) Hospitals applying for a startup bonus must submit to
418 the agency by March 1 their Accreditation Council for Graduate
419 Medical Education or Osteopathic Postdoctoral Training
420 Institution approval validating the new resident positions
421 approved in physician specialties in statewide supply/demand
422 deficit in the current fiscal year. An applicant hospital may
423 validate a change in the number of residents by comparing the
424 prior period Accreditation Council for Graduate Medical
425 Education or Osteopathic Postdoctoral Training Institution
426 approval to the current year.
427 (b) Any unobligated startup bonus funds on April 15 of each
428 fiscal year shall be proportionally allocated to hospitals
429 participating under subsection (3) for existing FTE residents in
430 the physician specialties in statewide supply/demand deficit.
431 This nonrecurring allocation shall be in addition to the funds
432 allocated in subsection (4). Notwithstanding subsection (4), the
433 allocation under this subsection shall not exceed $100,000 per
434 FTE resident.
435 (c) For purposes of this subsection, physician specialties

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436 <u>and subspecialties, both adult and pediatric, in statewide</u>
437 <u>supply/demand deficit are those identified in the General</u>
438 <u>Appropriations Act.</u>
439 <u>(d) The agency shall distribute all funds authorized under</u>
440 <u>the Graduate Medical Education Startup Bonus program on or</u>
441 <u>before the final business day of the fourth quarter of a state</u>
442 <u>fiscal year.</u>
443 <u>(6)</u>~~(5)~~ Beginning in the 2015-2016 state fiscal year, the
444 agency shall reconcile each participating hospital's total
445 number of FTE residents calculated for the state fiscal year 2
446 years prior with its most recently available Medicare cost
447 reports covering the same time period. Reconciled FTE counts
448 shall be prorated according to the portion of the state fiscal
449 year covered by a Medicare cost report. Using the same
450 definitions, methodology, and payment schedule specified in this
451 section, the reconciliation shall apply any differences in
452 annual allocations calculated under subsection (4) to the
453 current year's annual allocations.
454 <u>(7)</u>~~(6)~~ The agency may adopt rules to administer this
455 section.
456 Section 5. Paragraph (a) of subsection (2) of section
457 409.911, Florida Statutes, is amended to read:
458 409.911 Disproportionate share program.—Subject to specific
459 allocations established within the General Appropriations Act
460 and any limitations established pursuant to chapter 216, the
461 agency shall distribute, pursuant to this section, moneys to
462 hospitals providing a disproportionate share of Medicaid or
463 charity care services by making quarterly Medicaid payments as
464 required. Notwithstanding the provisions of s. 409.915, counties

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are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and charity care to be used in calculating the disproportionate share payment:

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

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

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

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

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

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

408.07 Definitions.—As used in this chapter, with the

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494 exception of ss. 408.031-408.045, the term:
495 (43) “Rural hospital” means an acute care hospital licensed
496 under chapter 395, having 100 or fewer licensed beds and an
497 emergency room, and which is:
498 (a) The sole provider within a county with a population
499 density of no greater than 100 persons per square mile;
500 (b) An acute care hospital, in a county with a population
501 density of no greater than 100 persons per square mile, which is
502 at least 30 minutes of travel time, on normally traveled roads
503 under normal traffic conditions, from another acute care
504 hospital within the same county;
505 (c) A hospital supported by a tax district or subdistrict
506 whose boundaries encompass a population of 100 persons or fewer
507 per square mile;
508 (d) A hospital with a service area that has a population of
509 100 persons or fewer per square mile. As used in this paragraph,
510 the term “service area” means the fewest number of zip codes
511 that account for 75 percent of the hospital’s discharges for the
512 most recent 5-year period, based on information available from
513 the hospital inpatient discharge database in the Florida Center
514 for Health Information and Policy Analysis at the Agency for
515 Health Care Administration; or
516 (e) A critical access hospital.
517
518 Population densities used in this subsection must be based upon
519 the most recently completed United States census. A hospital
520 that received funds under s. 409.9116 for a quarter beginning no
521 later than July 1, 2002, is deemed to have been and shall
522 continue to be a rural hospital from that date through June 30,

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523 2015, if the hospital continues to have 100 or fewer licensed
524 beds and an emergency room~~, or meets the criteria of s.~~
525 ~~395.602(2)(e)4~~. An acute care hospital that has not previously
526 been designated as a rural hospital and that meets the criteria
527 of this subsection shall be granted such designation upon
528 application, including supporting documentation, to the Agency
529 for Health Care Administration.
530 Section 9. Effective upon this act becoming a law, the
531 Division of Law Revision and Information is directed to rename
532 part II of chapter 409, Florida Statutes, as "Insurance
533 Affordability Programs" and to incorporate ss. 409.720-409.731,
534 Florida Statutes, under this part.
535 Section 10. Effective upon this act becoming a law, section
536 409.720, Florida Statutes, is created to read:
537 409.720 Short title.—Sections 409.720-409.731 may be cited
538 as the "Florida Health Insurance Affordability Exchange Program"
539 or "FHIX."
540 Section 11. Effective upon this act becoming a law, section
541 409.721, Florida Statutes, is created to read:
542 409.721 Program authority.—The Florida Health Insurance
543 Affordability Exchange Program, or FHIX, is created in the
544 agency to assist Floridians in purchasing health benefits
545 coverage and gaining access to health services. The products and
546 services offered by FHIX are based on the following principles:
547 (1) FAIR VALUE.—Financial assistance will be rationally
548 allocated regardless of differences in categorical eligibility.
549 (2) CONSUMER CHOICE.—Participants will be offered
550 meaningful choices in the way they can redeem the value of the
551 available assistance.

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552 (3) SIMPLICITY.—Obtaining assistance will be consumer-
553 friendly, and customer support will be available when needed.
554 (4) PORTABILITY.—Participants can continue to access the
555 services and products of FHIX despite changes in their
556 circumstances.
557 (5) PROMOTES EMPLOYMENT.—Assistance will be offered in a
558 way that incentivizes employment.
559 (6) CONSUMER EMPOWERMENT.—Assistance will be offered in a
560 manner that maximizes individual control over available
561 resources.
562 (7) RISK ADJUSTMENT.—The amount of assistance will reflect
563 participants' medical risk.
564 Section 12. Effective upon this act becoming a law, section
565 409.722, Florida Statutes, is created to read:
566 409.722 Definitions.—As used in ss. 409.720-409.731, the
567 term:
568 (1) "Agency" means the Agency for Health Care
569 Administration.
570 (2) "Applicant" means an individual who applies for
571 determination of eligibility for health benefits coverage under
572 this part.
573 (3) "Corporation" means Florida Health Choices, Inc., as
574 established under s. 408.910.
575 (4) "Enrollee" means an individual who has been determined
576 eligible for and is receiving health benefits coverage under
577 this part.
578 (5) "FHIX marketplace" or "marketplace" means the single,
579 centralized market established under s. 408.910 which
580 facilitates health benefits coverage.

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581 (6) “Florida Health Insurance Affordability Exchange
582 Program” or “FHIX” means the program created under ss. 409.720-
583 409.731.
584 (7) “Florida Healthy Kids Corporation” means the entity
585 created under s. 624.91.
586 (8) “Florida Kidcare program” or “Kidcare program” means
587 the health benefits coverage administered through ss. 409.810-
588 409.821.
589 (9) “Health benefits coverage” means the payment of
590 benefits for covered health care services or the availability,
591 directly or through arrangements with other persons, of covered
592 health care services on a prepaid per capita basis or on a
593 prepaid aggregate fixed-sum basis.
594 (10) “Inactive status” means the enrollment status of a
595 participant previously enrolled in health benefits coverage
596 through the FHIX marketplace who lost coverage through the
597 marketplace for non-payment, but maintains access to his or her
598 balance in a health savings account or health reimbursement
599 account.
600 (11) “Medicaid” means the medical assistance program
601 authorized by Title XIX of the Social Security Act, and
602 regulations thereunder, and part III and part IV of this
603 chapter, as administered in this state by the agency.
604 (12) “Modified adjusted gross income” means the
605 individual’s or household’s annual adjusted gross income as
606 defined in s. 36B(d)(2) of the Internal Revenue Code of 1986 and
607 which is used to determine eligibility for FHIX.
608 (13) “Patient Protection and Affordable Care Act” or
609 “Affordable Care Act” means Pub. L. No. 111-148, as further

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610 amended by the Health Care and Education Reconciliation Act of
611 2010, Pub. L. No. 111-152, and any amendments to, and
612 regulations or guidance under, those acts.
613 (14) “Premium credit” means the monthly amount paid by the
614 agency per enrollee in the Florida Health Insurance
615 Affordability Exchange Program toward health benefits coverage.
616 (15) “Qualified alien” means an alien as defined in 8
617 U.S.C. s. 1641(b) or (c).
618 (16) “Resident” means a United States citizen or qualified
619 alien who is domiciled in this state.
620 Section 13. Effective upon this act becoming a law, section
621 409.723, Florida Statutes, is created to read:
622 409.723 Participation.—
623 (1) ELIGIBILITY.—In order to participate in FHIX, an
624 individual must be a resident and must meet the following
625 requirements, as applicable:
626 (a) Qualify as a newly eligible enrollee, who must be an
627 individual as described in s. 1902(a)(10)(A)(i)(VIII) of the
628 Social Security Act or s. 2001 of the Affordable Care Act and as
629 may be further defined by federal regulation.
630 (b) Meet and maintain the responsibilities under subsection
631 (4).
632 (c) Qualify as a participant in the Florida Healthy Kids
633 program under s. 624.91, subject to the implementation of Phase
634 Three under s. 409.727.
635 (2) ENROLLMENT.—To enroll in FHIX, an applicant must submit
636 an application to the department for an eligibility
637 determination.
638 (a) Applications may be submitted by mail, fax, online, or

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639 any other method permitted by law or regulation.
640 (b) The department is responsible for any eligibility
641 correspondence and status updates to the participant and other
642 agencies.
643 (c) The department shall review a participant's eligibility
644 every 12 months.
645 (d) An application or renewal is deemed complete when the
646 participant has met all the requirements under subsection (4).
647 (3) PARTICIPANT RIGHTS.—A participant has all of the
648 following rights:
649 (a) Access to the FHIX marketplace to select the scope,
650 amount, and type of health care coverage and other services to
651 purchase.
652 (b) Continuity and portability of coverage to avoid
653 disruption of coverage and other health care services when the
654 participant's economic circumstances change.
655 (c) Retention of applicable unspent credits in the
656 participant's health savings or health reimbursement account
657 following a change in the participant's eligibility status.
658 Credits are valid for an inactive status participant for up to 5
659 years after the participant first enters an inactive status.
660 (d) Ability to select more than one product or plan on the
661 FHIX marketplace.
662 (e) Choice of at least two health benefits products that
663 meet the requirements of the Affordable Care Act.
664 (4) PARTICIPANT RESPONSIBILITIES.—A participant has all of
665 the following responsibilities:
666 (a) Complete an initial application for health benefits
667 coverage and an annual renewal process;

668 (b) Annually provide evidence of participation in one of
669 the following activities at the levels required under paragraph
670 (c):
671 1. Proof of employment.
672 2. On-the-job training or job placement activities.
673 3. Pursuit of educational opportunities.
674 (c) Engage in the activities required under paragraph (b)
675 at the following minimum levels:
676 1. For a parent of a child younger than 18 years of age, a
677 minimum of 20 hours weekly.
678 2. For a childless adult, a minimum of 30 hours weekly.
679
680 A participant who is a disabled adult or a caregiver of a
681 disabled child or adult may submit a request for an exception to
682 these requirements to the corporation and, thereafter, shall
683 annually submit to the department a request to renew the
684 exception to the hourly level requirements.
685 (d) Learn and remain informed about the choices available
686 on the FHIX marketplace and the uses of credits in the
687 individual accounts.
688 (e) Execute a contract with the department to acknowledge
689 that:
690 1. FHIX is not an entitlement and state and federal funding
691 may end at any time;
692 2. Failure to pay required premiums or cost sharing will
693 result in a transition to inactive status; and
694 3. Noncompliance with work or educational requirements will
695 result in a transition to inactive status.
696 (f) Select plans and other products in a timely manner.

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697 (g) Comply with program rules and the prohibitions against
698 fraud, as described in s. 414.39.
699 (h) Timely make monthly premium and any other cost-sharing
700 payments.
701 (i) Meet minimum coverage requirements by selecting a high-
702 deductible health plan combined with a health savings or health
703 reimbursement account if not selecting a plan offering more
704 extensive coverage.
705 (5) COST SHARING.—
706 (a) Enrollees are assessed monthly premiums based on their
707 modified adjusted gross income. The maximum monthly premium
708 payments are set at the following income levels:
709 1. At or below 22 percent of the federal poverty level: $3.
710 2. Greater than 22 percent, but at or below 50 percent, of
711 the federal poverty level: $8.
712 3. Greater than 50 percent, but at or below 75 percent, of
713 the federal poverty level: $15.
714 4. Greater than 75 percent, but at or below 100 percent, of
715 the federal poverty level: $20.
716 5. Greater than 100 percent of the federal poverty level:
717 $25.
718 (b) Depending on the products and services selected by the
719 enrollee, the enrollee may also incur additional cost-sharing,
720 such as copayments, deductibles, or other out-of-pocket costs.
721 (c) An enrollee may be subject to an inappropriate
722 emergency room visit charge of up to $8 for the first visit and
723 up to $25 for any subsequent visit, based on the enrollee’s
724 benefit plan, to discourage inappropriate use of the emergency
725 room.

726 (d) Cumulative annual cost sharing per enrollee may not
727 exceed 5 percent of an enrollee’s annual modified adjusted gross
728 income.
729 (e) If, after a 30-day grace period, a full premium payment
730 has not been received, the enrollee shall be transitioned from
731 coverage to inactive status and may not reenroll for a minimum
732 of 6 months, unless a hardship exception has been granted.
733 Enrollees may seek a hardship exception under the Medicaid Fair
734 Hearing Process.
735 Section 14. Effective upon this act becoming a law, section
736 409.724, Florida Statutes, is created to read:
737 409.724 Available assistance.—
738 (1) PREMIUM CREDITS.—
739 (a) Standard amount.—The standard monthly premium credit is
740 equivalent to the applicable risk-adjusted capitation rate paid
741 to Medicaid managed care plans under part IV of this chapter.
742 (b) Supplemental funding.—Subject to federal approval,
743 additional resources may be made available to enrollees and
744 incorporated into FHIX.
745 (c) Savings accounts.—In addition to the benefits provided
746 under this section, the corporation must offer each enrollee
747 access to an individual account that qualifies as a health
748 reimbursement account or a health savings account. Eligible
749 unexpended funds from the monthly premium credit must be
750 deposited into each enrollee’s individual account in a timely
751 manner. Enrollees may also be rewarded for healthy behaviors,
752 adherence to wellness programs, and other activities established
753 by the corporation which demonstrate compliance with prevention
754 or disease management guidelines. Funds deposited into these

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755 accounts may be used to pay cost-sharing obligations or to
756 purchase other health-related items to the extent permitted
757 under federal law.
758 (d) Enrollee contributions.—The enrollee may make deposits
759 to his or her account at any time to supplement the premium
760 credit, to purchase additional FHIX products, or to offset other
761 cost-sharing obligations.
762 (e) Third parties.—Third parties, including, but not
763 limited to, an employer or relative, may also make deposits on
764 behalf of the enrollee into the enrollee's FHIX marketplace
765 account. The enrollee may not withdraw any funds as a refund,
766 except those funds the enrollee has deposited into his or her
767 account.
768 (2) CHOICE COUNSELING.—The agency and the corporation shall
769 work together to develop a choice counseling program for FHIX.
770 The choice counseling program must ensure that participants have
771 information about the FHIX marketplace program, products, and
772 services and that participants know where and whom to call for
773 questions or to make their plan selections. The choice
774 counseling program must provide culturally sensitive materials
775 and must take into consideration the demographics of the
776 projected population.
777 (3) EDUCATION CAMPAIGN.—The agency, the corporation, and
778 the Florida Healthy Kids Corporation must coordinate an ongoing
779 enrollee education campaign beginning in Phase One, as provided
780 in s. 409.27, informing participants, at a minimum:
781 (a) How the transition process to the FHIX marketplace will
782 occur and the timeline for the enrollee's specific transition.
783 (b) What plans are available and how to research

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784 information about available plans.
785 (c) Information about other available insurance
786 affordability programs for the individual and his or her family.
787 (d) Information about health benefits coverage, provider
788 networks, and cost sharing for available plans in each region.
789 (e) Information on how to complete the required annual
790 renewal process, including renewal dates and deadlines.
791 (f) Information on how to update eligibility if the
792 participant's data have changed since his or her last renewal or
793 application date.
794 (4) CUSTOMER SUPPORT.—Beginning in Phase Two, the Florida
795 Healthy Kids Corporation shall provide customer support for
796 FHIX, shall address general program information, financial
797 information, and customer service issues, and shall provide
798 status updates on bill payments. Customer support must also
799 provide a toll-free number and maintain a website that is
800 available in multiple languages and that meets the needs of the
801 enrollee population.
802 (5) INACTIVE PARTICIPANTS.—The corporation must inform the
803 inactive participant about other insurance affordability
804 programs and electronically refer the participant to the federal
805 exchange or other insurance affordability programs, as
806 appropriate.
807 Section 15. Effective upon this act becoming a law, section
808 409.725, Florida Statutes, is created to read:
809 409.725 Available products and services.—The FHIX
810 marketplace shall offer the following products and services:
811 (1) Authorized products and services pursuant to s.
812 408.910.

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813 (2) Medicaid managed care plans under part IV of this
814 chapter.
815 (3) Authorized products under the Florida Healthy Kids
816 Corporation pursuant to s. 624.91.
817 (4) Employer-sponsored plans.
818 Section 16. Effective upon this act becoming a law, section
819 409.726, Florida Statutes, is created to read:
820 409.726 Program accountability.—
821 (1) All managed care plans that participate in FHIX must
822 collect and maintain encounter level data in accordance with the
823 encounter data requirements under s. 409.967(2)(d) and are
824 subject to the accompanying penalties under s. 409.967(2)(h)2.
825 The agency is responsible for the collection and maintenance of
826 the encounter level data.
827 (2) The corporation, in consultation with the agency, shall
828 establish access and network standards for contracts on the FHIX
829 marketplace and shall ensure that contracted plans have
830 sufficient providers to meet enrollee needs. The corporation, in
831 consultation with the agency, shall develop quality of coverage
832 and provider standards specific to the adult population.
833 (3) The department shall develop accountability measures
834 and performance standards to be applied to applications and
835 renewal applications for FHIX which are submitted online, by
836 mail, by fax, or through referrals from a third party. The
837 minimum performance standards are:
838 (a) Application processing speed.—Ninety percent of all
839 applications, from all sources, must be processed within 45
840 days.
841 (b) Applications processing speed from online sources.—

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842 Ninety-five percent of all applications received from online
843 sources must be processed within 45 days.
844 (c) Renewal application processing speed.—Ninety percent of
845 all renewals, from all sources, must be processed within 45
846 days.
847 (d) Renewal application processing speed from online
848 sources.—Ninety-five percent of all applications received from
849 online sources must be processed within 45 days.
850 (4) The agency, the department, and the Florida Healthy
851 Kids Corporation must meet the following standards for their
852 respective roles in the program:
853 (a) Eighty-five percent of calls must be answered in 20
854 seconds or less.
855 (b) One hundred percent of all contacts, which include, but
856 are not limited to, telephone calls, faxed documents and
857 requests, and e-mails, must be handled within 2 business days.
858 (c) Any self-service tools available to participants, such
859 as interactive voice response systems, must be operational 7
860 days a week, 24 hours a day, at least 98 percent of each month.
861 (5) The agency, the department, and the Florida Healthy
862 Kids Corporation must conduct an annual satisfaction survey to
863 address all measures that require participant input specific to
864 the FHIX marketplace program. The parties may elect to
865 incorporate these elements into the annual report required under
866 subsection (7).
867 (6) The agency and the corporation shall post online
868 monthly enrollment reports for FHIX.
869 (7) An annual report is due no later than July 1 to the
870 Governor, the President of the Senate, and the Speaker of the

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871 House of Representatives. The annual report must be coordinated
872 by the agency and the corporation and must include, but is not
873 limited to:
874 (a) Enrollment and application trends and issues.
875 (b) Utilization and cost data.
876 (c) Customer satisfaction.
877 (d) Funding sources in health savings accounts or health
878 reimbursement accounts.
879 (e) Enrollee use of funds in health savings accounts or
880 health reimbursement accounts.
881 (f) Types of products and plans purchased.
882 (g) Movement of enrollees across different insurance
883 affordability programs.
884 (h) Recommendations for program improvement.
885 Section 17. Effective upon this act becoming a law, section
886 409.727, Florida Statutes, is created to read:
887 409.727 Implementation schedule.—The agency, the
888 corporation, the department, and the Florida Healthy Kids
889 Corporation shall begin implementation of FHIX immediately, with
890 statewide implementation in all regions, as described in s.
891 409.966(2), by January 1, 2016.
892 (1) READINESS REVIEW.—Before implementation of any phase
893 under this section, the agency shall conduct a readiness review
894 in consultation with the FHIX Workgroup described in s. 409.729.
895 The agency must determine, at a minimum, the following readiness
896 milestones:
897 (a) Functional readiness of the service delivery platform
898 for the phase.
899 (b) Plan availability and presence of plan choice.

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900 (c) Provider network capacity and adequacy of the available
901 plans in the region.
902 (d) Availability of customer support.
903 (e) Other factors critical to the success of FHIX.
904 (2) PHASE ONE.—
905 (a) Phase One begins on July 1, 2015. The agency, the
906 corporation, the department, and the Florida Healthy Kids
907 Corporation shall coordinate activities to ensure that
908 enrollment begins by July 1, 2015.
909 (b) To be eligible during this phase, a participant must
910 meet the requirements under s. 409.723(1)(a).
911 (c) An enrollee is entitled to receive health benefits
912 coverage in the same manner as provided under and through the
913 selected managed care plans in the Medicaid managed care program
914 in part IV of this chapter.
915 (d) An enrollee shall have a choice of at least two managed
916 care plans in each region.
917 (e) Choice counseling and customer service must be provided
918 in accordance with s. 409.724(2).
919 (3) PHASE TWO.—
920 (a) Beginning no later than January 1, 2016, and contingent
921 upon federal approval, participants may enroll or transition to
922 health benefits coverage under the FHIX marketplace.
923 (b) To be eligible during this phase, a participant must
924 meet the requirements under s. 409.723(1)(a) and (b).
925 (c) An enrollee may select any benefit, service, or product
926 available.
927 (d) The corporation shall notify an enrollee of his or her
928 premium credit amount and how to access the FHIX marketplace

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929 selection process.
930 (e) A Phase One enrollee must be transitioned to the FHIX
931 marketplace by April 1, 2016. An enrollee who does not select a
932 plan or service on the FHIX marketplace by that deadline shall
933 be moved to inactive status.
934 (f) An enrollee shall have a choice of at least two managed
935 care plans in each region which meet or exceed the Affordable
936 Care Act's requirements and which qualify for a premium credit
937 on the FHIX marketplace.
938 (g) Choice counseling and customer service must be provided
939 in accordance with s. 409.724(2) and (4).
940 (4) PHASE THREE.—
941 (a) No later than July 1, 2016, the corporation and the
942 Florida Healthy Kids Corporation must begin the transition of
943 enrollees under s. 624.91 to the FHIX marketplace.
944 (b) Eligibility during this phase is based on meeting the
945 requirements of Phase Two and s. 409.723(1)(c).
946 (c) An enrollee may select any benefit, service, or product
947 available under s. 409.725.
948 (d) A Florida Healthy Kids enrollee who selects a FHIX
949 marketplace plan must be provided a premium credit equivalent to
950 the average capitation rate paid in his or her county of
951 residence under Florida Healthy Kids as of June 30, 2016. The
952 enrollee is responsible for any difference in costs and may use
953 any remaining funds for supplemental benefits on the FHIX
954 marketplace.
955 (e) The corporation shall notify an enrollee of his or her
956 premium credit amount and how to access the FHIX marketplace
957 selection process.

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958 (f) Choice counseling and customer service must be provided
959 in accordance with s. 409.724(2) and (4).
960 (g) Enrollees under s. 624.91 must transition to the FHIX
961 marketplace by September 30, 2016.
962 Section 18. Effective upon this act becoming a law, section
963 409.728, Florida Statutes, is created to read:
964 409.728 Program operation and management.—In order to
965 implement ss. 409.720-409.731:
966 (1) The Agency for Health Care Administration shall do all
967 of the following:
968 (a) Contract with the corporation for the development,
969 implementation, and administration of the Florida Health
970 Insurance Affordability Exchange Program and for the release of
971 any federal, state, or other funds appropriated to the
972 corporation.
973 (b) Administer Phase One of FHIX.
974 (c) Provide administrative support to the FHIX Workgroup
975 under s. 409.729.
976 (d) Transition the FHIX enrollees to the FHIX marketplace
977 beginning January 1, 2016, in accordance with the transition
978 workplan. Stakeholders that serve low-income individuals and
979 families must be consulted during the implementation and
980 transition process through a public input process. All regions
981 must complete the transition no later than April 1, 2016.
982 (e) Timely transmit enrollee information to the
983 corporation.
984 (f) Beginning with Phase Two, determine annually the risk-
985 adjusted rate to be paid per month based on historical
986 utilization and spending data for the medical and behavioral

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987 health of this population, projected forward, and adjusted to
988 reflect the eligibility category, medical and dental trends,
989 geographic areas, and the clinical risk profile of the
990 enrollees.
991 (g) Transfer to the corporation such funds as approved in
992 the General Appropriations Act for the premium credits.
993 (h) Encourage Medicaid managed care plans to apply as
994 vendors to the marketplace to facilitate continuity of care and
995 family care coordination.
996 (2) The Department of Children and Families shall, in
997 coordination with the corporation, the agency, and the Florida
998 Healthy Kids Corporation, determine eligibility of applications
999 and application renewals for FHIX in accordance with s. 409.902
1000 and shall transmit eligibility determination information on a
1001 timely basis to the agency and corporation.
1002 (3) The Florida Healthy Kids Corporation shall do all of
1003 the following:
1004 (a) Retain its duties and responsibilities under s. 624.91
1005 for Phase One and Phase Two of the program.
1006 (b) Provide customer service for the FHIX marketplace, in
1007 coordination with the agency and the corporation.
1008 (c) Transfer funds and provide financial support to the
1009 FHIX marketplace, including the collection of monthly cost
1010 sharing.
1011 (d) Conduct financial reporting related to such activities,
1012 in coordination with the corporation and the agency.
1013 (e) Coordinate activities for the program with the agency,
1014 the department, and the corporation.
1015 (4) Florida Health Choices, Inc., shall do all of the

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1016 following:
1017 (a) Begin the development of FHIX during Phase One.
1018 (b) Implement and administer Phase Two and Phase Three of
1019 the FHIX marketplace and the ongoing operations of the program.
1020 (c) Offer health benefits coverage packages on the FHIX
1021 marketplace, including plans compliant with the Affordable Care
1022 Act.
1023 (d) Offer FHIX enrollees a choice of at least two plans per
1024 county at each benefit level which meet the requirements under
1025 the Affordable Care Act.
1026 (e) Provide an opportunity for participation in Medicaid
1027 managed care plans if those plans meet the requirements of the
1028 FHIX marketplace.
1029 (f) Offer enhanced or customized benefits to FHIX
1030 marketplace enrollees.
1031 (g) Provide sufficient staff and resources to meet the
1032 program needs of enrollees.
1033 (h) Provide an opportunity for plans contracted with or
1034 previously contracted with the Florida Healthy Kids Corporation
1035 under s. 624.91 to participate with FHIX if those plans meet the
1036 requirements of the program.
1037 (i) Encourage insurance agents licensed under chapter 626
1038 to identify and assist enrollees. This act does not prohibit
1039 these agents from receiving usual and customary commissions from
1040 insurers and health maintenance organizations that offer plans
1041 in the FHIX marketplace.
1042 Section 19. Effective upon this act becoming a law, section
1043 409.729, Florida Statutes, is created to read:
1044 409.729 Long-term reorganization.—The FHIX Workgroup is

1045 created to facilitate the implementation of FHIX and to plan for
1046 a multiyear reorganization of the state's insurance
1047 affordability programs. The FHIX Workgroup consists of two
1048 representatives each from the agency, the department, the
1049 Florida Healthy Kids Corporation, and the corporation. An
1050 additional representative of the agency serves as chair. The
1051 FHIX Workgroup must hold its organizational meeting no later
1052 than 30 days after the effective date of this act and must meet
1053 at least bimonthly. The role of the FHIX Workgroup is to make
1054 recommendations to the agency. The responsibilities of the
1055 workgroup include, but are not limited to:
1056 (1) Recommend a Phase Two implementation plan no later than
1057 October 1, 2015.
1058 (2) Review network and access standards for plans and
1059 products.
1060 (3) Assess readiness and recommend actions needed to
1061 reorganize the state's insurance affordability programs for each
1062 phase or region. If a phase or region receives a nonreadiness
1063 recommendation, the agency must notify the Legislature of that
1064 recommendation, the reasons for such a recommendation, and
1065 proposed plans for achieving readiness.
1066 (4) Recommend any proposed change to the Title XIX-funded
1067 or Title XXI-funded programs based on the continued availability
1068 and reauthorization of the Title XXI program and its federal
1069 funding.
1070 (5) Identify duplication of services among the corporation,
1071 the agency, and the Florida Healthy Kids Corporation currently
1072 and under FHIX's proposed Phase Three program.
1073 (6) Evaluate any fiscal impacts based on the proposed

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1074 transition plan under Phase Three.
1075 (7) Compile a schedule of impacted contracts, leases, and
1076 other assets.
1077 (8) Determine staff requirements for Phase Three.
1078 (9) Develop and present a final transition plan that
1079 incorporates all elements under this section no later than
1080 December 1, 2015, in a report to the Governor, the President of
1081 the Senate, and the Speaker of the House of Representatives.
1082 Section 20. Effective upon this act becoming a law, section
1083 409.730, Florida Statutes, is created to read:
1084 409.730 Federal participation.—The agency may seek federal
1085 approval to implement FHIX.
1086 Section 21. Effective upon this act becoming a law, section
1087 409.731, Florida Statutes, is created to read:
1088 409.731 Program expiration.—The Florida Health Insurance
1089 Affordability Exchange Program expires at the end of Phase One
1090 if the state does not receive federal approval for Phase Two or
1091 at the end of the state fiscal year in which any of these
1092 conditions occurs:
1093 (1) The federal match contribution falls below 90 percent.
1094 (2) The federal match contribution falls below the
1095 increased Federal Medical Assistance Percentage for medical
1096 assistance for newly eligible mandatory individuals as specified
1097 in the Affordable Care Act.
1098 (3) The federal match for the FHIX program and the Medicaid
1099 program are blended under federal law or regulation in such a
1100 manner that causes the overall federal contribution to diminish
1101 when compared to separate, nonblended federal contributions.
1102 Section 22. Effective upon this act becoming a law, section

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1103 408.70, Florida Statutes, is repealed.
1104 Section 23. Effective upon this act becoming a law, section
1105 408.910, Florida Statutes, is amended to read:
1106 408.910 Florida Health Choices Program.—
1107 (1) LEGISLATIVE INTENT.—The Legislature finds that a
1108 significant number of the residents of this state do not have
1109 adequate access to affordable, quality health care. The
1110 Legislature further finds that increasing access to affordable,
1111 quality health care can be best accomplished by establishing a
1112 competitive market for purchasing health insurance and health
1113 services. It is therefore the intent of the Legislature to
1114 create and expand the Florida Health Choices Program to:
1115 (a) Expand opportunities for Floridians to purchase
1116 affordable health insurance and health services.
1117 (b) Preserve the benefits of employment-sponsored insurance
1118 while easing the administrative burden for employers who offer
1119 these benefits.
1120 (c) Enable individual choice in both the manner and amount
1121 of health care purchased.
1122 (d) Provide for the purchase of individual, portable health
1123 care coverage.
1124 (e) Disseminate information to consumers on the price and
1125 quality of health services.
1126 (f) Sponsor a competitive market that stimulates product
1127 innovation, quality improvement, and efficiency in the
1128 production and delivery of health services.
1129 (2) DEFINITIONS.—As used in this section, the term:
1130 (a) “Corporation” means the Florida Health Choices, Inc.,
1131 established under this section.

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1132 (b) “Corporation’s marketplace” means the single,
1133 centralized market established by the program that facilitates
1134 the purchase of products made available in the marketplace.
1135 (c) “Florida Health Insurance Affordability Exchange
1136 Program” or “FHIX” is the program created under ss. 409.720-
1137 409.731 for low-income, uninsured residents of this state.
1138 (d) ~~(c)~~ “Health insurance agent” means an agent licensed
1139 under part IV of chapter 626.
1140 (e) ~~(d)~~ “Insurer” means an entity licensed under chapter 624
1141 which offers an individual health insurance policy or a group
1142 health insurance policy, a preferred provider organization as
1143 defined in s. 627.6471, an exclusive provider organization as
1144 defined in s. 627.6472, ~~or~~ a health maintenance organization
1145 licensed under part I of chapter 641, ~~or~~ a prepaid limited
1146 health service organization or discount medical plan
1147 organization licensed under chapter 636, or a managed care plan
1148 contracted with the Agency for Health Care Administration under
1149 the managed medical assistance program under part IV of chapter
1150 409.
1151 (f) “Patient Protection and Affordable Care Act” or
1152 “Affordable Care Act” means Pub. L. No. 111-148, as further
1153 amended by the Health Care and Education Reconciliation Act of
1154 2010, Pub. L. No. 111-152, and any amendments to or regulations
1155 or guidance under those acts.
1156 (g) ~~(e)~~ “Program” means the Florida Health Choices Program
1157 established by this section.
1158 (3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health
1159 Choices Program is created as a single, centralized market for
1160 the sale and purchase of various products that enable

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1161 individuals to pay for health care. These products include, but
1162 are not limited to, health insurance plans, health maintenance
1163 organization plans, prepaid services, service contracts, and
1164 flexible spending accounts. The components of the program
1165 include:
1166 (a) Enrollment of employers.
1167 (b) Administrative services for participating employers,
1168 including:
1169 1. Assistance in seeking federal approval of cafeteria
1170 plans.
1171 2. Collection of premiums and other payments.
1172 3. Management of individual benefit accounts.
1173 4. Distribution of premiums to insurers and payments to
1174 other eligible vendors.
1175 5. Assistance for participants in complying with reporting
1176 requirements.
1177 (c) Services to individual participants, including:
1178 1. Information about available products and participating
1179 vendors.
1180 2. Assistance with assessing the benefits and limits of
1181 each product, including information necessary to distinguish
1182 between policies offering creditable coverage and other products
1183 available through the program.
1184 3. Account information to assist individual participants
1185 with managing available resources.
1186 4. Services that promote healthy behaviors.
1187 5. Health benefits coverage information about health
1188 insurance plans compliant with the Affordable Care Act.
1189 6. Consumer assistance and enrollment services for the

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1190 Florida Health Insurance Affordability Exchange Program, or
1191 FHIX.
1192 (d) Recruitment of vendors, including insurers, health
1193 maintenance organizations, prepaid clinic service providers,
1194 provider service networks, and other providers.
1195 (e) Certification of vendors to ensure capability,
1196 reliability, and validity of offerings.
1197 (f) Collection of data, monitoring, assessment, and
1198 reporting of vendor performance.
1199 (g) Information services for individuals and employers.
1200 (h) Program evaluation.
1201 (4) ELIGIBILITY AND PARTICIPATION.—Participation in the
1202 program is voluntary and shall be available to employers,
1203 individuals, vendors, and health insurance agents as specified
1204 in this subsection.
1205 (a) Employers eligible to enroll in the program include
1206 those employers that meet criteria established by the
1207 corporation and elect to make their employees eligible through
1208 the program.
1209 (b) Individuals eligible to participate in the program
1210 include:
1211 1. Individual employees of enrolled employers.
1212 2. Other individuals that meet criteria established by the
1213 corporation.
1214 (c) Employers who choose to participate in the program may
1215 enroll by complying with the procedures established by the
1216 corporation. The procedures must include, but are not limited
1217 to:
1218 1. Submission of required information.

1219 2. Compliance with federal tax requirements for the
1220 establishment of a cafeteria plan, pursuant to s. 125 of the
1221 Internal Revenue Code, including designation of the employer’s
1222 plan as a premium payment plan, a salary reduction plan that has
1223 flexible spending arrangements, or a salary reduction plan that
1224 has a premium payment and flexible spending arrangements.
1225 3. Determination of the employer’s contribution, if any,
1226 per employee, provided that such contribution is equal for each
1227 eligible employee.
1228 4. Establishment of payroll deduction procedures, subject
1229 to the agreement of each individual employee who voluntarily
1230 participates in the program.
1231 5. Designation of the corporation as the third-party
1232 administrator for the employer’s health benefit plan.
1233 6. Identification of eligible employees.
1234 7. Arrangement for periodic payments.
1235 8. Employer notification to employees of the intent to
1236 transfer from an existing employee health plan to the program at
1237 least 90 days before the transition.
1238 (d) All eligible vendors who choose to participate and the
1239 products and services that the vendors are permitted to sell are
1240 as follows:
1241 1. Insurers licensed under chapter 624 may sell health
1242 insurance policies, limited benefit policies, other risk-bearing
1243 coverage, and other products or services.
1244 2. Health maintenance organizations licensed under part I
1245 of chapter 641 may sell health maintenance contracts, limited
1246 benefit policies, other risk-bearing products, and other
1247 products or services.

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1248 3. Prepaid limited health service organizations may sell
1249 products and services as authorized under part I of chapter 636,
1250 and discount medical plan organizations may sell products and
1251 services as authorized under part II of chapter 636.
1252 4. Prepaid health clinic service providers licensed under
1253 part II of chapter 641 may sell prepaid service contracts and
1254 other arrangements for a specified amount and type of health
1255 services or treatments.
1256 5. Health care providers, including hospitals and other
1257 licensed health facilities, health care clinics, licensed health
1258 professionals, pharmacies, and other licensed health care
1259 providers, may sell service contracts and arrangements for a
1260 specified amount and type of health services or treatments.
1261 6. Provider organizations, including service networks,
1262 group practices, professional associations, and other
1263 incorporated organizations of providers, may sell service
1264 contracts and arrangements for a specified amount and type of
1265 health services or treatments.
1266 7. Corporate entities providing specific health services in
1267 accordance with applicable state law may sell service contracts
1268 and arrangements for a specified amount and type of health
1269 services or treatments.
1270
1271 A vendor described in subparagraphs 3.-7. may not sell products
1272 that provide risk-bearing coverage unless that vendor is
1273 authorized under a certificate of authority issued by the Office
1274 of Insurance Regulation and is authorized to provide coverage in
1275 the relevant geographic area. Otherwise eligible vendors may be
1276 excluded from participating in the program for deceptive or

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1277 predatory practices, financial insolvency, or failure to comply
1278 with the terms of the participation agreement or other standards
1279 set by the corporation.
1280 (e) Eligible individuals may participate in the program
1281 voluntarily. Individuals who join the program may participate by
1282 complying with the procedures established by the corporation.
1283 These procedures must include, but are not limited to:
1284 1. Submission of required information.
1285 2. Authorization for payroll deduction, if applicable.
1286 3. Compliance with federal tax requirements.
1287 4. Arrangements for payment.
1288 5. Selection of products and services.
1289 (f) Vendors who choose to participate in the program may
1290 enroll by complying with the procedures established by the
1291 corporation. These procedures may include, but are not limited
1292 to:
1293 1. Submission of required information, including a complete
1294 description of the coverage, services, provider network, payment
1295 restrictions, and other requirements of each product offered
1296 through the program.
1297 2. Execution of an agreement to comply with requirements
1298 established by the corporation.
1299 3. Execution of an agreement that prohibits refusal to sell
1300 any offered product or service to a participant who elects to
1301 buy it.
1302 4. Establishment of product prices based on applicable
1303 criteria.
1304 5. Arrangements for receiving payment for enrolled
1305 participants.

1306 6. Participation in ongoing reporting processes established
1307 by the corporation.
1308 7. Compliance with grievance procedures established by the
1309 corporation.
1310 (g) Health insurance agents licensed under part IV of
1311 chapter 626 are eligible to voluntarily participate as buyers'
1312 representatives. A buyer's representative acts on behalf of an
1313 individual purchasing health insurance and health services
1314 through the program by providing information about products and
1315 services available through the program and assisting the
1316 individual with both the decision and the procedure of selecting
1317 specific products. Serving as a buyer's representative does not
1318 constitute a conflict of interest with continuing
1319 responsibilities as a health insurance agent if the relationship
1320 between each agent and any participating vendor is disclosed
1321 before advising an individual participant about the products and
1322 services available through the program. In order to participate,
1323 a health insurance agent shall comply with the procedures
1324 established by the corporation, including:
1325 1. Completion of training requirements.
1326 2. Execution of a participation agreement specifying the
1327 terms and conditions of participation.
1328 3. Disclosure of any appointments to solicit insurance or
1329 procure applications for vendors participating in the program.
1330 4. Arrangements to receive payment from the corporation for
1331 services as a buyer's representative.
1332 (5) PRODUCTS.—
1333 (a) The products that may be made available for purchase
1334 through the program include, but are not limited to:

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1335 1. Health insurance policies.
1336 2. Health maintenance contracts.
1337 3. Limited benefit plans.
1338 4. Prepaid clinic services.
1339 5. Service contracts.
1340 6. Arrangements for purchase of specific amounts and types
1341 of health services and treatments.
1342 7. Flexible spending accounts.
1343 (b) Health insurance policies, health maintenance
1344 contracts, limited benefit plans, prepaid service contracts, and
1345 other contracts for services must ensure the availability of
1346 covered services.
1347 (c) Products may be offered for multiyear periods provided
1348 the price of the product is specified for the entire period or
1349 for each separately priced segment of the policy or contract.
1350 (d) The corporation shall provide a disclosure form for
1351 consumers to acknowledge their understanding of the nature of,
1352 and any limitations to, the benefits provided by the products
1353 and services being purchased by the consumer.
1354 (e) The corporation must determine that making the plan
1355 available through the program is in the interest of eligible
1356 individuals and eligible employers in the state.
1357 (6) PRICING.—Prices for the products and services sold
1358 through the program must be transparent to participants and
1359 established by the vendors. The corporation may ~~shall~~ annually
1360 assess a surcharge for each premium or price set by a
1361 participating vendor. Any ~~The~~ surcharge may not be more than 2.5
1362 percent of the price and shall be used to generate funding for
1363 administrative services provided by the corporation and payments

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1364 to buyers' representatives; however, a surcharge may not be
1365 assessed for products and services sold in the FHIX marketplace.
1366 (7) THE MARKETPLACE PROCESS.—The program shall provide a
1367 single, centralized market for purchase of health insurance,
1368 health maintenance contracts, and other health products and
1369 services. Purchases may be made by participating individuals
1370 over the Internet or through the services of a participating
1371 health insurance agent. Information about each product and
1372 service available through the program shall be made available
1373 through printed material and an interactive Internet website.
1374 (a) Marketplace purchasing.—A participant needing personal
1375 assistance to select products and services shall be referred to
1376 a participating agent in his or her area.
1377 1.~~(a)~~ Participation in the program may begin at any time
1378 during a year after the employer completes enrollment and meets
1379 the requirements specified by the corporation pursuant to
1380 paragraph (4)(c).
1381 2.~~(b)~~ Initial selection of products and services must be
1382 made by an individual participant within the applicable open
1383 enrollment period.
1384 3.~~(c)~~ Initial enrollment periods for each product selected
1385 by an individual participant must last at least 12 months,
1386 unless the individual participant specifically agrees to a
1387 different enrollment period.
1388 4.~~(d)~~ If an individual has selected one or more products
1389 and enrolled in those products for at least 12 months or any
1390 other period specifically agreed to by the individual
1391 participant, changes in selected products and services may only
1392 be made during the annual enrollment period established by the

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1393 corporation.
1394 5.~~(c)~~ The limits established in subparagraphs 2., 3., and
1395 4. ~~paragraphs (b)-(d)~~ apply to any risk-bearing product that
1396 promises future payment or coverage for a variable amount of
1397 benefits or services. The limits do not apply to initiation of
1398 flexible spending plans if those plans are not associated with
1399 specific high-deductible insurance policies or the use of
1400 spending accounts for any products offering individual
1401 participants specific amounts and types of health services and
1402 treatments at a contracted price.
1403 (b) FHIX marketplace purchasing.—
1404 1. Participation in the FHIX marketplace may begin at any
1405 time during the year.
1406 2. Initial enrollment periods for certain products selected
1407 by an individual enrollee which are noncompliant with the
1408 Affordable Care Act may be required to last at least 12 months,
1409 unless the individual participant specifically agrees to a
1410 different enrollment period.
1411 (8) CONSUMER INFORMATION.—The corporation shall:
1412 (a) Establish a secure website to facilitate the purchase
1413 of products and services by participating individuals. The
1414 website must provide information about each product or service
1415 available through the program.
1416 (b) Inform individuals about other public health care
1417 programs.
1418 (9) RISK POOLING.—The program may use methods for pooling
1419 the risk of individual participants and preventing selection
1420 bias. These methods may include, but are not limited to, a
1421 postenrollment risk adjustment of the premium payments to the

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1422 vendors. The corporation may establish a methodology for
1423 assessing the risk of enrolled individual participants based on
1424 data reported annually by the vendors about their enrollees.
1425 Distribution of payments to the vendors may be adjusted based on
1426 the assessed relative risk profile of the enrollees in each
1427 risk-bearing product for the most recent period for which data
1428 is available.
1429 (10) EXEMPTIONS.—
1430 (a) Products, other than the products set forth in
1431 subparagraphs (4)(d)1.-4., sold as part of the program are not
1432 subject to the licensing requirements of the Florida Insurance
1433 Code, as defined in s. 624.01 or the mandated offerings or
1434 coverages established in part VI of chapter 627 and chapter 641.
1435 (b) The corporation may act as an administrator as defined
1436 in s. 626.88 but is not required to be certified pursuant to
1437 part VII of chapter 626. However, a third party administrator
1438 used by the corporation must be certified under part VII of
1439 chapter 626.
1440 (c) Any standard forms, website design, or marketing
1441 communication developed by the corporation and used by the
1442 corporation, or any vendor that meets the requirements of
1443 paragraph (4)(f) is not subject to the Florida Insurance Code,
1444 as established in s. 624.01.
1445 (11) CORPORATION.—There is created the Florida Health
1446 Choices, Inc., which shall be registered, incorporated,
1447 organized, and operated in compliance with part III of chapter
1448 112 and chapters 119, 286, and 617. The purpose of the
1449 corporation is to administer the program created in this section
1450 and to conduct such other business as may further the

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1451 administration of the program.
1452 (a) The corporation shall be governed by a 15-member board
1453 of directors consisting of:
1454 1. Three ex officio, nonvoting members to include:
1455 a. The Secretary of Health Care Administration or a
1456 designee with expertise in health care services.
1457 b. The Secretary of Management Services or a designee with
1458 expertise in state employee benefits.
1459 c. The commissioner of the Office of Insurance Regulation
1460 or a designee with expertise in insurance regulation.
1461 2. Four members appointed by and serving at the pleasure of
1462 the Governor.
1463 3. Four members appointed by and serving at the pleasure of
1464 the President of the Senate.
1465 4. Four members appointed by and serving at the pleasure of
1466 the Speaker of the House of Representatives.
1467 5. Board members may not include insurers, health insurance
1468 agents or brokers, health care providers, health maintenance
1469 organizations, prepaid service providers, or any other entity,
1470 affiliate, or subsidiary of eligible vendors.
1471 (b) Members shall be appointed for terms of up to 3 years.
1472 Any member is eligible for reappointment. A vacancy on the board
1473 shall be filled for the unexpired portion of the term in the
1474 same manner as the original appointment.
1475 (c) The board shall select a chief executive officer for
1476 the corporation who shall be responsible for the selection of
1477 such other staff as may be authorized by the corporation's
1478 operating budget as adopted by the board.
1479 (d) Board members are entitled to receive, from funds of

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1480 the corporation, reimbursement for per diem and travel expenses
1481 as provided by s. 112.061. No other compensation is authorized.
1482 (e) There is no liability on the part of, and no cause of
1483 action shall arise against, any member of the board or its
1484 employees or agents for any action taken by them in the
1485 performance of their powers and duties under this section.
1486 (f) The board shall develop and adopt bylaws and other
1487 corporate procedures as necessary for the operation of the
1488 corporation and carrying out the purposes of this section. The
1489 bylaws shall:
1490 1. Specify procedures for selection of officers and
1491 qualifications for reappointment, provided that no board member
1492 shall serve more than 9 consecutive years.
1493 2. Require an annual membership meeting that provides an
1494 opportunity for input and interaction with individual
1495 participants in the program.
1496 3. Specify policies and procedures regarding conflicts of
1497 interest, including the provisions of part III of chapter 112,
1498 which prohibit a member from participating in any decision that
1499 would inure to the benefit of the member or the organization
1500 that employs the member. The policies and procedures shall also
1501 require public disclosure of the interest that prevents the
1502 member from participating in a decision on a particular matter.
1503 (g) The corporation may exercise all powers granted to it
1504 under chapter 617 necessary to carry out the purposes of this
1505 section, including, but not limited to, the power to receive and
1506 accept grants, loans, or advances of funds from any public or
1507 private agency and to receive and accept from any source
1508 contributions of money, property, labor, or any other thing of

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1509 value to be held, used, and applied for the purposes of this
1510 section.
1511 (h) The corporation may establish technical advisory panels
1512 consisting of interested parties, including consumers, health
1513 care providers, individuals with expertise in insurance
1514 regulation, and insurers.
1515 (i) The corporation shall:
1516 1. Determine eligibility of employers, vendors,
1517 individuals, and agents in accordance with subsection (4).
1518 2. Establish procedures necessary for the operation of the
1519 program, including, but not limited to, procedures for
1520 application, enrollment, risk assessment, risk adjustment, plan
1521 administration, performance monitoring, and consumer education.
1522 3. Arrange for collection of contributions from
1523 participating employers, third parties, governmental entities,
1524 and individuals.
1525 4. Arrange for payment of premiums and other appropriate
1526 disbursements based on the selections of products and services
1527 by the individual participants.
1528 5. Establish criteria for disenrollment of participating
1529 individuals based on failure to pay the individual's share of
1530 any contribution required to maintain enrollment in selected
1531 products.
1532 6. Establish criteria for exclusion of vendors pursuant to
1533 paragraph (4)(d).
1534 7. Develop and implement a plan for promoting public
1535 awareness of and participation in the program.
1536 8. Secure staff and consultant services necessary to the
1537 operation of the program.

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1538 9. Establish policies and procedures regarding
1539 participation in the program for individuals, vendors, health
1540 insurance agents, and employers.
1541 10. Provide for the operation of a toll-free hotline to
1542 respond to requests for assistance.
1543 11. Provide for initial, open, and special enrollment
1544 periods.
1545 12. Evaluate options for employer participation which may
1546 conform to ~~with~~ common insurance practices.
1547 13. Administer the Florida Health Insurance Affordability
1548 Exchange Program in accordance with ss. 409.720-409.731.
1549 14. Coordinate with the Agency for Health Care
1550 Administration, the Department of Children and Families, and the
1551 Florida Healthy Kids Corporation on the transition plan for FHIX
1552 and any subsequent transition activities.
1553 (12) REPORT.—The board of the corporation shall ~~Beginning~~
1554 ~~in the 2009-2010 fiscal year,~~ submit by February 1 an annual
1555 report to the Governor, the President of the Senate, and the
1556 Speaker of the House of Representatives documenting the
1557 corporation's activities in compliance with the duties
1558 delineated in this section.
1559 (13) PROGRAM INTEGRITY.—To ensure program integrity and to
1560 safeguard the financial transactions made under the auspices of
1561 the program, the corporation is authorized to establish
1562 qualifying criteria and certification procedures for vendors,
1563 require performance bonds or other guarantees of ability to
1564 complete contractual obligations, monitor the performance of
1565 vendors, and enforce the agreements of the program through
1566 financial penalty or disqualification from the program.

1567 (14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—
1568 (a) *Definitions.*—For purposes of this subsection, the term:
1569 1. “Buyer’s representative” means a participating insurance
1570 agent as described in paragraph (4)(g).
1571 2. “Enrollee” means an employer who is eligible to enroll
1572 in the program pursuant to paragraph (4)(a).
1573 3. “Participant” means an individual who is eligible to
1574 participate in the program pursuant to paragraph (4)(b).
1575 4. “Proprietary confidential business information” means
1576 information, regardless of form or characteristics, that is
1577 owned or controlled by a vendor requesting confidentiality under
1578 this section; that is intended to be and is treated by the
1579 vendor as private in that the disclosure of the information
1580 would cause harm to the business operations of the vendor; that
1581 has not been disclosed unless disclosed pursuant to a statutory
1582 provision, an order of a court or administrative body, or a
1583 private agreement providing that the information may be released
1584 to the public; and that is information concerning:
1585 a. Business plans.
1586 b. Internal auditing controls and reports of internal
1587 auditors.
1588 c. Reports of external auditors for privately held
1589 companies.
1590 d. Client and customer lists.
1591 e. Potentially patentable material.
1592 f. A trade secret as defined in s. 688.002.
1593 5. “Vendor” means a participating insurer or other provider
1594 of services as described in paragraph (4)(d).
1595 (b) *Public record exemptions.*—

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1596 1. Personal identifying information of an enrollee or
1597 participant who has applied for or participates in the Florida
1598 Health Choices Program is confidential and exempt from s.
1599 119.07(1) and s. 24(a), Art. I of the State Constitution.
1600 2. Client and customer lists of a buyer's representative
1601 held by the corporation are confidential and exempt from s.
1602 119.07(1) and s. 24(a), Art. I of the State Constitution.
1603 3. Proprietary confidential business information held by
1604 the corporation is confidential and exempt from s. 119.07(1) and
1605 s. 24(a), Art. I of the State Constitution.
1606 (c) *Retroactive application.*—The public record exemptions
1607 provided for in paragraph (b) apply to information held by the
1608 corporation before, on, or after the effective date of this
1609 exemption.
1610 (d) *Authorized release.*—
1611 1. Upon request, information made confidential and exempt
1612 pursuant to this subsection shall be disclosed to:
1613 a. Another governmental entity in the performance of its
1614 official duties and responsibilities.
1615 b. Any person who has the written consent of the program
1616 applicant.
1617 c. The Florida Kidcare program for the purpose of
1618 administering the program authorized in ss. 409.810-409.821.
1619 2. Paragraph (b) does not prohibit a participant's legal
1620 guardian from obtaining confirmation of coverage, dates of
1621 coverage, the name of the participant's health plan, and the
1622 amount of premium being paid.
1623 (e) *Penalty.*—A person who knowingly and willfully violates
1624 this subsection commits a misdemeanor of the second degree,

1625 punishable as provided in s. 775.082 or s. 775.083.
1626 (f) *Review and repeal.*—This subsection is subject to the
1627 Open Government Sunset Review Act in accordance with s. 119.15,
1628 and shall stand repealed on October 2, 2016, unless reviewed and
1629 saved from repeal through reenactment by the Legislature.
1630 Section 24. Effective upon this act becoming a law,
1631 subsection (2) of section 409.904, Florida Statutes, is amended
1632 to read:
1633 409.904 Optional payments for eligible persons.—The agency
1634 may make payments for medical assistance and related services on
1635 behalf of the following persons who are determined to be
1636 eligible subject to the income, assets, and categorical
1637 eligibility tests set forth in federal and state law. Payment on
1638 behalf of these Medicaid eligible persons is subject to the
1639 availability of moneys and any limitations established by the
1640 General Appropriations Act or chapter 216.
1641 (2) A family, a pregnant woman, a child under age 21, a
1642 person age 65 or over, or a blind or disabled person, who would
1643 be eligible under any group listed in s. 409.903(1), (2), or
1644 (3), except that the income or assets of such family or person
1645 exceed established limitations. For a family or person in one of
1646 these coverage groups, medical expenses are deductible from
1647 income in accordance with federal requirements in order to make
1648 a determination of eligibility. A family or person eligible
1649 under the coverage known as the "medically needy," is eligible
1650 to receive the same services as other Medicaid recipients, with
1651 the exception of services in skilled nursing facilities and
1652 intermediate care facilities for the developmentally disabled.
1653 <u>Effective October 1, 2015, persons eligible under "medically</u>

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1654 needy” shall be limited to children under the age of 21 and
1655 pregnant women. This subsection expires October 1, 2019.
1656 Section 25. Effective upon this act becoming a law, section
1657 624.91, Florida Statutes, is amended to read:
1658 624.91 The Florida Healthy Kids Corporation Act.—
1659 (1) SHORT TITLE.—This section may be cited as the “William
1660 G. ‘Doc’ Myers Healthy Kids Corporation Act.”
1661 (2) LEGISLATIVE INTENT.—
1662 (a) The Legislature finds that increased access to health
1663 care services could improve children’s health and reduce the
1664 incidence and costs of childhood illness and disabilities among
1665 children in this state. Many children do not have comprehensive,
1666 affordable health care services available. It is the intent of
1667 the Legislature that the Florida Healthy Kids Corporation
1668 provide comprehensive health insurance coverage to such
1669 children. The corporation is encouraged to cooperate with any
1670 existing health service programs funded by the public or the
1671 private sector.
1672 (b) It is the intent of the Legislature that the Florida
1673 Healthy Kids Corporation serve as one of several providers of
1674 services to children eligible for medical assistance under Title
1675 XXI of the Social Security Act. Although the corporation may
1676 serve other children, the Legislature intends the primary
1677 recipients of services provided through the corporation be
1678 school-age children with a family income below 200 percent of
1679 the federal poverty level, who do not qualify for Medicaid. It
1680 is also the intent of the Legislature that state and local
1681 government Florida Healthy Kids funds be used to continue
1682 coverage, subject to specific appropriations in the General

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1683 Appropriations Act, to children not eligible for federal
1684 matching funds under Title XXI.
1685 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only residents
1686 of this state are eligible ~~the following individuals are~~
1687 ~~eligible~~ for state-funded assistance in paying Florida Healthy
1688 Kids premiums pursuant to s. 409.814.~~:~~
1689 ~~(a) Residents of this state who are eligible for the~~
1690 ~~Florida Kidcare program pursuant to s. 409.814.~~
1691 ~~(b) Notwithstanding s. 409.814, legal aliens who are~~
1692 ~~enrolled in the Florida Healthy Kids program as of January 31,~~
1693 ~~2004, who do not qualify for Title XXI federal funds because~~
1694 ~~they are not qualified aliens as defined in s. 409.811.~~
1695 (4) NONENTITLEMENT.—Nothing in this section shall be
1696 construed as providing an individual with an entitlement to
1697 health care services. No cause of action shall arise against the
1698 state, the Florida Healthy Kids Corporation, or a unit of local
1699 government for failure to make health services available under
1700 this section.
1701 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—
1702 (a) There is created the Florida Healthy Kids Corporation,
1703 a not-for-profit corporation.
1704 (b) The Florida Healthy Kids Corporation shall:
1705 1. Arrange for the collection of any individual, family,
1706 ~~local contributions,~~ or employer payment or premium, in an
1707 amount to be determined by the board of directors, to provide
1708 for payment of premiums for comprehensive insurance coverage and
1709 for the actual or estimated administrative expenses.
1710 2. Arrange for the collection of any voluntary
1711 contributions to provide for payment of Florida Kidcare program

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1712 or Florida Health Insurance Affordability Exchange Program
1713 premiums ~~for children who are not eligible for medical~~
1714 ~~assistance under Title XIX or Title XXI of the Social Security~~
1715 ~~Act~~.
1716 3. ~~Subject to the provisions of s. 409.8134, accept~~
1717 ~~voluntary supplemental local match contributions that comply~~
1718 ~~with the requirements of Title XXI of the Social Security Act~~
1719 ~~for the purpose of providing additional Florida Kidcare coverage~~
1720 ~~in contributing counties under Title XXI.~~
1721 ~~4.~~ Establish the administrative and accounting procedures
1722 for the operation of the corporation.
1723 4.~~5.~~ Establish, with consultation from appropriate
1724 professional organizations, standards for preventive health
1725 services and providers and comprehensive insurance benefits
1726 appropriate to children, provided that such standards for rural
1727 areas shall not limit primary care providers to board-certified
1728 pediatricians.
1729 5.~~6.~~ Determine eligibility for children seeking to
1730 participate in the Title XXI-funded components of the Florida
1731 Kidcare program consistent with the requirements specified in s.
1732 409.814~~, as well as the non-Title-XXI-eligible children as~~
1733 ~~provided in subsection (3)~~.
1734 6.~~7.~~ Establish procedures under which ~~providers of local~~
1735 ~~match to,~~ applicants to and participants in the program may have
1736 grievances reviewed by an impartial body and reported to the
1737 board of directors of the corporation.
1738 7.~~8.~~ Establish participation criteria and, if appropriate,
1739 contract with an authorized insurer, health maintenance
1740 organization, or third-party administrator to provide

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1741 administrative services to the corporation.
1742 8.~~9.~~ Establish enrollment criteria that include penalties
1743 or waiting periods of 30 days for reinstatement of coverage upon
1744 voluntary cancellation for nonpayment of family or individual
1745 premiums.
1746 9.~~10.~~ Contract with authorized insurers or any provider of
1747 health care services, meeting standards established by the
1748 corporation, for the provision of comprehensive insurance
1749 coverage to participants. Such standards shall include criteria
1750 under which the corporation may contract with more than one
1751 provider of health care services in program sites.
1752 a. Health plans shall be selected through a competitive bid
1753 process. The Florida Healthy Kids Corporation shall purchase
1754 goods and services in the most cost-effective manner consistent
1755 with the delivery of quality medical care.
1756 b. The maximum administrative cost for a Florida Healthy
1757 Kids Corporation contract shall be 15 percent. For health and
1758 dental care contracts, the minimum medical loss ratio for a
1759 Florida Healthy Kids Corporation contract shall be 85 percent.
1760 The calculations must use uniform financial data collected from
1761 all plans in a format established by the corporation and shall
1762 be computed for each plan on a statewide basis. Funds shall be
1763 classified in a manner consistent with 45 C.F.R. part 158 ~~For~~
1764 ~~dental contracts, the remaining compensation to be paid to the~~
1765 ~~authorized insurer or provider under a Florida Healthy Kids~~
1766 ~~Corporation contract shall be no less than an amount which is 85~~
1767 ~~percent of premium; to the extent any contract provision does~~
1768 ~~not provide for this minimum compensation, this section shall~~
1769 ~~prevail~~.

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1770 c. The health plan selection criteria and scoring system,
1771 and the scoring results, shall be available upon request for
1772 inspection after the bids have been awarded.
1773 d. Effective July 1, 2016, health and dental services
1774 contracts of the corporation must transition to the FHIX
1775 marketplace under s. 409.722. Qualifying plans may enroll as
1776 vendors with the FHIX marketplace to maintain continuity of care
1777 for participants.
1778 10.~~11.~~ Establish disenrollment criteria in the event ~~local~~
1779 ~~matching~~ funds are insufficient to cover enrollments.
1780 11.~~12.~~ Develop and implement a plan to publicize the
1781 Florida Kidcare program, the eligibility requirements of the
1782 program, and the procedures for enrollment in the program and to
1783 maintain public awareness of the corporation and the program.
1784 12.~~13.~~ Secure staff necessary to properly administer the
1785 corporation. Staff costs shall be funded from state ~~and local~~
1786 ~~matching funds~~ and such other private or public funds as become
1787 available. The board of directors shall determine the number of
1788 staff members necessary to administer the corporation.
1789 13.~~14.~~ In consultation with the partner agencies, provide a
1790 report on the Florida Kidcare program annually to the Governor,
1791 the Chief Financial Officer, the Commissioner of Education, the
1792 President of the Senate, the Speaker of the House of
1793 Representatives, and the Minority Leaders of the Senate and the
1794 House of Representatives.
1795 14.~~15.~~ Provide information on a quarterly basis online to
1796 the Legislature and the Governor which compares the costs and
1797 utilization of the full-pay enrolled population and the Title
1798 XXI-subsidized enrolled population in the Florida Kidcare

1799 program. The information, at a minimum, must include:
1800 a. The monthly enrollment and expenditure for full-pay
1801 enrollees in the Medikids and Florida Healthy Kids programs
1802 compared to the Title XXI-subsidized enrolled population; and
1803 b. The costs and utilization by service of the full-pay
1804 enrollees in the Medikids and Florida Healthy Kids programs and
1805 the Title XXI-subsidized enrolled population.
1806 15.~~16.~~ Establish benefit packages that conform to the
1807 provisions of the Florida Kidcare program, as created in ss.
1808 409.810-409.821.
1809 16. Contract with other insurance affordability programs
1810 and FHIX to provide customer service or other enrollment-focused
1811 services.
1812 17. Annually develop performance metrics for the following
1813 focus areas:
1814 a. Administrative functions.
1815 b. Contracting with vendors.
1816 c. Customer service.
1817 d. Enrollee education.
1818 e. Financial services.
1819 f. Program integrity.
1820 (c) Coverage under the corporation’s program is secondary
1821 to any other available private coverage held by, or applicable
1822 to, the participant child or family member. Insurers under
1823 contract with the corporation are the payors of last resort and
1824 must coordinate benefits with any other third-party payor that
1825 may be liable for the participant’s medical care.
1826 (d) The Florida Healthy Kids Corporation shall be a private
1827 corporation not for profit, organized pursuant to chapter 617,

1828 and shall have all powers necessary to carry out the purposes of
1829 this act, including, but not limited to, the power to receive
1830 and accept grants, loans, or advances of funds from any public
1831 or private agency and to receive and accept from any source
1832 contributions of money, property, labor, or any other thing of
1833 value, to be held, used, and applied for the purposes of this
1834 act.
1835 (6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—
1836 (a) The Florida Healthy Kids Corporation shall operate
1837 subject to the supervision and approval of a board of directors.
1838 The board chair shall be an appointee designated by the
1839 Governor, and the board shall be ~~chaired by the~~ ~~Chief Financial~~
1840 ~~Officer or her or his designee, and~~ composed of 12 other
1841 members. The Senate shall confirm the designated chair and other
1842 board appointees. The board members shall be appointed ~~selected~~
1843 for 3-year terms. ~~of office as follows:~~
1844 ~~1. The Secretary of Health Care Administration, or his or~~
1845 ~~her designee.~~
1846 ~~2. One member appointed by the Commissioner of Education~~
1847 ~~from the Office of School Health Programs of the Florida~~
1848 ~~Department of Education.~~
1849 ~~3. One member appointed by the Chief Financial Officer from~~
1850 ~~among three members nominated by the Florida Pediatric Society.~~
1851 ~~4. One member, appointed by the Governor, who represents~~
1852 ~~the Children's Medical Services Program.~~
1853 ~~5. One member appointed by the Chief Financial Officer from~~
1854 ~~among three members nominated by the Florida Hospital~~
1855 ~~Association.~~
1856 ~~6. One member, appointed by the Governor, who is an expert~~

1857 ~~on child health policy.~~
1858 ~~7. One member, appointed by the Chief Financial Officer,~~
1859 ~~from among three members nominated by the Florida Academy of~~
1860 ~~Family Physicians.~~
1861 ~~8. One member, appointed by the Governor, who represents~~
1862 ~~the state Medicaid program.~~
1863 ~~9. One member, appointed by the Chief Financial Officer,~~
1864 ~~from among three members nominated by the Florida Association of~~
1865 ~~Counties.~~
1866 ~~10. The State Health Officer or her or his designee.~~
1867 ~~11. The Secretary of Children and Families, or his or her~~
1868 ~~designee.~~
1869 ~~12. One member, appointed by the Governor, from among three~~
1870 ~~members nominated by the Florida Dental Association.~~
1871 (b) A member of the board of directors serves at the
1872 pleasure of the Governor ~~may be removed by the official who~~
1873 ~~appointed that member~~. The board shall appoint an executive
1874 director, who is responsible for other staff authorized by the
1875 board.
1876 (c) Board members are entitled to receive, from funds of
1877 the corporation, reimbursement for per diem and travel expenses
1878 as provided by s. 112.061.
1879 (d) There shall be no liability on the part of, and no
1880 cause of action shall arise against, any member of the board of
1881 directors, or its employees or agents, for any action they take
1882 in the performance of their powers and duties under this act.
1883 (e) Board members who are serving as of the effective date
1884 of this act may remain on the board until January 1, 2016.
1885 (7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

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1886 (a) The corporation shall not be deemed an insurer. The
1887 officers, directors, and employees of the corporation shall not
1888 be deemed to be agents of an insurer. Neither the corporation
1889 nor any officer, director, or employee of the corporation is
1890 subject to the licensing requirements of the insurance code or
1891 the rules of the Department of Financial Services. However, any
1892 marketing representative utilized and compensated by the
1893 corporation must be appointed as a representative of the
1894 insurers or health services providers with which the corporation
1895 contracts.
1896 (b) The board has complete fiscal control over the
1897 corporation and is responsible for all corporate operations.
1898 (c) The Department of Financial Services shall supervise
1899 any liquidation or dissolution of the corporation and shall
1900 have, with respect to such liquidation or dissolution, all power
1901 granted to it pursuant to the insurance code.
1902 (8) TRANSITION PLANS.—The corporation shall confer with the
1903 Agency for Health Care Administration, the Department of
1904 Children and Families, and Florida Health Choices, Inc., to
1905 develop transition plans for the Florida Health Insurance
1906 Affordability Exchange Program as created under ss. 409.720-
1907 409.731.
1908 Section 26. Section 18 of chapter 2012-33, 2012 Laws of
1909 Florida, is amended to read:
1910 Section 18. Notwithstanding s. 430.707, Florida Statutes,
1911 and subject to federal approval of an additional site for the
1912 Program of All-Inclusive Care for the Elderly (PACE), the Agency
1913 for Health Care Administration shall contract with a current
1914 PACE organization authorized to provide PACE services in

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1915 Southeast Florida to develop and operate a PACE program in
1916 Broward County to serve frail elders who reside in Broward
1917 County or Miami-Dade County. The organization shall be exempt
1918 from chapter 641, Florida Statutes. The agency, in consultation
1919 with the Department of Elderly Affairs and subject to an
1920 appropriation, shall approve up to 150 initial enrollee slots in
1921 the Broward program established by the organization.
1922 Section 27. Effective upon this act becoming a law, section
1923 624.915, Florida Statutes, is repealed.
1924 Section 28. Effective upon this act becoming a law, the
1925 Division of Law Revision and Information is directed to replace
1926 the phrase "the effective date of this act" wherever it occurs
1927 in this act with the date the act becomes a law.
1928 Section 29. Except as otherwise expressly provided in this
1929 act and except for this section, which shall take effect upon
1930 this act becoming a law, this act shall take effect July 1,
1931 2015.

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