925284

LEGISLATIVE ACTION

Senate	.	House
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Floor: NC/2R	.	
04/24/2019 11:43 AM	.	
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Senator Thurston moved the following:

Senate Amendment (with title amendment)

Delete line 135

and insert:

Section 4. The Division of Law Revision is directed to rename part II of chapter 409, Florida Statutes, as "Insurance Affordability Programs" and to incorporate ss. 409.72-409.731, Florida Statutes, under this part.

Section 5. Section 409.72, Florida Statutes, is created to read:

409.72 Short title.—Sections 409.72-409.731 may be cited as

925284

the "Florida Health Insurance Affordability Exchange Program" ("FHIX").

Section 6. Section 409.721, Florida Statutes, is created to read:

409.721 Program authority.—The Florida Health Insurance Affordability Exchange Program (FHIX) is created within the Agency for Health Care Administration to assist Floridians in purchasing health benefits coverage and gaining access to health services. The products and services offered by FHIX are based on the following principles:

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

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

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

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

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

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

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

Section 7. Section 409.722, Florida Statutes, is created to read:


925284

409.722 Definitions.—As used in ss. 409.72-409.731, the term:

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

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

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

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

(5) "Federal exchange" or "exchange" means an insurance platform regulated by the Federal Government which offers tiers of health plans from the least comprehensive plan to the most comprehensive plan.

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

(7) "Florida Health Insurance Affordability Exchange Program" or "FHIX" means the program created under ss. 409.72-409.731.

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

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

(10) "Health benefits coverage" means the payment of benefits for covered health care services or the availability,


925284

directly or through arrangements with other persons, of covered health care services on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(11) "Inactive status" means the enrollment status of a participant previously enrolled in health benefits coverage through FHIX who lost coverage for noncompliance pursuant to s. 409.723, but who maintains access to his or her balance in a health savings account or health reimbursement account.

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

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

(14) "Patient Protection and Affordable Care Act" or "Affordable Care Act" means Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and regulations adopted pursuant to those acts.

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

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

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

Section 8. Section 409.723, Florida Statutes, is created to read:


925284

409.723 Participation.—

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

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

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

(c) Qualify for participation in the Florida Healthy Kids program under s. 624.91, subject to the implementation of Phase Two under s. 409.727.

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

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

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

(c) The department shall review a participant’s eligibility at least every 12 months.

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

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

(a) Access to the FHIX marketplace or federal exchange to

925284

select the scope, amount, and type of health care coverage and other services to be purchased.

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

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

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

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

(4) PARTICIPANT RESPONSIBILITIES.—A participant must:

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

(b) Provide evidence of participation in one or more of the following activities at the levels required under paragraph (c):

1. Paid employment.

2. On-the-job training or job placement activities. Evidence of participation in job placement activities must include registration with CareerSource Florida and may include other documentation such as, but not limited to, written acknowledgment from a potential employer of receipt of an employment application from the participant; confirmation from a potential employer of a job interview with the participant; documentation of job-seeking activities; and documentation of


925284

assistance or training related to preparing a resume, completing an employment application, or interviewing skills.

3. Educational pursuits.

A participant who is a disabled adult or the caregiver of a disabled child or adult may submit a request to the department for an exception to the requirements in this paragraph. Such participant shall annually submit to the department a request to renew the exception. The term "disabled" means any person who has one or more permanent physical or mental impairments that substantially limit his or her ability to perform one or more major life activities of daily living, as defined by the Americans with Disabilities Act, without receiving more than 8 hours of assistance per day.

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

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

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

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

(e) Execute a contract with the department which acknowledges that:

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

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

3. Noncompliance with the participation requirements as


925284

established under this section will result in a transition to inactive status.

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

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

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

(i) Meet minimum coverage requirements by selecting either a high-deductible health plan combined with a health savings or a reimbursement account or a combination of plans or products with an actuarial value that meets or exceeds benefits available under the federal exchange.

(5) COST SHARING.—

(a) Except for enrollees eligible under paragraph (1)(c), enrollees are assessed monthly premiums based on their modified adjusted gross income. The maximum monthly premium payments are set at the following income levels:

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

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

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

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

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

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

925284

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

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

(e) If, after a 30-day grace period, a full premium payment has not been received, the enrollee shall be transitioned from coverage to inactive status and may not reenroll for a minimum of 6 months, unless a hardship exception has been granted. Enrollees may seek a hardship exception under the Medicaid Fair Hearing Process.

(f) Enrollees eligible under paragraph (1)(c) must pay premiums according to the Title XXI state plan amendment and follow disenrollment criteria for noncompliance in accordance with s. 624.91.

Section 9. Section 409.724, Florida Statutes, is created to read:

409.724 Available assistance.—

(1) PREMIUM CREDITS.—

(a) *Standard amount.*—The agency shall develop a monthly premium credit structure appropriate to a benefit plan that meets the bronze metal standard of the Affordable Care Act.

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

(c) *Savings accounts.*—In addition to the benefits provided

925284

under this section, the corporation shall offer each enrollee access to an individual account that qualifies as a health reimbursement account or a health savings account.

1. Unexpended funds.—Eligible unexpended funds from the monthly premium credit must be deposited into each enrollee's individual account in a timely manner. Funds deposited into these individual accounts may be used to pay cost-sharing obligations or to purchase other health-related items to the extent permitted under federal and state law.

2. Healthy behaviors.—Enrollees may receive credits to their individual accounts for healthy behaviors, adherence to wellness programs, and other activities that demonstrate compliance with prevention or disease management guidelines.

3. Enrollee contributions.—The enrollee may make deposits to his or her account at any time to supplement the premium credit, to purchase additional FHIX products, or to offset other cost-sharing obligations.

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

(2) CHOICE COUNSELING.—The agency, in consultation with the Florida Healthy Kids Corporation and the corporation, shall develop a choice counseling program for FHIX. The choice counseling program must ensure that participants have information about the FHIX marketplace program, the federal exchange, products, and services and that participants know where and whom to call for questions or to make their plan

925284

selections. The choice counseling program must provide culturally sensitive materials and must take into consideration the demographics of the projected population.

(3) EDUCATION CAMPAIGN.—The agency, the corporation, and the Florida Healthy Kids Corporation must coordinate in advance of Phase One an ongoing education campaign to inform participants, at a minimum, of the following:

(a) How the FHIX marketplace operates and the timeline for enrollment.

(b) Plans that are available and how to find information about these plans.

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

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

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

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

(4) CUSTOMER SUPPORT.—The Florida Healthy Kids Corporation shall provide customer support for FHIX, including, but not limited to, general program information, financial information, and enrollee payments. Customer support must also provide a toll-free telephone number and maintain a website that is available in multiple languages and that meets the needs of the enrollee population.

(5) INACTIVE PARTICIPANTS.—The corporation must inform the

925284

inactive participant about other insurance affordability programs and electronically refer the participant to the federal exchange or other insurance affordability programs, as appropriate.

Section 10. Section 409.725, Florida Statutes, is created to read:

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

(1) Those authorized pursuant to s. 408.910.

(2) Products authorized by the federal exchange.

(3) Products authorized by the Florida Healthy Kids Corporation pursuant to s. 624.91.

(4) Premium credits for participation in employer-sponsored plans.

Section 11. Section 409.726, Florida Statutes, is created to read:

409.726 Program accountability.—

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

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

925284

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

(a) *Application processing speed.*—Ninety percent of all applications, regardless of the method of submission, must be processed within 45 days.

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

(c) *Renewal application processing speed.*—Ninety percent of all renewals, regardless of the method of submission, must be processed within 45 days.

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

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

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

(b) All contacts, including, but not limited to, telephone calls, faxed documents and requests, and e-mails, must be handled within 2 business days.

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

(5) The agency, the department, and the Florida Healthy

925284

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

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

(7) Beginning in 2020, an annual report is due no later than July 1 to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The annual report must be coordinated by the agency and the corporation and must include at least the following:

(a) Enrollment and application trends and issues.

(b) Utilization and cost data.

(c) Customer satisfaction.

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

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

(f) Types of products and plans purchased.

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

(h) Recommendations for program improvement.

Section 12. Section 409.727, Florida Statutes, is created to read:

409.727 Readiness review and implementation schedule.—The agency, the corporation, the department, and the Florida Healthy Kids Corporation shall begin implementation of FHIX on the effective date of this act, with enrollment for Phase One


925284

beginning by January 1, 2020.

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

(a) Functional readiness of the service delivery platform.

(b) Plan availability and presence of plan choice.

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

(d) Availability of customer support.

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

(2) PHASE ONE.—The agency, the corporation, and the Florida Healthy Kids Corporation shall coordinate implementation activities to ensure that enrollment begins by January 1, 2020, and is available in all regions by July 1, 2020.

(a) Beginning no later than January 1, 2020, and contingent upon federal approval, participants may enroll in health benefits coverage under the FHIX marketplace or the federal exchange, if eligible.

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

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

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

(e) An enrollee must have a choice of at least two managed

925284

care plans in each region which meet or exceed the Affordable Care Act's requirements and which qualify for a premium credit on the FHIX marketplace or federal exchange.

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

(3) PHASE TWO.—

(a) Not later than July 1, 2020, the corporation and the Florida Healthy Kids Corporation shall begin the transition of enrollees under s. 624.91 to the FHIX marketplace.

(b) Eligibility during this phase is based on meeting the requirements of s. 409.723(1)(c) and (4).

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

(d) A Florida Healthy Kids enrollee who selects an FHIX marketplace plan or federal exchange plan shall be provided a premium credit equivalent to the average capitation rate paid in his or her county of residence under Florida Healthy Kids as of June 30, 2020. The enrollee is responsible for any difference in costs and may use any unexpended funds deposited in his or her savings account under s. 409.724(1)(c) for supplemental benefits on the FHIX marketplace or federal exchange.

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

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

(g) Enrollees under s. 624.91 must transition to the FHIX marketplace and coverage under s. 409.725 by September 30, 2020.

(h) A provision that is applicable to an individual under

925284

s. 624.91 is available and applicable to an enrollee who is eligible under s. 409.723(1)(c).

Section 13. Section 409.728, Florida Statutes, is created to read:

409.728 Program operation and management.—In order to implement ss. 409.72-409.731:

(1) The agency shall do all of the following:

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

(b) Provide administrative support to the FHIX Workgroup established pursuant to s. 409.729.

(c) Consult with stakeholders that serve low-income individuals and families during implementation, using a public input process.

(d) Timely transmit enrollee information to the corporation.

(e) Annually determine the appropriate premium credit based on the difference in the price of a benchmark product on the FHIX marketplace and the enrollee premium contribution as outlined in s. 409.723(5)(a). For purposes of this paragraph, the benchmark product on the FHIX marketplace is the bronze-level plan under the Affordable Care Act. For plans on the FHIX marketplace, the agency shall annually establish a retroactive methodology to adjust premium revenue to the relative clinical risk profile of each plan’s enrollees.

(f) Transfer funds allocated for premium credits by General


925284

Appropriations Act to the corporation.

(g) Adopt rules in coordination with the corporation and the Florida Healthy Kids Corporation in order to implement FHIX, including modifying existing rules implementing the Children's Health Insurance Program and adapting adult-focused provisions for children to accommodate the seamless transition of Healthy Kids enrollees to FHIX.

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

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

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

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

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

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

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

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

(a) Develop and maintain the FHIX marketplace.

925284

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

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

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

(e) Offer the opportunity to participate in the federal exchange.

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

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

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

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

Section 14. Section 409.729, Florida Statutes, is created to read:

409.729 Long-term reorganization.—The FHIX Workgroup is created to facilitate the implementation of FHIX and to plan for the reorganization of the state’s insurance affordability programs. The FHIX Workgroup consists of two representatives

925284

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

(1) Developing and presenting a final implementation plan that meets the requirements of this part in a report submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than November 1, 2019.

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

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

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

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

(6) Evaluating any fiscal impacts based on the proposed transition plan under Phase Two.

925284

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

(8) Determining staff requirements for Phase Two.

Section 15. Section 409.73, Florida Statutes, is created to read:

409.73 Legislative review.—The agency may seek federal approval to implement FHIX as provided in ss. 409.72-409.731. The agency is prohibited from implementing the FHIX waiver without specific legislative approval unless the terms and conditions of the approved waiver are substantially consistent with the statutory requirements for this program.

Section 16. Section 409.731, Florida Statutes, is created to read:

409.731 Program expiration.—

(1) The Florida Health Insurance Affordability Exchange Program expires at the end of the state fiscal year in which any of these conditions occurs:

(a) The federal match contribution for the newly eligible under the Affordable Care Act falls below 90 percent.

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

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

(2) Provided the conditions specified in subsection (1) have not previously occurred, the Florida Health Insurance

925284

Affordability Exchange Program shall expire on July 1, 2022, unless reviewed and reenacted by the Legislature.

(3) The Health Outcomes Review Commission is established to assess the following indicators:

(a) *Patient outcomes.*—Selected measures from the National Healthcare Quality Report or similarly credible sources will be applied to FHIX enrollees and compared to outcomes for Managed Medical Assistance enrollees and uninsured patients.

(b) *Fiscal impact.*—Actual annual state general revenue expenditures for the FHIX program will be compared to predicted expenditures.

(c) *Access to care.*—Potentially preventable hospitalization rates for acute and chronic conditions and potentially preventable emergency department visits among FHIX enrollees will be compared to Managed Medical Assistance enrollees and uninsured patients.

(4) The Health Outcomes Review Commission shall consist of nine members appointed by the Governor, the President of the Senate, and the Speaker of the House. The Governor and each presiding officer shall appoint one healthcare professional, one private business representative, and one elected official.

(5) The commission shall be appointed no later than January 1, 2021, and shall meet regularly to select specific indicators, review preliminary data, and develop a framework for a final report. Staff support shall be provided to the commission by the Agency for Health Care Administration.

(6) The commission’s final report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House by January 1, 2022.

925284

Section 17. Section 408.70, Florida Statutes, is repealed.

Section 18. Section 408.910, Florida Statutes, is amended to read:

408.910 Florida Health Choices Program.—

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

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

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

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

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

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

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

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

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

925284

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

(c) "Florida Health Insurance Affordability Exchange Program" or "FHIX" is the program created under ss. 409.72-409.731 for low-income, uninsured residents of this state.

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

(e) ~~(d)~~ "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, an exclusive provider organization as defined in s. 627.6472, a health maintenance organization licensed under part I of chapter 641, ~~or~~ a prepaid limited health service organization or discount plan organization licensed under chapter 636.

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

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

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

925284

flexible spending accounts. The components of the program include:

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

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

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

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

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

4. Services that promote healthy behaviors.

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

6. Consumer assistance with web-based information services for the Florida Health Insurance Affordability Exchange Program, or ("FHIX").

(d) Recruitment of vendors, including insurers, health


925284

maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.

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

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

(g) Information services for individuals and employers.

(h) Program evaluation.

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

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

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

1. Individual employees of enrolled employers.

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

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

1. Submission of required information.

2. Compliance with federal tax requirements for the establishment of a cafeteria plan, pursuant to s. 125 of the Internal Revenue Code, including designation of the employer's

925284

plan as a premium payment plan, a salary reduction plan that has flexible spending arrangements, or a salary reduction plan that has a premium payment and flexible spending arrangements.

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

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

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

6. Identification of eligible employees.

7. Arrangement for periodic payments.

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

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

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

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

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


925284

as authorized under part II of chapter 636.

4. Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

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

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

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

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


925284

(e) Eligible individuals may participate in the program voluntarily. Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures must include, but are not limited to:

1. Submission of required information.

2. Authorization for payroll deduction, if applicable.

3. Compliance with federal tax requirements.

4. Arrangements for payment.

5. Selection of products and services.

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

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

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

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

4. Establishment of product prices based on applicable criteria.

5. Arrangements for receiving payment for enrolled participants.

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

7. Compliance with grievance procedures established by the


925284

corporation.

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

1. Completion of training requirements.

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

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

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

(5) PRODUCTS.—

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

1. Health insurance policies.

2. Health maintenance contracts.

3. Limited benefit plans.


925284

4. Prepaid clinic services.

5. Service contracts.

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

7. Flexible spending accounts.

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

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

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

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

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

(7) THE MARKETPLACE PROCESS.—The program shall provide a


925284

single, centralized market for purchase of health insurance, health maintenance contracts, and other health products and services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive Internet website.

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

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

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

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

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

5.~~(e)~~ The limits established in subparagraphs 2., 3., and 4. ~~paragraphs (b)-(d)~~ apply to any risk-bearing product that

925284

promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(b) *FHIX marketplace purchasing.*—

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

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

(8) CONSUMER INFORMATION.—The corporation shall:

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

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

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


925284

Distribution of payments to the vendors may be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

(10) EXEMPTIONS.—

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

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

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

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

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

925284

1. Three ex officio, nonvoting members to include:

a. The Secretary of Health Care Administration or a designee with expertise in health care services.

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

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

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

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

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

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

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

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

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

(e) There is no liability on the part of, and no cause of


925284

action shall arise against, any member of the board or its employees or agents for any action taken by them in the performance of their powers and duties under this section.

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

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

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

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

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

(h) The corporation may establish technical advisory panels


925284

consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

(i) The corporation shall:

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

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

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

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

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

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

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

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

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


925284

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

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

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

13. Administer the Florida Health Insurance Affordability Exchange Program in accordance with ss. 409.72-409.731.

14. Coordinate with the Agency for Health Care Administration, the Department of Children and Families, and the Florida Healthy Kids Corporation in developing and implementing the enrollee transition plan.

15. Coordinate with the federal exchange to provide FHIX enrollees with the option of selecting plans from either the FHIX marketplace or the federal exchange.

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

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

925284

(14) EXEMPTION FROM PUBLIC RECORDS REQUIREMENTS.—

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

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

2. "Enrollee" means an employer who is eligible to enroll in the program pursuant to paragraph (4)(a).

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

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

a. Business plans.

b. Internal auditing controls and reports of internal auditors.

c. Reports of external auditors for privately held companies.

d. Client and customer lists.

e. Potentially patentable material.

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

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

(b) *Public record exemptions.*—

925284

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

2. Client and customer lists of a buyer's representative held by the corporation are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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

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

(d) *Authorized release.*—

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

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

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

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

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

(e) *Penalty.*—A person who knowingly and willfully violates this subsection commits a misdemeanor of the second degree,


925284

punishable as provided in s. 775.082 or s. 775.083.

Section 19. Subsection (2) of section 409.904, Florida Statutes, is amended to read:

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

(2) A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled. Effective July 1, 2020, persons eligible under "medically needy" shall be limited to children under 21 years of age and pregnant women. This subsection expires October 1, 2023.

Section 20. Section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

925284

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

(2) LEGISLATIVE INTENT.—

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

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

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


925284

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

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

~~(b) Notwithstanding s. 409.814, a legal alien who is enrolled in the Florida Healthy Kids program as of January 31, 2004, who does not qualify for Title XXI federal funds because he or she is not a lawfully residing child as defined in s. 409.811.~~

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

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

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

(b) The Florida Healthy Kids Corporation shall:

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

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


925284

3. ~~Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional Florida Kidcare coverage in contributing counties under Title XXI.~~

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

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

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

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

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

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


925284

premiums.

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

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

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

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

d. Effective July 1, 2020, health and dental services


925284

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

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

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

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

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

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

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


925284

b. The costs and utilization by service of the full-pay enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population.

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

16. Contract with other insurance affordability programs to provide such services that are consistent with this act.

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

a. Administrative functions.

b. Contracting with vendors.

c. Customer service.

d. Enrollee education.

e. Financial services.

f. Program integrity.

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

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


925284

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

(6) BOARD OF DIRECTORS AND MANAGEMENT SUPERVISION.—

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

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

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

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

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

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

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

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

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


925284

~~the state Medicaid program.~~

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

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

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

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

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

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

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

(e) Terms for board members appointed under this act are effective January 1, 2020.

(7) LICENSING NOT REQUIRED; FISCAL OPERATION.—

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

925284

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

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

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

(8) TRANSITION PLANS.—The corporation shall confer with the Agency for Health Care Administration, the Department of Children and Families, and Florida Health Choices, Inc., to develop transition plans for the Florida Health Insurance Affordability Exchange Program as created under ss. 409.72-409.731.

Section 21. Section 624.915, Florida Statutes, is repealed.

Section 22. The Division of Law Revision and Information is directed to replace the phrase "the effective date of this act" wherever it occurs in this act with the date the act becomes a law.

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

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

And the title is amended as follows:

Delete lines 2 - 30

and insert:

An act relating to health care coverage; creating ss.

925284

627.6046 and 627.65612, F.S.; defining the terms "operative date" and "preexisting medical condition" with respect to individual and group health insurance policies, respectively; requiring insurers, contingent upon the occurrence of either of two specified events, to make at least one comprehensive major medical health insurance policy available to all residents of this state within a specified timeframe; prohibiting such insurers from excluding, limiting, denying, or delaying coverage under such policies due to preexisting medical conditions; requiring such policies to have been actively marketed on a specified date and during a certain timeframe before that date; providing applicability; amending s. 641.31, F.S.; defining the terms "operative date" and "preexisting medical condition" with respect to health maintenance contracts; requiring health maintenance organizations, contingent upon the occurrence of either of two specified events, to make at least one comprehensive major medical health maintenance contract available to all residents of this state within a specified timeframe; prohibiting such health maintenance organizations from excluding, limiting, denying, or delaying coverage under such contracts due to preexisting medical conditions; requiring such contracts to have been actively marketed on a specified date and during a certain timeframe before that date; providing a directive to the Division of Law Revision and Information; creating s. 409.72,


925284

F.S.; providing a short title; creating s. 409.721, F.S.; creating the Florida Health Insurance Affordability Exchange Program (FHIX) within the Agency for Health Care Administration; providing program authority and principles; creating s. 409.722, F.S.; defining terms; creating s. 409.723, F.S.; providing eligibility and enrollment criteria; providing patient rights and responsibilities; defining the term "disabled"; providing premium levels; creating s. 409.724, F.S.; providing for premium credits and choice counseling; establishing an education campaign; providing for customer support and disenrollment; creating s. 409.725, F.S.; providing for available products and services; creating s. 409.726, F.S.; requiring the department to develop accountability measures and performance standards governing the administration of the program; creating s. 409.727, F.S.; providing for a readiness review and a two-phase implementation schedule; creating s. 409.728, F.S.; providing program operation and management duties; creating s. 409.729, F.S.; providing for the development of a long-term reorganization plan and the formation of the FHIX Workgroup; creating s. 409.73, F.S.; authorizing the agency to seek federal approval; prohibiting the agency from implementing the FHIX waiver under certain circumstances; creating s. 409.731, F.S.; providing for program expiration; providing for the establishment of a commission; providing purposes and


925284

duties of the commission and for the appointment of members; requiring a commission report to be submitted to the Governor and the Legislature; repealing s. 408.70, F.S., relating to legislative findings regarding access to affordable health care; amending s. 408.910, F.S.; revising legislative intent; redefining terms; revising the scope of the Florida Health Choices Program and the pricing of services under the program; providing requirements for operation of the marketplace; providing additional duties for the corporation to perform; requiring an annual report to the Governor and the Legislature; amending s. 409.904, F.S.; limiting eligible persons in the Medically Needy program to those under the age of 21 and pregnant women, and specifying an effective date; providing an expiration date for the program; amending s. 624.91, F.S.; revising eligibility requirements for state-funded assistance; revising the duties and powers of the Florida Healthy Kids Corporation; revising provisions for the appointment of members of the board of the Florida Healthy Kids Corporation; requiring transition plans; repealing s. 624.915, F.S., relating to the operating fund of the Florida Healthy Kids Corporation; providing a directive to the Division of Law Revision and Information; providing an effective date.