Health & Human Services Committee

Monday, June 01, 2015
3:00 PM - 6:00 PM
Webster Hall

Action Packet

Steve Crisafulli
Speaker

Jason Brodeur
Chair

COMMITTEE MEETING REPORT

Health & Human Services Committee

6/1/2015 3:00:00PM

Location: Webster Hall (212 Knott)

Summary: No Bills Considered

Committee meeting was reported out: Tuesday, June 02, 2015 9:12:15AM

COMMITTEE MEETING REPORT

Health & Human Services Committee

6/1/2015 3:00:00PM

Location: Webster Hall (212 Knott)

Attendance:

	Present	*Absent*	*Excused*
Jason Brodeur (Chair)	X		
Bryan Avila	X		
Lori Berman	X		
Colleen Burton	X		
Gwyndolen Clarke-Reed	X		
Fred Costello	X		
Janet Cruz	X		
W. Travis Cummings	X		
Katie Edwards	X		
Gayle Harrell	X		
Mia Jones	X		
Shevrin Jones	X		
MaryLynn Magar	X		
Cary Pigman	X		
Paul Renner	X		
Kenneth Roberson	X		
Chris Sprowls	X		
Jay Trumbull	X		
Totals:	**18**	**0**	**0**

Committee meeting was reported out: Tuesday, June 02, 2015 9:12:15AM

COMMITTEE MEETING REPORT

Health & Human Services Committee

6/1/2015 3:00:00PM

Location: Webster Hall (212 Knott)

Workshop

SB 2-A relating to a Health Insurance Affordability Exchange

Committee meeting was reported out: Tuesday, June 02, 2015 9:12:15AM

COMMITTEE MEETING REPORT

Health & Human Services Committee

6/1/2015 3:00:00PM

Location: Webster Hall (212 Knott)

Presentation/Workshop/Other Business Appearances:

Health Insurance Affordability Exchange
Naff, Rose M - Information Only
CEO, Florida Health Choices, Inc.
200 W. College Ave
Tallahassee FL 32301
Phone: (850) 222-0933

Health Insurance Affordability Exchange
Senior, Justin (Lobbyist) (State Employee) - Information Only
Agency for Health Care Administration
Deputy Secretary for Medicaid
2727 Mahan Dr
Tallahassee FL 32308
Phone: (850) 412-4007

Health Insurance Affordability Exchange
Baker, Amy (State Employee) (At Request Of Chair) - Information Only
Economic and Demographic Research
Pepper Building, Suite 574
Tallahassee Florida 32399
Phone: (850) 487-1402

Committee meeting was reported out: Tuesday, June 02, 2015 9:12:15AM

2015 AGENCY LEGISLATIVE BILL ANALYSIS
Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 2A, as amendment by #260258
BILL TITLE:	**An Act Related to Health Insurance Affordability Exchange**
BILL SPONSOR:	Senator Bean, Chair, Senate Health Policy Committee
EFFECTIVE DATE:	Upon becoming law

COMMITTEES OF REFERENCE
1)
2)
3)
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	June 1, 2015
LEAD AGENCY ANALYST:	Kristin Sokoloski, Medicaid Program Coordination
ADDITIONAL ANALYST(S):	
LEGAL ANALYST:	
FISCAL ANALYST:	

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

SB 2A, as amended, creates the Florida Health Insurance Affordability Exchange Program or FHIX. SB 2A, as amended, outlines general program responsibilities for the Agency for Health Care Administration (Agency), the Department of Children and Families (Department), the Florida Healthy Kids Corporation and the Florida Health Choices, Inc., in the operation of the FHIX program.

In order to implement the FHIX program and SB 2A, as amended,, the Agency for Health Care Administration will need to seek federal authority, including waiver and state plan amendment. Federal approval of the program in its entirety as written is highly unlikely. The structure of the program and the work and cost sharing requirements make it uncertain whether the FHIX will provide more Floridians with health coverage or whether it will cause fewer Floridians to have coverage.

The stated purpose of the FHIX program is to assist Floridians in purchasing health benefits coverage and gaining access to health services via either the new FHIX marketplace of via the federal market-place created by the ACA. The law directs the Florida Health Choices Corporation to administer the FHIX program, including the FHIX marketplace and ongoing operations of the program in accordance with ss. 409.720-409.731, F.S. Specifically, those in the newly eligible adult group under the ACA and those currently enrolled under the Florida Healthy Kids program (as outlined in Chapter 624, F.S.) will be required to enroll in insurance products offered through the FHIX marketplace, operated by Florida Health Choices, Inc., or the federal marketplace.

The FHIX provides for Premium assistance for the purchase of FHIX products, and enrollees will be required to contribute a monthly premium to continue enrollment, as well as to pay co-payments for services dependent on the product chosen from the FHIX. Failure to pay cost sharing or non-compliance with other program requirements would result in a six month "inactive" period where the enrollee would be locked out of the FHIX program. The law establishes Health Savings or Health Reimbursement Accounts for enrollees, into which any unexpended funds from the monthly premium credit will be deposited, along with any additional funds contributed by the enrollee or a third party. Enrollees will be required to participate in on-the-job training or placement activities, or pursuit of educational opportunities for 20 to 30 hours a week in order to be eligible. Job training or job placement activities must be validated through registration with CareerSource Florida.

SB 2A, as amended, limits the Medically Needy program, to children and pregnant women only, effective July 1, 2016 concurrent with the implementation of Phase 2 of the FHIX program, and sunsets authority for the Medically Needy program as a whole effective October 1, 2019.

SB 2A, as amended, will have a fiscal impact on the Agency. Due to the anticipated additional enrollment of eligible FHIX and Medicaid population and increased need for choice counseling, actuarial and fiscal agent services. The total estimated fiscal impact in FY 2015-16 will be $2,351,628,054 with the total impact being $4,264,643,986 in FY 2016-17 and $5,734,054,031 in FY 2017-18. It is anticipated that there will be some additional FHIX and Medicaid program enrollment as a result of what is known as "crowd out". "Crowd out" is a term used to identify those who currently purchase health insurance directly from an insurance company or through the exchange, who will enroll in the FHIX and Medicaid programs once a state choses to add the newly eligible adult group under the ACA.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

As of May 1, 2015, there were approximately 3.8 million Floridians in Medicaid and the Children's Health Insurance Program (CHIP). As of February 2015, approximately 1.6 million Floridians had selected

private insurance plans in the federal marketplace under the Affordable Care Act. Many of these persons may be below 138% of the federal poverty level (FPL), and thus would become Medicaid eligible in the event of an expansion. Although SB 2A, as amended, would allow those eligible for FHIX to remain in their exchange plan, premiums previously paid by the individual would be paid, under the FHIX program, by the state. This could present funding difficulties which are further outlined on page 18 of this analysis in the discussion of premium credits.

Medicaid:

The Florida Agency for Health Care Administration serves as the federally designated single state agency for the administration of the Medicaid program under part 431 of Title 42 of the Code of Federal Regulation.

The state Medicaid program covers newborns up to 200% of the FPL, children age 1-5 up to 138% of FPL, and children age 6-18 up to 100% of the FPL, 19-20 year olds and parents up to 18% of the FPL, pregnant women up to 185% of the FPL, and the disabled up to 75% of the FPL for an individual.

Under the Medicaid program, costs are shared by the state and federal governments, with the federal government payment being approximately 59.56% of the costs.

Not covered:

- Florida Medicaid does not currently cover non-pregnant, non-disabled childless adults

Florida Medicaid Medically Needy Program

The Medically Needy program is currently authorized by the Florida Medicaid State Plan for persons who would otherwise be eligible(i.e., children, parents, pregnant women and disabled adults) except that their family income or assets exceeds the Florida Medicaid State Plan threshold for Medicaid eligibility. There is no limit on overall income, but eligibility is restricted to individuals with limited assets, such as savings or property other than a residence. Currently, in the event that subtracting the amount of allowable medical expenses incurred by these individuals from their monthly income would cause the remainder to fall below the Medically Needy Income Level (MNIL), these individuals become eligible for Medicaid. They receive Medicaid services on a fee-for-service basis.

Statewide Medicaid Managed Care Program

In 2011, the Florida Legislature required the Agency to expand managed care statewide for most Medicaid recipients. The program has two components: the Long-Term Care (LTC) program and the Managed Medical Assistance (MMA) program. The MMA program covers most recipients of any age who are eligible to receive full Medicaid benefits.

Children's Health Insurance Program:

The Florida Agency for Health Care Administration serves as the federally designated single state agency for the administration of the Title XXI Children's Health Insurance Program.

Under the Florida Children's Health Insurance Program (CHIP), insurance is offered to all resident children who are not eligible for the Title XIX Medicaid program, regardless of their family income. For children up to 200% of the federal poverty level, the cost of the coverage is subsidized. The subsidy is jointly funded by the state and federal government. Families contribute through the payment of premiums and other cost sharing. The federal share of the subsidized programs is currently 71.8%. Under the Affordable Care Act, the federal share will increase by 23 percentage points effective October 1, 2015.

Federal funding for the CHIP program ends in 2017, with all federal authorization ending in 2019.

The CHIP program has several program components, that, along with Title XIX Medicaid for Children, are collectively known as "Florida KidCare."

- Children through age 1:
  1. <200% FPL.
  2. Eligible for full Medicaid benefits.
- Children age 1 through 4:
  1. Between 134 – 200% FPL
  2. Enrolled in the Title XXI Funded MediKids Program.
  3. These children receive their health insurance benefits through health plans contracted with the Agency for Health Care Administration under the Managed Medical Assistance health plans.
- Children age 5 through 18:
  1. Between 134 - 200% of the FPL
  2. Enrolled in the Title XXI Funded Florida Healthy Kids program.
  3. These children receive their health insurance benefits through the health plans contracted with the Florida Healthy Kids Program.
- Title XXI CMS
  1. Children age 1 through 18
  2. Between 134 – 200% of the FPL
  3. These children receive their health insurance benefits through the Department of Health's CMS network.

The Florida KidCare program is made up of a partnership of state agencies and the Florida Healthy Kids Corporation. The Florida KidCare program has functioned, since its inception in 1998, as an umbrella program that includes Medicaid, MediKids, Healthy Kids, and the Children's Medical Services Network (CMSN). The Agency for Health Care Administration is the lead agency for federal and state funding and federal compliance. The Florida Healthy Kids corporation is responsible for performing the administrative functions, including screening for Medicaid eligibility, eligibility determination for CHIP, premium billing and collection, refunds and customer service. Other program partners include the Department of Children and Family Services, the Department of Health, and the Office of Insurance Regulation.

Department of Children and Families

Federal regulation requires that each state have one single state agency as the conduit for state Medicaid eligibility. Specifically, 42 CFR 431.10 (c) states that the State Medicaid agency is able to designate the responsibility to determine Medicaid eligibility to only one of three entities by designating such in their Medicaid State Plan: 1) the Medicaid Agency; 2) the Title IV-A agency (in Florida's case = DCF); or 3) the Health Insurance Exchange.

Medicaid eligibility in Florida is determined by the Department of Children and Families (DCF).

Florida Health Choices:

In May 2008, SB 2534 was signed into law, which created the Florida Health Choices Corporation.

The Corporation was established with the goal of increasing access to affordable, quality health care by creating a competitive market for purchasing health insurance and health services.

The Corporation is administered by a 15-member board made up of appointees chosen by the Governor, the Senate president and the House speaker.

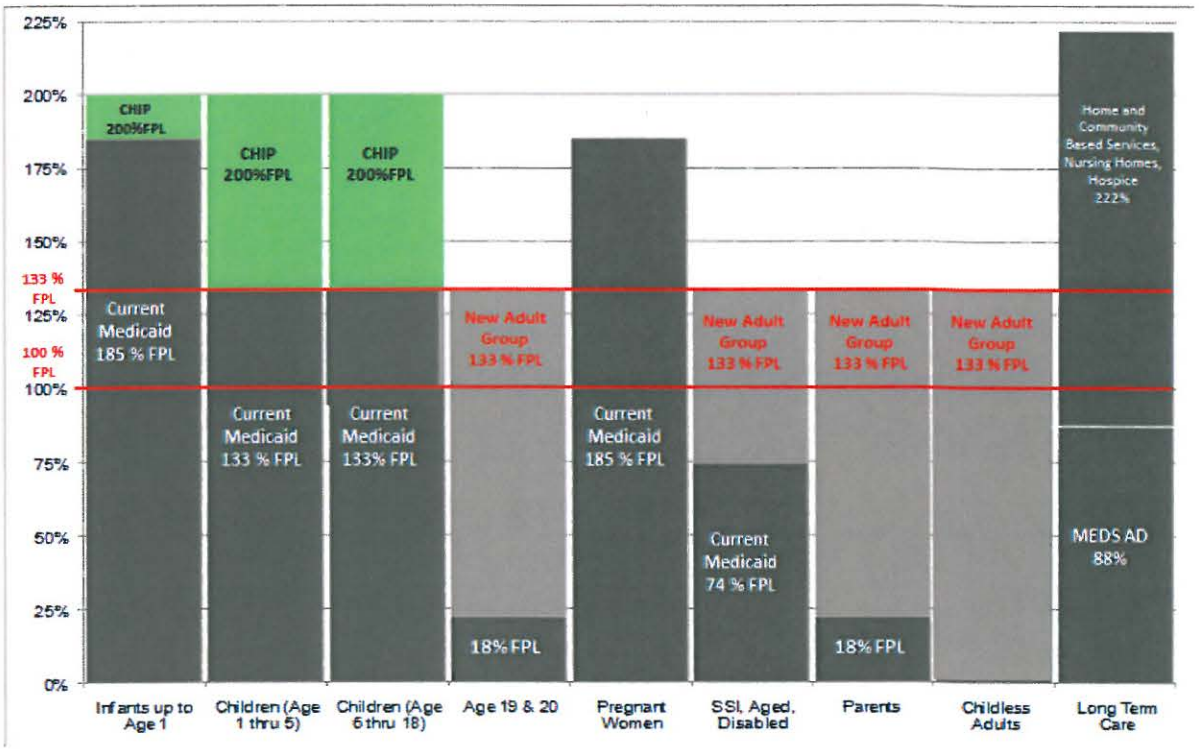
In 2014, Florida Health Choices began to roll out Florida's Health Insurance Marketplace in phases. Florida Health Choices, Inc., operates two exchanges where people can purchase individual health

plans, discount plans, limited benefit plans and identity theft protection. Fifty-nine families and individuals have purchased discount plans, and during an abbreviated open enrollment period for comprehensive coverage, 56 lives enrolled. Florida Health Choices, Inc., will launch a third exchange in March 2015 to serve members of Florida's largest professional association.

Traditional Expansion under the Patient Protection and Affordable Care Act:

In March 2010, President Obama signed into law the Affordable Care Act (ACA). The ACA required states to expand their Medicaid program to all residents with incomes below 138% of the federal poverty level. After review, the Supreme Court determined that the federal government could not require that the states expand their Medicaid programs to the newly eligible populations, and made the Medicaid expansion optional.

The following chart represents current Medicaid eligibility levels in Florida and the new adult groups under the ACA (represented in light grey).



2. **EFFECT OF THE BILL:**

Overview:

SB 2A, as amended, creates the F FHIX and outlines general program responsibilities for the Agency, the Department, the FHK and the Florida Health Choices, Inc..

In order to implement the FHIX program and SB 2A, as amended,, the Agency for Health Care Administration will need to seek federal authority, including waiver and state plan amendment. Federal approval of the program in its entirety as written is highly unlikely. The structure of the program and the work and cost sharing requirements make it uncertain whether the FHIX will provide more Floridians with health coverage or whether it will cause fewer Floridians to have coverage.

The stated purpose of the FHIX program is to assist Floridians in purchasing health benefits coverage and gaining access to health services via either the new FHIX marketplace of via the federal market-place created by the ACA. The law directs the Florida Health Choices Corporation to administer the FHIX program, including the FHIX marketplace and ongoing operations of the program in accordance with ss. 409.720-409.731, F.S. Specifically, those in the newly eligible adult group under the ACA and those currently enrolled under the Florida Healthy Kids program (as outlined in Chapter 624, F.S.) will be required to enroll in insurance products offered through the FHIX marketplace, operated by Florida Health Choices, Inc., or the federal marketplace.

The FHIX provides for Premium assistance for the purchase of FHIX products, and enrollees will be required to contribute a monthly premium to continue enrollment, as well as to pay co-payments for services dependent on the product chosen from the FHIX. Failure to pay cost sharing or non-compliance with other program requirements would result in a six month "inactive" period where the enrollee would be locked out of the FHIX program. The law establishes Health Savings or Health Reimbursement Accounts for enrollees, into which any unexpended funds from the monthly premium credit will be deposited, along with any additional funds contributed by the enrollee or a third party. Enrollees will be required to participate in on-the-job training or placement activities, or pursuit of educational opportunities for 20 to 30 hours a week in order to be eligible. Job training or job placement activities must be validated through registration with CareerSource Florida.

SB 2A, as amended, limits the Medically Needy program, to children and pregnant women only, effective July 1, 2016 concurrent with the implementation of Phase 2 of the FHIX program, and sunsets authority for the Medically Needy program as a whole effective October 1, 2019.

SB 2A, as amended, will have a fiscal impact on the Agency. Due to the anticipated additional enrollment of eligible FHIX and Medicaid population and increased need for choice counseling, actuarial and fiscal agent services. The total estimated fiscal impact in FY 2015-16 will be $2,351,628,054 with the total impact being $4,264,643,986 in FY 2016-17 and $5,734,054,031 in FY 2017-18. It is anticipated that there will be some additional FHIX and Medicaid program enrollment as a result of what is known as "crowd out". "Crowd out" is a term used to identify those who currently purchase health insurance directly from an insurance company or through the exchange, who will enroll in the FHIX and Medicaid programs once a state choses to add the newly eligible adult group under the ACA.

Intent:

SB 2A, as amended, creates the FHIX to assist Floridians in purchasing health benefits coverage and gaining access to health services

Program Eligibility

To participate in FHIX, a resident of the state must:

- Qualify as newly eligible adult enrollee under the ACA
  - It is estimated that approximately 960,051 adults will be eligible in this category. Note: this number represents the approximate number of people in this category who would be eligible for this program as outlined in the Legislation. Some may already have purchased coverage through the Federal Exchange.
- And meet and maintain the responsibilities under s. 409.723 (4), Florida Statutes;
  - Section 409.723 (4) , Florida Statutes, contains work/training requirements, including the requirement for job seekers to validate their efforts through registration with CareerSource Florida.
- Or qualify for Florida Healthy Kids program under s. 624.91, Florida Statutes
  - Based on the February 2015 Social Services Estimating Conference caseload estimates for FY 2015-16, there will be 153,982 children eligible in this category.
    - Note: It is not explicitly addressed in the bill language whether the full pay component of the Healthy Kids program will also move to the FHIX during Phase 3. If that is the intention of the legislation, an additional 36,982 would be eligible in this category.

There will most likely be some additional FHIX and Medicaid program enrollment as a result of what is known as "crowd out". "Crowd out" is a term used to identify those who currently purchase health insurance directly from an insurance company or through the federal exchange, who will enroll in the FHIX and Medicaid programs once a state chooses to add the newly eligible adult group under the ACA. This group could include both those who are eligible under the traditional Medicaid program but who have previously purchased their own health insurance and those in the newly eligible adult group who have previously purchased their own health insurance. It is estimated that there are approximately 140,818 individuals in this category, but that only 56,327 would present for services in FY 2015-16. See Fiscal Analysis section for further detail. Although SB 2A, as amended, would allow those eligible for FHIX to remain in their exchange plan, premiums previously paid by the individual would be paid, under the FHIX program, by the state.

Program Enrollment:

SB 2A, as amended, makes the Department responsible for program eligibility and enrollment through section 409.723 (2), Florida Statutes.

The Department can only deem applications for initial enrollment or for renewal can only be deemed complete when the participant has met all the requirements under section 409.723 (4), as applicable. These include the work and educational requirements, including the validation of job search activities through CareerSource Florida.

As outlined below, Phase 1 enrollment is to begin by January 1, 2016. This timeline is extremely aggressive and may present some challenges on the part of the state with regard to preparing and processing the eligibility enrollment applications and enrollment in the system.

Note: It is unclear what the intent is regarding ongoing eligibility functions for the non-Healthy Kids components of Florida's CHIP population. Currently, the Florida Healthy Kids Corporation conducts eligibility for all CHIP program components, including MediKids and CMS.

Implementation Schedule

SB 2A, as amended, outlines a two-phase implementation schedule, with implementation to begin by the effective date of the act (upon becoming law) with the program to be available in all regions by July 1, 2016.. The first phase of the program will roll out on January 1, 2016, and the second

phase will roll out on July 1, 2016. This is an extremely aggressive time-frame and it will be difficult if not impossible to obtain federal authority, contract with health plans, conduct readiness reviews, and go through choice counseling in the time allotted.

Phase 1: Contingent upon federal approval.

- Enrollment begins by January 1, 2016
- Enrollees must meet qualifications under ss. 409.723 (1)(a) and (b), F.S., which means they are in the Newly Eligible Adult Group under the ACA and meet the work/training requirements; This does not include Florida Healthy Kids group
- Premium credits must be in place
- Collection of monthly premium contributions from enrollees begins
- Benefits will be received through a plan under the FHIX marketplace or through the federal exchange; enrollees may select any available product; with a choice of at least two plans per region which meet or exceed the ACA requirements and qualify for a premium credit on the FHIX marketplace or the federal exchange.
    - Note: The newly eligible adult population will likely be required by federal CMS to select a plan that meets or exceeds the ACA requirements.
- The Florida Health Choices Corporation must notify enrollees of their premium credit amount and how to access the FHIX marketplace selection process

Phase 2: Begins July 1, 2016. Note: Although the legislation does not specifically state that the implementation of Phase 2 is contingent upon federal approval, federal approval will be needed.

- Enrollment to begin by July 1, 2016
- Must meet qualifications under s. 409.723 (1) (c) and (4), Florida Statutes - qualified for the Florida Healthy Kids (FHK(program under s. 624.91, Florida Statutes
- May select any benefit, service, or product available under s. 409.975, F.S. (All products on FHIX)
- Premium credits in place
- The Florida Healthy Kids Corporation and the Florida Health Choices Corporation shall work together to transition children from Florida Healthy Kids to the FHIX. The transition from FHK to FHIX must be complete by September 30, 2016.
- Effective July 1, 2016, health and dental services contracts of FHK must transition to the FHIX marketplace, qualifying plans may enroll as vendors with the FHIX marketplace to maintain continuity of care for participants
- The Florida Health Choices Corporation must notify enrollees of their premium credit amount and how to access the FHIX marketplace selection process

Note: Section 409.723 (4) contains the work and education requirements for participants in the FHIX program. It is unclear whether, in stating that enrollees in Phase 2 of FHIX must meet the requirements of s. 409.923 (4) the intent is for parents of children current enrolled in the Florida Healthy Kids program to meet these requirements.

Federal and State Authority

SB 2A, as amended, provides, pursuant to section 409.730, Florida Statutes, that the Agency may seek federal approval to implement FHIX.

The Agency will need federal authority, either by amending its current 1115 waiver or creating a new 1115 waiver.

With regards to the implementation timeline, it should be noted that it is extremely aggressive and that the state may not be able to secure federal authority quickly enough to accomplish the deadlines established. The federal government will have to be flexible with its own requirements for the Agency to meet the various deadlines.

- If the Agency used the current 1115 Managed Medical Assistance waiver for the FHIX program, the structured amendment and public notice requirements are problematic. Amendments must be submitted 120 days before the proposed effective date, and documents must be posted for a 30-day "public comment" period before amendment submission. Even assuming that the Agency could have documents ready to post immediately upon completion of the 2015A Special Legislative Session (June 22, 2015), the earliest effective date for Phase 1 under the regular amendment schedule would be on/around December 1, 2015. This assumes that the federal government will have no questions and no major changes to the FHIX proposal
- If the Agency uses a new 1115 waiver to implement the FHIX program the timeline for approval could be longer. There are no deadlines for the federal government to approve an amendment of a new 1115 waiver.
- NOTE: Federal CMS indicated in a March 2013 publication that any 1115 waiver for premium assistance programs (such as that proposed in SB 2A, as amended,) would have end dates of no later than December 31, 2016, and that, starting in 2017, State Innovation Waiver authority would begin which could allow a range of State-designated initiatives. If, in order to implement the premium assistance component of FHIX, the state was required to request an Innovation waiver (1332 waiver), it would be unlikely that waiver could be effective prior to 2017 without significant federal flexibility.

SB 2A, as amended, includes provision for amendment/ promulgation of rules relating to the FHIX program and its intersection with the CHIP program. Specifically, the Agency is required to adopt rules, in coordination with the corporation and FHK in order to implement FHIX, including modifying existing rules implementing the CHIP, and adapting adult focused provisions (of the FHIX) for children to accommodate the seamless transition of Healthy Kids enrollees to FHIX.

Public Input:

SB 2A, as amended, includes provisions for a public input process. Specifically, the Agency is required to consult with stakeholders that serve low income individuals and families during the implementation, using a public input process.

Education Campaign

SB 2A, as amended,, through section 409.724 (3), Florida Statutes, directs the Agency for Health Care Administration (Agency), the Florida Healthy Kids Corporation and the Florida Health Choices Corporation to undertake an education campaign with regards to the FHIX program. The campaign is to begin during Phase 1 of the implementation.

Choice Counseling

In addition to the education campaign requirements, SB 2A, as amended, designates the Agency, in consultation with the Florida Healthy Kids Corporation and the Florida Health Choices

Corporation, a as being responsible for the development of a choice counseling for the FHIX program.

It is our assumption that the Agency will leverage its current Choice Counseling/Enrollment Broker function to provide these services. Additional staffing, as well as additional phone lines and equipment, would be needed to accommodate higher call center volume. Some costs will be incurred relating to systems changes to accommodate the newly eligible group and volume of mail services needed as well. There will also be additional costs associated with printing, mailing and postage. In addition, there would likely be additional costs associated with the new and different choices available to the enrollees. Creation of different choice materials, new enrollment systems modules, and training for call center staff would result in additional costs.

Customer Support:

Pursuant to section 409.74 (4), Florida Statutes, the FHK will be responsible for the provision of coordinated customer support for the FHIX program, including the provision of general program information, financial information, customer service, and status updates on bill payments.

The FHK will also be responsible for maintaining a toll-free number and website available in multiple languages and for annually developing performance measures for the following areas:

- Administrative functions
- Contracting with vendors
- Customer service
- Enrollee education
- Financial services
- Program integrity

Note: It is not further clarified in the legislation what is intended by the reference to "Program integrity" above. Under federal law, each state is required to designate a single state agency responsible for administering the Medicaid program. States can delegate certain functions associated with the administration of the program (for instance, eligibility determinations) but cannot delegate Medicaid Program Integrity functions.

The Agency and the Department will continue to maintain their own customer service functions, and standards for call center and contact processing for the Agency and the Department are included in the Program Accountability section of the legislation and this analysis.

Participant Rights & Responsibilities

Section 409.723 (3) and (4), Florida Statutes, outlines participant rights and responsibilities.

Participant rights include:

- Access to FHIX Marketplace or federal exchange`
- Continuity/Portability of coverage
- Retention of applicable unspent credits in the health savings or health reimbursement account
- Ability to choose more than one product on the FHIX marketplace or federal exchange
- Ability to choose from at least two health benefit products that meet the requirements of the Affordable Care Act

Participant Responsibilities include:

- Completion of initial application for health benefits coverage and the annual renewal process
- Provide evidence of participation in one of more of the following activities at the level required under paragraph (c) of the section, including
- On-the-job training or job placement activities that are validated through registration with CareerSource Florida, or pursuit of educational opportunities at the following hourly levels:
    - Parent/child younger than 18: 20 hours weekly
    - Childless Adult: 30 hours weekly
    - Disabled adult or caregiver of disabled child or adult: May submit a request for an exception (submitted annually). Requests for exceptions are to be submitted to the Department of Children and Family Services.
- Learning about choices and use of credits
- Executing a contract with DCF acknowledging:
    - FHIX is not an entitlement
    - Failure to pay premiums or cost sharing will result in participant being moved to inactive status
    - Noncompliance with the participation requirements in s. 409.723 will result in participant being moved to inactive status
- Selecting plans in a timely manner
- Complying with program rules
- Making premium and other payments timely
- Meeting minimum coverage requirements by selecting either a high-deductible health plan combined with a health savings or health reimbursement account or a combination of plans or products with an actuarial value that meets or exceeds benefits available under the federal exchange.

Products Available Through FHIX:

SB 2A, as amended, provides that FHIX enrollees shall have a choice of the products available on the FHIX exchange operated by Florida Health Choices Corporation. Products available include:

- Products outlined in s. 408.910, F.S.:
    - Entity under Chapter 624, F.S., which offers individual or group health insurance policy, Preferred provider organization,
    - Exclusive provider organization,
    - Health maintenance organization,
    - Prepaid limited health services organization; discount medical plan, or
- Products outlined in section 624.91, Florida Statutes (FHK plans)
- Premium credits for participation in Employer sponsored plans

Note: The newly eligible adult population will likely be required by federal CMS to select a plan that meets or exceeds the ACA requirements.

Premium Credits:

Under the FHIX program, the state will develop a premium credit amount for each program enrollee with which they can purchase a product on the FHIX exchange or federal exchange. The premium

credit is defined as the monthly amount paid by the Agency for Health Care Administration (Agency) per enrollee in the FHIX toward health benefit coverage.

The standard monthly premium credit is equivalent to the applicable risk-adjusted capitation rate paid to the MMA plans. As outlined in section 409.728 (1)(f), Florida Statutes, the Agency will determine annually the risk-adjusted rate to be paid per month based on historical utilization and spending data for the medical and behavioral health of this population, projected forward, and adjusted to reflect the eligibility category, medical and dental trends, geographic areas, and the clinical risk profile of the enrollees. SB 2A, as amended, also directs the Agency to transfer to the Corporation (Florida Health Choices) such funds as approved in the General Appropriations Act for the premium credits. The Agency's system will need to include records of all program enrollees.

Note: Although it is not explicitly described in the legislation, it is assumed that Florida Health Choices will have the responsibility of transferring premium payment to the FHIX plans, as funding for this will be transferred to the Corporation pursuant to section 409.728 (1)(f), Florida Statutes. Mechanisms will have to be established by the Corporation to facilitate the payment of premiums to the health plans.

During Phase 2, the Florida Healthy Kids group will transition to the FHIX exchange. Pursuant to section 409.727 (4), F.S., premium credits for this group will be determined based on the average capitation rate paid under FHK in their county as of June 30, 2016 (the month immediately preceding the beginning of Phase 2 enrollment). It is not clear whether the Agency will continue to transfer funding for the Florida Healthy Kids population to the Florida Healthy Kids Corporation, (as it does today) who will in turn transfer this funding to the Corporation (Florida Health Choices), or if it is intended for the Agency to transfer the funds for these premium credits directly to the Corporation.

According to section 409.727 (3), Florida Statutes, participants in the FHIX may select any benefit, service, or product available through the FHIX exchange. If the cost of the product is lower than the premium credit, any remaining premium credit will be transferred to the enrollee's health savings/reimbursement account. Specific to the Phase 3 transition of the Florida Healthy Kids population, SB 2A, as amended, provides, through section 409.727 (4) (d), Florida Statutes, that a participant transitioning from Florida Healthy Kids is responsible for any difference in costs and may use remaining funds for supplemental benefits on the FHIX marketplace. The Florida Health Choices Corporation is responsible, pursuant to sections 409.727 (3) and (4), Florida Statutes, for notifying enrollees of their premium credit amount and how to access the FHIX marketplace selection process or federal exchange.

Note: It should be noted that the structure of premium assistance program raises issues:

The FHIX products will have to conform to ACA requirements, which means that they cannot be medically underwritten (can vary somewhat by age, but cannot charge people different premiums based on their illness burden). However, members of the expansion group will have subsidies based on the Agency's risk adjustment process, which means healthier people will have lower subsidies than people with a higher illness burden. Purchase choices will be distorted by the amount of subsidy available, and there is no mechanism to make sure plan revenue is adjusted for the relative risk the plans enrollees. A spiral could very likely ensue, as plans try to raise their premiums to cover their costs. This would make FHIX products unaffordable for most of the target population, and could cause some enrollees to lose their coverage

There is also a risk of an adverse selection driven spiral when plans must use adjusted community rating (cannot medically underwrite), but there is no mechanism to risk adjust their revenue. Even if the spiral did not occur because the consumers were willing to supplement the subsidies out-of-pocket, the average differential between a healthy person's capitation rate and a high-deductible premium is unlikely to sufficiently fund a health savings account that can offset the out-of-pocket costs in a year where the healthy person has an adverse medical situation (or a pregnancy).

Further actuarial analysis would be required to understand implications for federal exchange enrollees, but given the FHIX law, as structure, it is difficult to see how the FHIX would lead to coverage for very many people in the target population. The spiral issues described above would mean that only sicker individuals would receive enough premium credits to buy insurance, and the strict work and cost sharing requirements would weed out a portion of even these persons. Healthy people currently with insurance on the federal exchange may even lose coverage, not gain it, due to the spiral effect.

Cost Sharing

SB 2A, as amended, outlines parameters for cost sharing for all program participants. Cost sharing includes the payment of monthly premiums/contributions, co-payments for services, as provided for by the specific product chosen on the FHIX exchange; and an additional co-payment for inappropriate use of emergency room services. The federal government will probably refuse to approve this part of the program. We are not aware of federal approval for mandatory premiums for people below the poverty line.

Monthly Premiums:

If a premium is not paid after a 30-day grace period, the participant is moved to "inactive" status for six months, unless a hardship exemption is requested and granted (409.723 (5), F.S.). Monthly premiums will be assessed as follows:

Monthly premium from $3 to $25 based on modified adjusted gross income (MAGI) (not sure if individual or family)

Percent of Federal Poverty Level	Monthly Premium Assessment
< 22 % FPL	$3
>22% - <50%FPL	$8
>50 - < 75%	$15
>75 - <100%	$20
>100%	$25

Note: Although it is not explicitly stated in Part II of Chapter 409, F.S., as created by SB 2A, as amended, it is assumed that Florida Healthy Kids will be responsible for the collection and tracking of the monthly premium. Florida Healthy Kids will need to develop a mechanism for notifying the Department of Children and Families, the Agency for Health Care Administration and Florida Health Choices when enrollees are moved to "inactive" status.

Co-Payments:

Program enrollees may incur additional cost sharing based on selection of products and services, including copayment, deductibles or other out-of-pocket expenses. In addition, enrollees may be subject to an inappropriate emergency room visit charge of up to $8 for the first visit and up to $25 for any subsequent visit, based on the enrollee's benefit plan.

Cumulative overall cost sharing may not exceed 5 percent of the enrollees annual MAGI. Overall cost sharing must be tracked against a 5 percent cap (s. 409.723 (5), Florida Statutes).

Note: A mechanism will have to be developed to track overall cost sharing for all enrollees in the FHIX program. The bill does not state which entity will have responsibility for this function. There is likely to be fiscal impact relating to this program element for whichever entity is determined responsible.

Health Savings/ Health Reimbursement Accounts:

SB 2A, as amended, requires that Florida Health Choices, as part of their responsibilities in the FHIX program, make available a health savings or health reimbursement account to all enrollees.

Section 409.724 (1) (c), Florida Statutes, establishes the provisions relating to health savings accounts/ health reimbursement accounts. Participants can use funds in these accounts to pay cost-sharing obligations or to purchase other health related items. Participants have the right to retention of applicable unspent credits in the health savings or health reimbursement account.

The following funds are deposited into the accounts:

- Unexpended funds from the monthly premium credit must be deposited into the accounts.
- Any funds awarded for healthy behaviors, adherence to wellness programs or other activities are deposited into these accounts.
- Enrollee contributions.
- Third party contributions.

Pursuant to section 409.723 (3), Florida Statutes, participants have the right to retain unspent credits in their health savings/reimbursement accounts following a change in their eligibility status, and, pursuant to section 409.722 (10), Florida Statutes, credits in the health saving/reimbursement accounts are valid for an inactive status participant for up to five years after the enrollee first enters inactive status.

Note: It is not explicitly stated in this legislation which entity will be responsible for maintaining the health savings/ reimbursement account, providing monthly or periodic statements regarding account balances, or dispensing funds from the account for use by the program enrollees. The Florida Healthy Kids Corporation is responsible, through section 624.91 (5) (a) 1, Florida Statutes, for the collection of voluntary contributions to provide for payments of Florida Kidcare program or Florida Health Insurance Affordability Exchange Program premiums.

Program Accountability:

SB 2A, as amended, includes provisions on program accountability, outlined in section 409.726, Florida Statutes, relating to encounter data maintenance and submission, access, provider network requirements, application processing and call and contact center standards.

Specifically:

- All plans must collect and maintain encounter data in accordance with s. 409.967 (2)(d), Florida Statutes, and are subject to penalties under s. 409.967 (2)(h)2, Florida Statutes. The Agency is responsible for the collection and maintenance of the encounter data.
    - Note: Currently, only Medicaid Health Plans submit encounter data to the Agency's Medicaid Management Information System (MMIS). Systems work will

be needed for both the Agency and any non-Medicaid health plans that wish to participate in the FHIX. Health Plans would have to be "enrolled" into the Medicaid provider Masterfile, and the Plans would have to register with EDI and test encounter transactions submission. In addition, Medicaid would have to have the recipients identified in the Florida MMIS to recognize the encounter as a valid transaction. This system work would make the FHIX timelines extremely difficult to meet, if not impossible.

- The Florida Health Choices Corporation, in consultation with the Agency, is required to establish standards for access and network standards, quality and provider participation.
- The Department of Children and Families is directed to develop accountability measures with regards to applications and renewal processes. Certain measures are explicitly outlined in statute:
  - Application processing speed: 90% within 45 days
  - Application processing speed/online sources: 95% within 45 days
  - Renewal application processing speed: 90% within 45 days
- Standards are outlined for the Agency, the Florida Healthy Kids Corporation and the Department with regards to call center and contact processing for the FHIX program:
  - 85% of all calls answered within 20 seconds
  - 100% of all consumer contacts "handled" within two days
  - Self-service tools operational 24/7 98% of each month
  - Conduct annual satisfaction survey regarding all measures that require participant input specific to FHIX program
  - Note: These standards are not applied to Florida Health Choices Corporation.
- The Agency and the Florida Health Choices Corporation are required to post online monthly enrollment reports for FHIX.

Plan Contracting:

In order to hold plans/insurers participating in the FHIX program to accountability measures such as encounter data maintenance and submission and to provider network requirements, quality measures and any other performance standards, the plans/insurers will need to be under an enforceable contract with one of the entities participating in the program.

NOTE: The legislation does not include any provisions relating to plan/insurer contracting.

As previously noted, it appears that Florida Health Choices is responsible for payment of premiums to plan/insurers under the FHIX program. As such, they will likely need to have a contract in place to make those payments. Florida Health Choices is also identified as the responsible party with regards to the establishment of provider network and quality standards.

FHIX Workgroup/ Long-Term Reorganization

SB 2A, as amended,, through section 409.729, Florida Statutes, creates an interagency workgroup. The stated purpose of the workgroup is to facilitate the implementation of the FHIX program and to plan for a multiyear reorganization of the state's insurance affordability programs (Florida Healthy Kids and FHIX). The Agency is responsible for providing administrative support to the FHIX Workgroup. The role of the workgroup is to make recommendations to the Agency for Health Care Administration.

Membership for the workgroup is outlined in the bill and consists of:

- 2 members from the Agency

- 2 members from the Department
- 2 members from Florida Healthy Kids
- 2 members from Florida Health Choices

A representative of the Agency for Health Care Administration will be designated to serve as the chair of the workgroup.

The workgroup must begin meeting 30 days after the effective date of the Act and must meet at least bimonthly afterwards.

Workgroup responsibilities include:

- Submit a final transition plan incorporating all phases by November 1, 2015, for submission to the Governor, Senate President and House Speaker.
- Review network and access standards for plans and products.
  - Note: Responsibilities with regards to network adequacy standards and review are not clear in the legislation. In section 409.726, Florida Statutes, it is established that the Florida Health Choices Corporation is responsible, in consultation with the Agency, for establishing these standards and for ensuring that the contract plans have sufficient providers to meet enrollee needs. In section 409.727, Florida Statutes, it is established that the Agency is responsible for conducting a readiness review, in consultation with the FHIX workgroup, that will include provider network capacity and adequacy of the available plans in each region, prior to implementation of Phase 1.
- Recommend actions needed to reorganize the state's insurance affordability programs (Florida Healthy Kids and FHIX)
- Recommend changes to Title XIX and XXI based on continued availability of the Title XXI (Children's Health Insurance Program) program and its federal funding.
- Identify duplication of services among the Agency, Florida Healthy Kids and Florida Health Choices Corporation under FHIX's Phase 2 program.
- Evaluate fiscal impact based on proposed implementation plan for Phase 2.
- For each phase or region, identify and report non-readiness to legislature.
- Compile a schedule of impacted contracts, leases, and other assets.
- Determine staff requirements for Phase 2.

Program Responsibilities:

SB 2A, as amended, outlines general program responsibilities for the Agency for Health Care Administration, the Department of Children and Families, the Florida Healthy Kids Corporation and the Florida Health Choices, Inc., in Section 409.728, Florida Statutes. Additional responsibilities for these four entities are found throughout the legislation.

Entity	Responsibility
The Agency for Health Care Administration	• Contracting with FHC (the Corporation) for development, implementation and administration of the FHIX program and for release of federal, state and other funds appropriated to the Corporation. • • Providing administrative support to the FHIX Workgroup created by SB 2A, as amended, • Transitioning Phase 1 enrollees to FHIX beginning January 1, 2016 or upon federal approval • Transmitting enrollee information to the Corporation • Beginning in Phase 2 (January 1, 2016 or upon federal approval), • Determining the "rate" or premium credit amount • Transferring funds to the Corporation for the premium credits • Consulting with stakeholders that serve low income individuals and families during the implementation, using a public input process • Adopt rules in coordination with the corporation and Florida Healthy Kids in order to implement FHIX, including modifying existing rules implementing the CHIP and adapting adult focused provisions for children

Entity	Responsibility
	to accommodate the seamless transition of Healthy Kids enrollees to FHIX. • Develop the Choice Counseling component of the FHIX program. • **Additional responsibilities are listed throughout the legislation, and include:** o 409.727 (1) Conducting a readiness review before implementation of any of the phases, including functional readiness of the service delivery platform for the phase; plan availability and present of plan choice; provider network capacity and adequacy; availability of customer support; other factors critical to the success of FHIX. o 409.724 (3) Agency, FHK and the Corporation must coordinate an Education campaign o 409.728 (1) (f) The Agency shall determine annually the risk-adjusted rate to be paid per month based on historical utilization and spending data for the medical and behavioral health of this population, projected forward, and adjusted to reflect the eligibility category, medical and dental trends, geographic areas, and the clinical risk profile of the enrollees and transfer to the corporation such funds as approved in the General Appropriations Act for the premium credits. o 409.726 (1) The Agency is responsible for the collection and maintenance of the encounter level data o 409.726 (2) The Corporation, in consultation with the Agency, is to establish and enforce access and network provider standards for plans under FHIX and also to establish quality and provider participation requirements o 409.726 (3) Standards outlined for AHCA, FHK and DCF for call center and contact processing for the FHIX program: • 85% of all calls answered within 20 seconds • 100% of all consumer contacts "handled" within two days • Self-service tools operational 24/7 98% of each month • Conduct annual satisfaction survey regarding all measures that require participant input specific to FHIX program o 409.726 (4) AHCA and Corporation (FHC) post online monthly enrollment reports for FHIX o 409.726 (7) The Agency and Corporation (FHC) are jointly responsible for submission of the Annual report due each July 1. o 409.729: Administrative Support and Chair of the FHIX Workgroup o 409.730 The Agency may seek federal approval to implement FHIX.

The Florida Healthy Kids Corporation:	• Retain current duties under 624.91 through Phase 1 • In coordination with the Agency and the Corporation (FHC) providing customer service for the FHIX marketplace • Transferring funds and financial support to the FHIX marketplace, including collection of monthly cost sharing • Conducting financial reporting related to the above • General program coordination with the Agency and the Corporation • **Additional responsibilities are listed throughout the legislation, and include:** o 409.724 (3) Agency, FHK and the Corporation must coordinate an Education campaign o 409.724 (4) Florida Healthy Kids Corporation is responsible for providing customer support for FHIX. 624.91 (5) (a) 16 & 17 Specifically, states that the FHK is responsible for contracting with other "insurance affordability programs" and FHIX to provide customer services or other enrollment focused services and to annually develop performance measures for the following areas: ▪ Administrative functions ▪ Contracting with vendors ▪ Customer service ▪ Enrollee education ▪ Financial services ▪ Program integrity o 409. 726 (4) Standards outlined for AHCA, FHK and DCF for call center and contact processing: ▪ 85% of all calls answered within 20 seconds ▪ 100% of all consumer contacts "handled" within two days ▪ Self-service tools operational 24/7 98% of each month ▪ Conduct annual satisfaction survey regarding all measures that require participant input specific to FHIX program o 409.727 (4) FHK and the Corporation (FHC) work together on the transition of children from FHK plans to FHIX Plans. o 409.728 (3) The Florida Healthy Kids Corporation is responsible for: ▪ Retain current duties under 624.91 through Phases 1 ▪ In coordination with the Agency and the Corporation (FHC) providing customer service for the FHIX marketplace ▪ Transferring funds and financial support to the FHIX marketplace, including collection of monthly cost sharing (▪ Conducting financial reporting related to the above ▪ General program coordination with the Agency and the Corporation o 624.91 (5) Effective 7/1/2016, health and dental services contracts of FHK must transition to the FHIX marketplace, qualifying plans may enroll as vendors with the FHIX marketplace to maintain continuity of care for participants. o 624.91 (5) (a) 1. FHK may be responsible for collecting the voluntary extra contributions

Florida Health Choices, Inc. (the Corporation)	• Develop and Maintain the FHIX marketplace • Implement and administer Phase 1 and Phase 2 and ongoing program operations • Offering health benefits package on the FHIX, including those compliant with the ACA • Offering FHIX enrollees a choice of at least two plans per region which meet ACA requirements • Offer enhanced or customized benefits to FHIX marketplace enrollees • Provide sufficient staff and resources to meet program needs or enrollees • Provide opportunity for former FHK plans to participate if qualified • Encourage insurance agents licensed under chapter 626 to identify and assist enrollees. **NOTE: Additional language included in SB 2A: "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." This may be problematic with regards to CMS approval.** • **Additional responsibilities are listed throughout the legislation, and include:** o 408.910 (7) (b) : Participation in the FHIX marketplace may begin at any time during the year. Initial enrollment periods for certain products selected by an individual which are noncompliant with the ACA may be required to last at least 12 months o 409.724 (1) (c) The Corporation (Florida Health Choices) must offer access to an individual account that qualified as a health reimbursement or health savings account (o 409.724 (2) Provide consultation to the Agency in their development of the choice counseling program for FHIX o 409.724 (3) Agency, FHK and the Corporation must coordinate an Education campaign o 409.724 (5) Corporation responsible for informing inactive participants about other "insurance affordability programs" and refer to federal exchange or other programs, as appropriate. o 409.726 (2) The Corporation, in consultation with the Agency, is to establish and enforce access and network provider standards for plans under FHIX and also to establish quality and provider participation requirements. o 409.726 (7) The Agency and Corporation (FHC) are jointly responsible for submission of the Annual report due each July 1 o 409.727 (3) & (4) Corporation must notify enrollees of their premium credit amount and how to access the FHIX marketplace selection process o 409.727 (3) Corporation must notify enrollees of their premium credit amount and how to access the FHIX marketplace selection process o 409.727 (4) FHK and the Corporation (FHC) work together on the transition of children from FHK plans to FHIX Plans Phase 2: Corporation must notify enrollees of their premium credit amount and how to access the FHIX marketplace selection process o 409.728 (4) Florida Health Choices is responsible for: ▪ Develop and maintenance of FHIX during Phase 1 and 2 and ongoing operation ▪ Offering health benefits package on the FHIX, including those compliant with the ACA ▪ Offering FHIX enrollees a choice of at least two plans per region which meet ACA requirements ▪ Offer enhanced or customized benefits to FHIX marketplace enrollees ▪ Provide sufficient staff and resources to meet program needs or enrollees ▪ Provider opportunity for former FHK plans to participate if qualified ▪ Encourage insurance agents licensed under chapter 626 to identify and assist enrollees. o Annual report due each July 1.

Department of Children and Families	• In coordination with the other entities, determining program eligibility and transmitting eligibility determination to the Agency and the Corporation (FHC) • **Additional responsibilities are listed throughout the legislation, and include:** o 409.723 (2) Responsible for processing applications for enrollment in FHIX: Responsible for: ▪ Eligibility correspondence and status updates to participant and other agencies ▪ Reviewing participating eligibility every 12 months o 409.723 (5) Enrollees may seek hardship exemption under the Fair Hearing Process (DCF) o 409.726 (4) DCF to develop measures regarding processing of applications and renewals (although bill specifically outlines measures for processing speed-- 45 days regardless of source) o Standards outlined for AHCA, FHK and DCF for call center and contact processing: ▪ 85% of all calls answered within 20 seconds ▪ 100% of all consumer contacts "handled" within two days ▪ Self-service tools operational 24/7 98% of each month ▪ Conduct annual satisfaction survey regarding all measures that require participant input specific to FHIX program

Program Expiration

SB 2A, as amended, provides for the expiration of the FHIX program under certain circumstances. Specifically, section 409.731, Florida Statutes, states that the FHIX program shall expire if:

- At the end of the state fiscal year in which any of the following occurs:
- FMAP falls below 90%
  - Note: It is not clear whether this refers to the FMAP for both the Title XIX program, which includes the newly eligible adult group, and the Title XXI program, which includes the Florida Healthy Kids group. If this includes both, the FHIX program would be dependent on both the continuing existence of enhanced Medicaid FMAP as currently outlined in the ACA and the enhanced CHIP funding which is currently outlined in the ACA for 2016-2019.
- FMAP falls below increased FMAP for newly eligible adult group in ACA.
- FMAP for FHIX and Title XIX are blended in some way under federal law that results in less FMAP than if unblended.

Medically Needy Program:

SB 2A, as amended, limits the Medically Needy program, to children and pregnant women only, effective July 1, 2016 concurrent with the implementation of Phase 2 of the FHIX program, and sunsets authority for the Medically Needy program as a whole effective October 1, 2019.

All components of SB 2A, as amended, are effective upon becoming law. The Agency will be required by federal CMS to notify impacted recipients of this change 30 days in advance of the change. In addition, the Medicaid state plan will need to be amended to amend the Medically Needy program component.

3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?

If yes, explain:	No Florida Administrative Code rules will be developed or eliminated.
What is the expected impact to the agency's core mission?	N/A
Rule(s) impacted (provide	N/A

references to F.A.C., etc.):	

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

List any known proponents and opponents:	N/A
Provide a summary of the proponents' and opponents' positions:	N/A

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?

If yes, provide a description:	Yes. 409.726 (7) The Agency and Corporation (FHC) are jointly responsible for submission of the Annual report due each July 1. In addition, the FHIX workgroup must submit a final transition plan incorporating all phases by November 1, 2015, to the Governor, Senate President and House Speaker.
Date Due:	July 1- annually. November 1, 2015 for transition reports.
Bill Section Number:	Sections 8 and 11

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQURIED BY THIS BILL?

Board:	Yes. Changes are made to the Florida Healthy Kids Corporation Board. 624.91 (6) The FHK Board is revised to have a chair and 23 members designated by the Governor and confirmed by the Florida Senate. Board members are appointed for 3 year terms and serve at the pleasure of the Governor. Current board members may remain until January 1, 2016.
Board Purpose:	The FHK Board is responsible for determining the amount for the collection of any family, local contributions, or employer payment or premium; reviewing grievances from providers of local match to, applicants to and participants in the program; and determining the number of staff members necessary to administer the corporation, has complete fiscal control over the corporation and is responsible for all corporate operations.
Who Appointments:	See comments above and below
Appointee Term:	3-year term
Changes:	The FHK Board is revised to have a chair and 23 members designated by the Governor and confirmed by the Florida Senate. Board members are appointed for 3 year terms and serve at the pleasure of the Governor. Current board members may remain until January 1, 2016.
Bill Section Number(s):	Section 17

FISCAL ANALYSIS

1. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?

The fiscal impact for this new program was estimated by updating existing analyses that have been prepared for the Social Services Estimating Conference (SSEC) in March 2013. Costs of the program are estimated using consensed-upon assumptions of a Medicaid expansion, adjusted for the impact of the Federal Health Insurer Tax. The population base is provided by the 2011-2013 three-year American Community Survey (Public Use Microdata Sample). Population projections for 2016 through 2018 are from the Florida Demographic Estimating Conference held February 2015 and the growth rates are used to increase the newly eligible population from the base to FY 2015-16. It is assumed that 85.8% of the newly eligible population will present for services, which is based on historical Medicaid program experience. A phase in of 50 percent for FY 2015-16, 65 percent for FY 2016-17 and 85 percent for FY 2017-18 is assumed. A total of 960,051 newly eligible individuals are assumed eligible with 411,862 presenting for services in FY 2015-16. The majority of these individuals are childless adults, 697,780, with 299,348 presenting for services in FY 2015-16. Note: these numbers represent the approximate number of people in this category who would be eligible for this program as outlined in the Legislation.

This analysis assumes that there will also be a "crowd out" population that will present for services and enroll in Medicaid with this bill. These are individuals who are currently purchasing insurance directly from an insurance company. A phase in of 40 percent for FY 2015-16, 80 percent for FY 2016-17 and 100 percent for FY 2017-18 is assumed. A total of 140,818 "crowd out" individuals are assumed, with 56,327 presenting for services in FY 2015-16. It is possible that an indeterminate amount of additional Floridians, currently receiving health benefits through the federal exchange, could "crowd-out" and increase this population.

The expenditures are based on the March 4, 2015 Social Services Estimating Conference for FY 2015-16 and then increased by 2.3 percent annually (based on the Chained Price Index for Medical Services). The adult Temporary Assistance for Needy Families (TANF) per member per month (PMPM) was used for the populations with the childless adult population PMPM 60 percent higher due to the assumption that this group of individuals would present for services with significant medical conditions and pent-up demand for services. Also, Health Insurance Provider Fee (HIPF) is included in the estimate at a fee load of 2.5 percent per year. The HIPF is the fee imposed under the ACA on most managed care plans engaged in business to provide health coverage.

Total coverage expenditures are estimated to be $2,972,156,979 in FY 2015-16 with $2,608,799,040 being associated with the newly eligible population and $363,357,939 being associated with the "crowd out" population. 100 percent of the expenditures will be covered by the Medical Care Trust Fund (MCTF). In FY 2016-17, total expenditures are estimated to be $4,263,293,986 with $3,519,863,642 associated with the newly eligible and $743,430,344 associated with "crowd out". 97.5 percent or $4,156,711,636 will be covered by the MCTF and $106,582,350 by General Revenue as effective January 1, 2017 the State will be responsible for 5 percent of the total expenditures. In FY 2017-18, total expenditures are estimated at $5,732,354,031 with 94.5 percent or $5,417,074,559 being covered by MCTF and $315,279,472 being covered by General Revenue. There will be an offset to these costs due to the monthly premium assessment collection but has not been estimated in this analysis.

Along with the coverage costs of the newly eligible population, this bill would generate additional resource needs. The Agency would need additional actuarial services for the calculation and maintenance of risk adjusted rates/premium assistance amounts in the amount of $500,000 per year which $250,000 will be MCTF and $250,000 general revenue. These services will be added on to the Agency's current actuarial services contract.

Additional Choice Counselling/Enrollment Broker services will be needed to support this new program and the increased Medicaid population. For FY 2015-16 an additional $6,200,000 is needed, of which $3,100,000 is from the MCTF and $3,100,000 from General Revenue. This cost will be added to the Agency's existing contract for enrollment broker services. There will be a need for additional funds in both FY 2016-17 and FY 2017-18, but those costs are still being developed.

Also, the Agency's Florida Medicaid Management Information System (FMMIS) will need to be enhanced due to the increase in population. At this time, until further business requirements and details are defined and estimated it is difficult to estimate a cost structure. Other states that have been through this process have paid between $2 and $5 million for this type of update. Using the Per Member Per Month cost structure of $1.25/pmpm and estimating an estimated additional newly eligible recipients added for the adult and children population, the estimated cost would be $600,000 for FY 2015-16 with $300,000 from the MCTF and $300,000 from General Revenue. It is estimated that $850,000 will be needed in FY 2016-17 and $1.2 million in FY 2017-18 to implement FMMIS enhancements. It is possible that the federal government may allow a 90/10 match rate on this since it is associated with the ACA but that is uncertain at this time.

Revenues:	N/A
Expenditures:	The total estimated fiscal impact in FY 2015-16 will be $2,351,628,054 with the total impact being $4,264,643,986 in FY 2016-17 and $5,734,054,031 in FY 2017-18.
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

TECHNOLOGY IMPACT

Does the legislation impact the agency's technology systems (i.e., IT support, licensing software, data storage, etc.)?	N/A
If yes, describe the anticipated impact to the agency including any fiscal impact.	N/A

FEDERAL IMPACT

Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)?	The federal (MCTF) estimated fiscal impact in FY 2015-16 will be $2,668,587,645 with the federal impact being $4,157,386,636 in FY 2016-17 and $5,417,924,559 in FY 2017-18.
If yes, describe the anticipated impact including any fiscal impact.	See the comment above

ADDITIONAL COMMENTS

FISCAL IMPACT:	Year 1 (FY 2015-16)	Year 2 (FY 2016-17)	Year 3 (FY 2017-18)

1. **Non-Recurring Impact:**

Total Non-Recurring Expenditures	**$ -**

2. **Recurring Impact:**

Revenues:			
Special Categories/Contracted Services			
G/A – Florida Health Choices Corporation	$2,972,156,979	$4,263,293,986	$5,732,354,031
Medically Needy - Multiple Medicaid Service Categories	(627,828,925)	-	-
100777 Contracted Services	7,300,000	1,350,000	1,700,000
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
Total Special Categories/Contracted Services	**$2,351,628,054**	**$4,264,643,986**	**$5,734,054,031**
Total Recurring Expenditures	**$2,351,628,054**	**$4,264,643,986**	**$5,734,054,031**

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3. **Total Revenues and Expenditures:**

Sub-Total Recurring Revenues	$0	$0	$0
Total Revenues	**$0**	**$0**	**$0**
Sub-Total Non-Recurring Expenditures	$0	$0	$0
Sub-Total Recurring Expenditures for Coverage	$2,972,156,979	$4,263,293,986	$5,732,354,031
Total Expenditures	**$2,972,156,979**	**$4,263,293,986**	**$5,732,354,031**
Sub-Total Non-Recurring Expenditures	$0	$0	$0
Sub-Total Recurring Expenditures for Medically Needy	**($627,828,925)**	**$0**	**$0**
Total Expenditures			
Sub-Total Non-Recurring Expenditures	$0	$0	$0
Sub-Total Recurring Expenditures for Contracted Services	**$7,300,000**	**$1,350,000**	**$1,700,000**
Total Expenditures			
Net Impact (Total Revenues minus Total Expenditures)	**($2,351,628,054)**	**($4,264,643,986)**	**($5,734,054,031)**

4. **Net Impact (By Fund)**

General Revenue Fund (1000)	$0	$106,582,350	$315,279,472
Medical Care Trust Fund (2474)	$2,972,156,979	$4,156,711,636	$5,417,074,559
General Revenue Fund (1000)	($221,292,065)		
Medical Care Trust Fund (2474)	($307,219,334)		
Grants and Donations Trust Fund (2339)	($99,317,526)		
General Revenue Fund (1000)			

	$3,650,000	$675,000	$850,000
Medical Care Trust Fund (2474)	$3,650,000	$675,000	$850,000
Net Impact (By Fund)	**$2,351,628,054**	**$4,264,643,986**	**$5,734,054,031**

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	• Pursuant to 42 C.F.R. 431.10, each state must specify a single State agency to administer and supervise the state's Medicaid services. "The authority of the Agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State." 42 C.F.R. 431.10. Pursuant to section 409.902, Florida Statutes, the Agency for Health Care Administration is designated as the single state agency responsible for administering Medicaid in Florida. Also, SB 2A, as amended, provides for program integrity functions to an entity other than the Agency. If this delegation seeks to cover functions covered by Medicaid Program Integrity, then there is a possible conflict with the requirements of 42 C.F.R. 431.10.