By Senator Torres

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1 A bill to be entitled
2 An act relating to health care coverage; providing a
3 directive to the Division of Law Revision to create
4 part V of chapter 408, F.S., entitled the "Healthy
5 Florida Act"; creating s. 408.95, F.S.; providing a
6 short title; creating s. 408.951, F.S.; providing
7 legislative findings and intent; creating s. 408.952,
8 F.S.; defining terms; creating s. 408.953, F.S.;
9 creating the Healthy Florida program, to be
10 administered by the Healthy Florida Board; creating
11 the Healthy Florida Board; declaring that the board is
12 an independent public entity not affiliated with an
13 agency or a department; specifying the composition and
14 governance of the board; specifying appointment
15 procedures and requirements; specifying terms of board
16 members; providing duties, qualifications, and
17 prohibited acts of board members; specifying that
18 board members may not receive compensation for service
19 but may be reimbursed for certain per diem and travel
20 expenses; defining the term "health care provider";
21 providing immunity from liability for certain acts
22 performed or obligations entered into by the board or
23 by board members, officers, or employees; requiring
24 the board to hire an executive director who is exempt
25 from civil service and who serves at the pleasure of
26 the board; providing that the board's meetings are
27 subject to public meetings requirements; authorizing
28 the board to adopt rules; creating s. 408.954, F.S.;
29 requiring the State Surgeon General of the Department

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30 of Health to establish a public advisory committee to
31 advise the board on policy matters; specifying the
32 composition of the committee and the authority
33 appointing each member; providing requirements for the
34 Governor, President of the Senate, and Speaker of the
35 House of Representatives in making appointments;
36 specifying terms of appointments and reappointments;
37 providing requirements for filling vacancies;
38 specifying that committee members serve without
39 compensation, except for reimbursement for per diem
40 and travel expenses and a specified amount under
41 certain circumstances; defining the term "full day of
42 attending a meeting"; providing requirements for the
43 minimum frequency and location of committee meetings;
44 requiring such meetings to be open to the public;
45 requiring the committee to elect a chair; specifying
46 terms the chair may serve; providing qualifications
47 and prohibited acts of committee members; creating s.
48 408.955, F.S.; specifying powers and duties of the
49 board in establishing and implementing comprehensive
50 universal single-payer health care coverage and a
51 health care cost control system for the benefit of
52 state residents; prohibiting carriers from offering
53 benefits or covering services for which coverage is
54 offered to individuals under the Healthy Florida
55 program; specifying benefits that may be offered by
56 carriers; requiring, after a certain timeframe,
57 certain board members to be program members; requiring
58 the board to develop certain proposals within a

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59 specified timeframe; authorizing the board to contract
60 with nonprofit organizations to provide certain
61 assistance to consumers and health care providers;
62 requiring the board to provide grants from certain
63 sources to the Agency for Health Care Administration
64 and the Department of Economic Opportunity for certain
65 purposes; requiring the board to provide for the
66 collection and availability of specified health care
67 data; requiring the board to make such data publicly
68 available in a specified manner; requiring the board
69 to conduct programs to promote and protect public,
70 environmental, and occupational health, using certain
71 data; requiring the board to provide for the
72 collection and availability of certain data within a
73 certain timeframe; creating s. 408.956, F.S.;
74 prohibiting law enforcement agencies from using
75 Healthy Florida moneys, facilities, property,
76 equipment, or personnel for certain purposes; creating
77 s. 408.957, F.S.; providing that every resident of
78 this state is eligible and entitled to enroll under
79 the Healthy Florida program; specifying that members
80 may not be required to pay any charge for enrollment
81 or membership; specifying that members may not be
82 required to pay any form of cost sharing for all
83 covered benefits; authorizing institutions of higher
84 education to purchase coverage under the program for
85 nonresident students and their dependents; creating s.
86 408.958, F.S.; specifying covered health care benefits
87 for members; creating s. 408.96, F.S.; providing

88 health care provider qualifications for participation
89 in the program; requiring the board to establish and
90 maintain certain procedures and standards for out-of-
91 state health care providers providing services under
92 certain circumstances; providing that members may
93 choose to receive health care services from any
94 participating provider, subject to certain conditions;
95 providing requirements for retaining membership under,
96 and procedures for withdrawing from, certain
97 enrollments; creating s. 408.961, F.S.; providing
98 requirements for care coordination provided by care
99 coordinators; specifying qualifications for care
100 coordinators; authorizing a health care provider to be
101 reimbursed for a health care service only if the
102 member is enrolled with a care coordinator at the time
103 the service is provided; requiring the program to
104 assist certain members in choosing a care coordinator;
105 requiring that a member remain enrolled with a care
106 coordinator until the member enrolls with a different
107 care coordinator or ceases to be a member; specifying
108 a member’s right to change care coordinators;
109 authorizing health care organizations to establish
110 certain rules relating to care coordination; providing
111 construction; requiring the board to develop by rule
112 and implement certain procedures and standards;
113 specifying requirements for a care coordinator to
114 maintain approval under the program; creating s.
115 408.962, F.S.; requiring the board to adopt rules
116 relating to contracting and payment methodologies for

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117 covered health care services and care coordination;
118 providing a requirement for payment rates; requiring
119 certain health care services to be paid for on a fee-
120 for-service basis unless and until the board
121 establishes another payment methodology; authorizing a
122 certain payment methodology for certain entities;
123 requiring that the program engage in good faith
124 negotiations with health care providers'
125 representatives; requiring that negotiations for drugs
126 be through a single entity on behalf of the entire
127 program; providing construction; prohibiting
128 participating providers from charging certain rates or
129 soliciting or accepting certain payments; providing an
130 exception; authorizing the board to adopt rules for
131 payment methodologies for the payment of certain
132 capital-related expenses of certain health facilities;
133 defining the term "health facility"; providing a prior
134 approval requirement for the payment of such expenses;
135 requiring that payment methodologies and payment rates
136 include a reimbursement component for direct and
137 indirect graduate medical education expenses;
138 requiring the board to adopt rules for payment
139 methodologies and procedures for services provided to
140 members while out of this state; creating s. 408.963,
141 F.S.; authorizing members to enroll with and receive
142 certain services from a health care organization;
143 specifying qualifications for a health care
144 organization; requiring the board to develop and
145 implement by rule certain procedures and standards for

146 health care organizations; requiring the board, in
147 developing and implementing such standards, to consult
148 with the Substance Abuse and Mental Health Program
149 Office within the Department of Children and Families;
150 providing requirements for health care organizations
151 to maintain approval under the program; authorizing
152 the board to adopt certain rules relating to
153 compliance; providing construction; prohibiting health
154 care organizations from using health information
155 technology or clinical practice guidelines for certain
156 purposes; providing that physicians and registered
157 nurses may override such technology and guidelines
158 under certain circumstances; creating s. 408.964,
159 F.S.; requiring the board to adopt rules establishing
160 program requirements and standards for the program,
161 health care organizations, care coordinators, and
162 health care providers; specifying the objectives of
163 such requirements and standards; requiring the board
164 to adopt rules establishing requirements and standards
165 for replacing and merging services provided by certain
166 other programs; providing requirements for for-profit
167 participating providers and care coordinators;
168 requiring participating providers to furnish certain
169 information for certain purposes; requiring the board
170 to consult with certain entities in developing
171 requirements and standards and making certain policy
172 determinations; creating s. 408.97, F.S.; requiring
173 the board to seek necessary federal waivers,
174 approvals, and arrangements and submit necessary state

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175 plan amendments to operate the program; specifying
176 requirements for the board in applying for such
177 waivers and in making such arrangements; requiring the
178 board to negotiate certain arrangements with the
179 Federal Government; authorizing the board to require
180 members or applicants to provide information for a
181 certain purpose; prohibiting other uses of such
182 information; authorizing the board to take additional
183 actions necessary to effectively implement the
184 program; providing requirements and authorizing
185 certain acts with respect to the program's
186 administration of federally matched public health
187 programs and Medicare; requiring the board to take
188 certain actions, upon a finding approved by the Chief
189 Financial Officer and the board, to reduce or
190 eliminate certain individual obligations or increase
191 an individual's eligibility for certain financial
192 support; providing applicability; authorizing the
193 board to require members or applicants to provide
194 certain information for certain purposes; requiring
195 members eligible for Medicare benefits to enroll in
196 Medicare to maintain eligibility in the program;
197 requiring the program to provide premium assistance to
198 members enrolling in a certain Medicare drug coverage
199 plan; requiring a member to provide the program, and
200 authorize the program to obtain, certain information
201 relating to a subsidy under the Social Security Act
202 for a certain purpose; requiring the board to attempt
203 to obtain such information from records available to

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204 it; requiring the program to make a reasonable effort
205 to notify members of certain obligations; providing
206 procedures for notifying members and for the
207 termination of coverage; prohibiting certain uses of
208 member information by the board; providing that the
209 board assumes responsibility for certain benefits and
210 services; creating s. 408.972, F.S.; providing
211 legislative intent regarding a revenue plan for the
212 program; creating s. 408.98, F.S.; defining terms;
213 specifying requirements for collective negotiation
214 rights between health care providers and the program;
215 requiring representatives of negotiating parties to
216 pay a fee to the board; requiring the board to set
217 certain fees by rule; prohibiting certain collective
218 actions; providing construction; creating s. 408.99,
219 F.S.; providing that the act does not become operative
220 until the State Surgeon General of the Department of
221 Health provides a specified notice to the Legislature;
222 requiring the Department of Health to publish the
223 notice on its website; creating s. 408.991, F.S.;
224 providing for severability; providing an effective
225 date.
226
227 Be It Enacted by the Legislature of the State of Florida:
228
229 Section 1. The Division of Law Revision is directed to
230 create part V of chapter 408, Florida Statutes, consisting of
231 ss. 408.95-408.991, Florida Statutes, to be entitled the
232 "Healthy Florida Act."

233 Section 2. Section 408.95, Florida Statutes, is created to
234 read:
235 408.95 Short title.—This part may be cited as the "Healthy
236 Florida Act."
237 Section 3. Section 408.951, Florida Statutes, is created to
238 read:
239 408.951 Legislative findings and intent.—
240 (1) The Legislature finds and declares all of the
241 following:
242 (a) All residents of this state have the right to health
243 care. While the federal Patient Protection and Affordable Care
244 Act (PPACA) brought many improvements in health care and health
245 care coverage, it still leaves many residents without coverage
246 or with inadequate coverage.
247 (b) Residents of this state, as individuals, employers, and
248 taxpayers, have experienced increases in the cost of health care
249 and health care coverage in recent years, including rising
250 premiums, deductibles, and copays, as well as restricted
251 provider networks and high out-of-network charges.
252 (c) Businesses have also experienced increases in the costs
253 of health care benefits for their employees and many employers
254 are shifting a larger share of the coverage costs to their
255 employees or dropping coverage entirely.
256 (d) Individuals often find that they are deprived of
257 affordable care and choice because of decisions by health
258 benefit plans guided by the plans' economic needs rather than by
259 consumers' health care needs.
260 (e) To address the fiscal crisis facing the health care
261 system and the state, and to ensure that residents of this state

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262 can exercise their right to health care, comprehensive health
263 care coverage needs to be provided.
264 (f) It is the intent of the Legislature to establish a
265 comprehensive universal single-payer health care coverage
266 program and a health care cost control system for the benefit of
267 all residents of this state.
268 (2)(a) It is further the intent of the Legislature to
269 establish the Healthy Florida (HF) program to provide universal
270 health coverage for every resident of this state, based on his
271 or her ability to pay, and for the program to be funded by
272 broad-based revenue.
273 (b) It is the intent of the Legislature for the state to
274 work to obtain waivers and other approvals relating to Medicaid,
275 the Children's Health Insurance Program, Medicare, the PPACA,
276 and any other federal programs so that any federal funds and
277 other subsidies that would otherwise be paid to the state,
278 residents of this state, and health care providers would be paid
279 by the Federal Government to this state and deposited in the
280 Healthy Florida Trust Fund.
281 (c) Under such waivers and approvals, such funds would be
282 used for health coverage that provides health benefits equal to
283 or exceeding those federal programs, as well as other program
284 modifications, including elimination of cost-sharing and
285 insurance premiums.
286 (d) The Legislature intends for the programs in paragraph
287 (b) to be replaced and merged into the HF program, which will
288 operate as a true single-payer program.
289 (e) If any necessary waivers or approvals are not obtained,
290 it is the intent of the Legislature that the state use Medicaid

291 state plan amendments and seek waivers and approvals to
292 maximize, and make as seamless as possible, the use of federally
293 matched public health programs and federal health programs in
294 the HF program.
295 (f) Thus, even if other programs such as Medicaid or
296 Medicare may contribute to paying for care, it is the goal of
297 this act that the coverage be delivered by the HF program and,
298 as much as possible, that the multiple sources of funding be
299 pooled with other HF program funds and not be apparent to HF
300 program members or participating providers.
301 (3) This act does not create any employment benefit, nor
302 does it require, prohibit, or limit the provision of any
303 employment benefit.
304 (4)(a) It is the intent of the Legislature not to change or
305 impact in any way the role or authority of any licensing board
306 or state agency that regulates the standards for or provision of
307 health care and the standards for health care providers as
308 established under current law, including, but not limited to,
309 chapters 381 through 408; chapters 410, 411, 413, and 429;
310 chapters 455 through 467; parts I through IV, X, and XIV of
311 chapter 468; chapters 486, 490, and 491; and the Florida
312 Insurance Code, as applicable.
313 (b) This act does not authorize the Healthy Florida Board,
314 the HF program, or the State Surgeon General of the Department
315 of Health to establish or revise licensure standards for health
316 care providers.
317 (5) It is the intent of the Legislature that neither health
318 information technology nor clinical practice guidelines limit
319 the effective exercise of the professional judgment of

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320 physicians and registered nurses. Physicians and registered
321 nurses are free to override health information technology and
322 clinical practice guidelines, if in their professional judgment,
323 it is in the best interest of the patient and consistent with
324 the patient's wishes.
325 (6)(a) It is the intent of the Legislature to provide an
326 exemption from public records requirements for the personal
327 identifying information of HF program members as set forth in s.
328 408.985.
329 (b) This act would also prohibit law enforcement agencies
330 from using the HF program's funds, facilities, property,
331 equipment, or personnel to investigate, enforce, or assist in
332 the investigation or enforcement of any criminal, civil, or
333 administrative violation or warrant for a violation of any law
334 that individuals register with the Federal Government or any
335 federal agency based on religion, national origin, ethnicity, or
336 immigration status.
337 (7) It is the further intent of the Legislature to address
338 the high cost of prescription drugs and ensure they are
339 affordable for patients.
340 Section 4. Section 408.952, Florida Statutes, is created to
341 read:
342 408.952 Definitions.—As used in this part, the term:
343 (1) "Affordable Care Act" or "PPACA" means the federal
344 Patient Protection and Affordable Care Act, Pub. L. No. 111-148,
345 as amended by the federal Health Care and Education
346 Reconciliation Act of 2010, Pub. L. No. 111-152, and any
347 amendments to, or regulations or guidance issued under, those
348 acts.

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349 (2) “Allied health practitioner” means a group of health
350 professionals who apply their expertise in all specialties to
351 prevent disease transmission and to diagnose, treat, and
352 rehabilitate people of all ages. Together with a range of
353 technical and support staff, they may deliver direct patient
354 care, rehabilitation, treatment, diagnostics, and health
355 improvement interventions to restore and maintain optimal
356 physical, sensory, psychological, cognitive, and social
357 functions. As used in this subsection, the term “health
358 professional” includes, but is not limited to, an audiologist,
359 an occupational therapist, a social worker, or a radiographer.
360 (3) “Board” means the Healthy Florida Board created in s.
361 408.953.
362 (4) “Care coordination” means services provided by a care
363 coordinator under s. 408.961.
364 (5) “Care coordinator” means an individual or entity
365 approved by the board to provide care coordination under s.
366 408.961.
367 (6) “Carrier” means a private health insurer holding a
368 valid certificate of authority under chapter 624, or a health
369 maintenance organization holding a valid certificate of
370 authority under chapter 641, issued by the Office of Insurance
371 Regulation.
372 (7) “Committee” means the public advisory committee
373 established under s. 408.954.
374 (8) “Essential community providers” means persons or
375 entities acting as safety net clinics, safety net health care
376 providers, or rural hospitals.
377 (9) “Federally matched public health program” means the

378 state’s Medicaid program under Title XIX of the Social Security
379 Act, 42 U.S.C. ss. 1396 et seq., and the Florida Kidcare Act,
380 the state’s Children’s Health Insurance Program under Title XXI
381 of the Social Security Act, 42 U.S.C. ss. 1397aa et seq.
382 (10) “Fund” means the Healthy Florida Trust Fund created
383 under s. 408.971.
384 (11) “Health care organization” means an entity that is
385 approved by the board under s. 408.963 to provide health care
386 services to members under the program.
387 (12) “Health care service” means any health care service,
388 including care coordination, which is included as a benefit
389 under the program.
390 (13) “Healthy Florida,” “HF,” or “program” means the
391 Healthy Florida program created in s. 408.953.
392 (14) “Implementation period” means the period under s.
393 408.955(6) during which the program is subject to special
394 eligibility and financing provisions until it is fully
395 implemented under that subsection.
396 (15) “Integrated health care delivery system” means a
397 provider organization that:
398 (a) Is fully integrated, operationally and clinically, in
399 order to provide a broad range of health care services,
400 including preventive care, prenatal and well-baby care,
401 immunizations, screening diagnostics, emergency services,
402 hospital and medical services, surgical services, and ancillary
403 services; and
404 (b) Is compensated by Healthy Florida using capitation or
405 facility budgets for the provision of health care services.
406 (16) “Long-term care” means long-term care, treatment,

407 maintenance, or services not covered under the Florida Kidcare
408 Act, as appropriate, with the exception of short-term
409 rehabilitation, and as defined by the board.
410 (17) "Medicaid" or "medical assistance" means a program
411 that is one of the following:
412 (a) The state Medicaid program under Title XIX of the
413 Social Security Act, 42 U.S.C. ss. 1396 et seq.
414 (b) The Florida Kidcare Act, the state's Children's Health
415 Insurance Program under Title XXI of the Social Security Act, 42
416 U.S.C. ss. 1397aa et seq.
417 (18) "Medicare" means Title XVIII of the Social Security
418 Act, 42 U.S.C. ss. 1395 et seq., and the programs thereunder.
419 (19) "Member" means an individual who is enrolled in the
420 program.
421 (20) "Out-of-state health care service" means a health care
422 service provided in person to a member while he or she is
423 physically located out of this state under either of the
424 following circumstances:
425 (a) It is medically necessary that the health care service
426 be provided while the member is physically out of this state.
427 (b) It is clinically appropriate and necessary, and cannot
428 be provided in this state, because the health care service can
429 only be provided by a particular health care provider physically
430 located out of the state. However, any health care service
431 provided to an HF member by a health care provider located
432 outside the state and qualified under s. 408.96 is not
433 considered an out-of-state service and must be covered as
434 otherwise provided in this part.
435 (21) "Participating provider" means any individual or

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436 entity that is a health care organization or that is a health
437 care provider qualified under s. 408.96 which provides health
438 care services to members under the program.
439 (22) "Prescription drug" has the same meaning as provided
440 in s. 499.003.
441 (23) "Resident" means an individual whose primary place of
442 abode is in this state, without regard to the individual's
443 immigration status.
444 Section 5. Section 408.953, Florida Statutes, is created to
445 read:
446 408.953 The Healthy Florida program; the Healthy Florida
447 Board; board appointments and governance.—
448 (1) The Healthy Florida program is hereby created and is to
449 be administered by the Healthy Florida Board created under this
450 section.
451 (2) The Healthy Florida Board is hereby created. The board
452 shall be an independent public entity not affiliated with an
453 agency or a department. The board shall be governed by an
454 executive board consisting of nine members who are residents of
455 this state. Of the members of the executive board, four shall be
456 appointed by the Governor, two shall be appointed by the
457 President of the Senate, and two shall be appointed by the
458 Speaker of the House of Representatives. The State Surgeon
459 General of the Department of Health or his or her designee shall
460 serve as a voting, ex officio member of the board.
461 (3) Members of the board, other than an ex officio member,
462 shall be appointed for a term of 4 years. Appointments by the
463 Governor shall be subject to confirmation by the Senate. A
464 member of the board may continue to serve until the appointment

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465 and qualification of his or her successor. Vacancies shall be
466 filled by appointment for an unexpired term. The board shall
467 elect a chair on an annual basis.
468 (4)(a) Each person appointed to the board must have
469 demonstrated and acknowledged expertise in health care.
470 (b) Appointing authorities shall also consider the
471 expertise of the other members of the board and attempt to make
472 appointments so that the board's composition reflects a
473 diversity of expertise in the various aspects of health care.
474 (c) Appointments to the board by the Governor, the
475 President of the Senate, and the Speaker of the House of
476 Representatives must consist of:
477 1. At least one representative of a labor organization
478 representing registered nurses.
479 2. At least one representative of the general public.
480 3. At least one representative of a labor organization.
481 4. At least one representative of the medical provider
482 community.
483 (5) Each member of the board shall have the responsibility
484 and duty to meet the requirements of this part, the Affordable
485 Care Act, and all applicable state and federal laws and
486 regulations; to serve the public interest of the individuals,
487 employers, and taxpayers seeking health care coverage through
488 the program; and to ensure the operational well-being and fiscal
489 solvency of the program.
490 (6) In making appointments to the board, the appointing
491 authorities shall take into consideration the cultural, ethnic,
492 and geographical diversity of the state so that the board's
493 composition reflects the communities of this state.

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494 (7)(a) A member of the board or of its staff may not be
495 employed by, a consultant to, a member of the board of directors
496 of, affiliated with, or otherwise be a representative of a
497 health care provider, a health care facility, or a health clinic
498 while serving on the board or on the board staff. A member of
499 the board or of its staff may not be a member, a board member,
500 or an employee of a trade association of health facilities,
501 health clinics, or health care providers while serving on the
502 board or on the staff of the board. A member of the board or of
503 its staff may not be a health care provider unless he or she
504 receives no compensation for rendering services as a health care
505 provider and does not have an ownership interest in a health
506 care practice.
507 (b) A board member may not receive compensation for his or
508 her service on the board, but may be reimbursed for per diem and
509 travel expenses in accordance with s. 112.061 while engaged in
510 the performance of official duties of the board.
511 (c) For purposes of this subsection, the term “health care
512 provider” means a health care professional licensed under
513 chapter 458, chapter 459, chapter 460, chapter 461, chapter 463,
514 chapter 464, chapter 465, chapter 466; part I, part III, part
515 IV, part V, or part X of chapter 468; chapter 483, chapter 484,
516 chapter 486, chapter 490, or chapter 491.
517 (8) A member of the board may not make, participate in
518 making, or in any way attempt to use his or her official
519 position to influence the making of a decision that he or she
520 knows, or has reason to know, will have a reasonably foreseeable
521 material financial effect, distinguishable from its effect on
522 the public generally, on him or her or a member of his or her

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523 immediate family, or on either of the following:
524 (a) Any source of income aggregating $250 or more in value
525 provided to, received by, or promised to the member within 12
526 months before the time when the decision is made, other than
527 gifts and other than loans by a commercial lending institution
528 in the regular course of business on terms available to the
529 public without regard to official status.
530 (b) Any business entity in which the member is a director,
531 officer, partner, trustee, or employee, or holds any position of
532 management.
533 (9) There may not be liability in a private capacity on the
534 part of the board or a member of the board, or an officer or
535 employee of the board, for or on account of an act performed or
536 obligation entered into in an official capacity when done in
537 good faith, without intent to defraud, and in connection with
538 the administration, management, or conduct of this part or
539 affairs related to this part.
540 (10) The board shall hire an executive director to
541 organize, administer, and manage the operations of the board.
542 The executive director is exempt from civil service and shall
543 serve at the pleasure of the board.
544 (11) The board's meetings are subject to s. 286.011.
545 (12) The board may adopt rules necessary to implement and
546 administer this part in accordance with chapter 120.
547 Section 6. Section 408.954, Florida Statutes, is created to
548 read:
549 408.954 Public advisory committee; composition;
550 appointments; duties.—
551 (1) The State Surgeon General of the Department of Health

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552 shall establish a public advisory committee to advise the board
553 on all matters of policy for the program.
554 (2) The members of the committee must include all of the
555 following:
556 (a) Four physicians, all of whom must be board certified in
557 their fields, and at least one of whom must be a psychiatrist.
558 The President of the Senate and the Governor shall each appoint
559 one member. The Speaker of the House of Representatives shall
560 appoint two of these members, both of whom shall be primary care
561 providers.
562 (b) Two registered nurses, to be appointed by the President
563 of the Senate.
564 (c) One licensed allied health practitioner, to be
565 appointed by the Speaker of the House of Representatives.
566 (d) One mental health care provider, to be appointed by the
567 President of the Senate.
568 (e) One dentist, to be appointed by the Governor.
569 (f) One representative of private hospitals, to be
570 appointed by the Governor.
571 (g) One representative of public hospitals, to be appointed
572 by the Governor.
573 (h) One representative of an integrated health care
574 delivery system, to be appointed by the Governor.
575 (i) Four consumers of health care. The Governor shall
576 appoint two of these members, one of whom shall be a member of
577 the disabled community. The President of the Senate shall
578 appoint a member who is 65 years of age or older. The Speaker of
579 the House of Representatives shall appoint the fourth member.
580 (j) One representative of organized labor, to be appointed

581 by the Speaker of the House of Representatives.
582 (k) One representative of organized labor, to be appointed
583 by the President of the Senate.
584 (l) One representative of essential community providers, to
585 be appointed by the President of the Senate.
586 (m) One representative of small business, which is a
587 business that employs less than 25 people, to be appointed by
588 the Governor.
589 (n) One representative of large business, which is a
590 business that employs more than 250 people, to be appointed by
591 the Speaker of the House of Representatives.
592 (o) One pharmacist, to be appointed by the Speaker of the
593 House of Representatives.
594 (3) In making appointments pursuant to this section, the
595 Governor, the President of the Senate, and the Speaker of the
596 House of Representatives shall make good faith efforts to ensure
597 that their appointments, as a whole, reflect, to the greatest
598 extent feasible, the social and geographic diversity of the
599 state.
600 (4) Any member appointed by the Governor, the President of
601 the Senate, or the Speaker of the House of Representatives shall
602 serve a 4-year term. These members may be reappointed for
603 succeeding 4-year terms.
604 (5) A vacancy that occurs must be filled within 30 days
605 after it occurs and in the same manner in which the vacating
606 member was initially selected or appointed. The State Surgeon
607 General of the Department of Health shall notify the appropriate
608 appointing authority of any expected vacancy on the public
609 advisory committee.

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610 (6) Members of the committee shall serve without
611 compensation, but shall be reimbursed for per diem and travel
612 expenses in accordance with s. 112.061, and except that a member
613 shall receive $100 for each full day of attending meetings of
614 the committee. As used in this subsection, the term “full day of
615 attending a meeting” means presence at, and participation in,
616 not less than 75 percent of the total meeting time of the
617 committee during any particular 24-hour period.
618 (7) The public advisory committee shall meet at least 6
619 times per year in a place convenient to the public. All meetings
620 of the committee must be open to the public pursuant to s.
621 286.011.
622 (8) The public advisory committee shall elect a chair who
623 shall serve for 2 years and who may be reelected for an
624 additional 2 years.
625 (9) Appointed committee members must have worked in the
626 field they represent on the committee for a period of at least 2
627 years before being appointed to the committee.
628 (10) It is unlawful for the committee members or any of
629 their assistants, clerks, or deputies to use for personal
630 benefit any information that is filed with, or obtained by, the
631 committee and that is not generally available to the public.
632 Section 7. Section 408.955, Florida Statutes, is created to
633 read:
634 408.955 Board powers and duties.—
635 (1) The board has all powers and duties necessary to
636 establish and implement the Healthy Florida program under this
637 part. The program must provide comprehensive universal single-
638 payer health care coverage and a health care cost control system

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639 for the benefit of all residents of this state.
640 (2) The board shall, to the maximum extent possible,
641 organize, administer, and market the program and services as a
642 single-payer program under the name “HF,” “Healthy Florida,” or
643 any other name as the board determines, regardless of the law or
644 source where the definition of a benefit is found, including, on
645 a voluntary basis, retiree health benefits. In implementing this
646 part, the board shall avoid jeopardizing federal financial
647 participation in the programs that are incorporated into Healthy
648 Florida and shall take care to promote public understanding and
649 awareness of available benefits and programs.
650 (3) The board shall consider any matter necessary to carry
651 out the provisions and purposes of this part. The board may have
652 no executive, administrative, or appointive duties except as
653 otherwise provided by law.
654 (4) The board shall employ necessary staff and authorize
655 reasonable expenditures, as necessary, from the Healthy Florida
656 Trust Fund to pay program expenses and to administer the
657 program.
658 (5) The board may do all of the following:
659 (a) Negotiate and enter into any necessary contracts,
660 including, but not limited to, contracts with health care
661 providers, integrated health care delivery systems, and care
662 coordinators.
663 (b) Sue and be sued.
664 (c) Receive and accept gifts, grants, or donations of
665 moneys from any agency of the Federal Government, any agency of
666 the state, and any municipality, county, or other political
667 subdivision of the state.

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668 (d) Receive and accept gifts, grants, or donations from
669 individuals, associations, private foundations, and
670 corporations, in compliance with the conflict of interest
671 provisions to be adopted by the board by rule.
672 (e) Share information with relevant state agencies,
673 consistent with the confidentiality provisions in this part,
674 which is necessary for the administration of the program.
675 (6) The board shall determine when individuals may begin
676 enrolling in the program. There must be an implementation period
677 that begins on the date that individuals may begin enrolling in
678 the program and ends on a date determined by the board.
679 (7) A carrier may not offer benefits or cover any services
680 for which coverage is offered to individuals under the program,
681 but may, if otherwise authorized, offer benefits to cover health
682 care services that are not offered to individuals under the
683 program. However, this part does not prohibit a carrier from
684 offering:
685 (a) Any benefits to or for individuals, including their
686 families, who are employed or self-employed in this state but
687 who are not residents of the state; or
688 (b) Any benefits during the implementation period to
689 individuals who enrolled or may enroll as members of the
690 program.
691 (8) After the end of the implementation period, a person
692 may not be a board member unless he or she is a member of the
693 program, except the ex officio member.
694 (9) No later than July 1, 2020, the board shall develop the
695 following proposals:
696 (a) A proposal, consistent with the principles of this

697 part, for the program to provide long-term care coverage,
698 including the development of a proposal, consistent with the
699 principles of this part, for the program's funding. In
700 developing the proposal, the board shall consult with an
701 advisory committee, appointed by the board chair, which includes
702 representatives of consumers and potential consumers of long-
703 term care, providers of long-term care, members of organized
704 labor, and other interested parties.
705 (b) Proposals for:
706 1. Accommodating employer retiree health benefits for
707 people who have been members of HF but live as retirees out of
708 this state; and
709 2. Accommodating employer retiree health benefits for
710 people who earned or accrued those benefits while residing in
711 this state before the implementation of HF and live as retirees
712 out of this state.
713 (c) A proposal for HF coverage of health care services
714 currently covered under the workers' compensation system,
715 including whether and how to continue funding for those services
716 under that system and whether and how to incorporate an element
717 of experience rating.
718 (10) The board may contract with nonprofit organizations to
719 provide:
720 (a) Assistance to consumers with respect to selection of a
721 care coordinator or health care organization, enrolling,
722 obtaining health care services, disenrolling, and other matters
723 relating to the program; and
724 (b) Assistance to health care providers providing, seeking,
725 or considering whether to provide health care services under the

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726 program, with respect to participating in a health care
727 organization and interacting with a health care organization.
728 (11) The board shall provide grants from funds in the
729 Healthy Florida Trust Fund or from funds otherwise appropriated
730 for this purpose to the Agency for Health Care Administration
731 for its functions as the state health planning agency under s.
732 408.034.
733 (12) The board shall provide funds from the Healthy Florida
734 Trust Fund or funds otherwise appropriated for this purpose to
735 the Department of Economic Opportunity for a program for
736 retraining and assisting with job transition for individuals
737 employed or previously employed in the fields of health
738 insurance, for health care service plans, and for other third-
739 party payments for health care or those individuals providing
740 services to health care providers to deal with third-party
741 payers for health care and whose jobs may be or have been ended
742 as a result of the implementation of the program, consistent
743 with otherwise applicable law.
744 (13)(a) The board shall provide for the collection and
745 availability of all of the following data to promote
746 transparency, assess adherence to patient care standards,
747 compare patient outcomes, and review utilization of health care
748 services paid for by the program:
749 1. Inpatient discharge data, including acuity and risk of
750 mortality.
751 2. Emergency department and ambulatory surgery data,
752 including charge data, length of stay, and patients' unit of
753 observation.
754 3. Hospital annual financial data, including all of the

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755 following:
756 a. Community benefits by hospital in dollar value.
757 b. Number of employees and classification by hospital unit.
758 c. Number of hours worked by hospital unit.
759 d. Employee wage information by job title and hospital
760 unit.
761 e. Number of registered nurses per staffed bed by hospital
762 unit.
763 f. Type and value of health information technology.
764 g. Annual spending on health information technology,
765 including purchases, upgrades, and maintenance.
766 (b) The board shall make all disclosed data collected under
767 paragraph (a) publicly available and searchable through a
768 website and through the Department of Health's public data sets.
769 (c) The board shall, directly and through grants to
770 nonprofit entities, conduct programs using data collected
771 through the Healthy Florida program to promote and protect
772 public, environmental, and occupational health, including
773 cooperation with other data collection and research programs of
774 the Department of Health, consistent with this part and
775 otherwise applicable law.
776 (d) Before full implementation of the program, the board
777 shall provide for the collection and availability of data on the
778 number of patients served by hospitals and the dollar value of
779 the care provided, at cost, for all of the following categories
780 of Department of Health data items:
781 1. Patients receiving charity care.
782 2. Contractual adjustments of county and indigent programs,
783 including traditional and managed care.

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784 3. Bad debts.

785 Section 8. Section 408.956, Florida Statutes, is created to
786 read:

787 408.956 Law enforcement agencies; prohibited acts relating
788 to Healthy Florida.—Notwithstanding any other law, a law
789 enforcement agency may not use Healthy Florida moneys,
790 facilities, property, equipment, or personnel to investigate,
791 enforce, or assist in the investigation or enforcement of any
792 criminal, civil, or administrative violation or warrant for a
793 violation of any requirement that individuals register with the
794 Federal Government or any federal agency based on religion,
795 national origin, ethnicity, or immigration status.

796 Section 9. Section 408.957, Florida Statutes, is created to
797 read:

798 408.957 Eligibility and enrollment.—

799 (1) Every resident of this state is eligible and entitled
800 to enroll as a member under the program.

801 (2)(a) A member may not be required to pay any fee,
802 payment, or other charge for enrolling in or being a member
803 under the program.

804 (b) A member may not be required to pay any premium,
805 copayment, coinsurance, deductible, or any other form of cost
806 sharing for all covered benefits.

807 (3) A college, university, or other institution of higher
808 education in this state may purchase coverage under the program
809 for a student, or a student's dependent, who is not a resident
810 of this state.

811 Section 10. Section 408.958, Florida Statutes, is created
812 to read:

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813 408.958 Benefits.—

814 (1) Covered health care benefits under the program include
815 all medical care determined to be medically appropriate by the
816 member's health care provider.

817 (2) Covered health care benefits for members must include,
818 but are not limited to, all of the following:

819 (a) Licensed inpatient and licensed outpatient medical and
820 health facility services.

821 (b) Inpatient and outpatient professional health care
822 provider medical services.

823 (c) Diagnostic imaging, laboratory services, and other
824 diagnostic and evaluative services.

825 (d) Medical equipment, appliances, and assistive
826 technology, including prosthetics, eyeglasses, and hearing aids
827 and the repair, technical support, and customization needed for
828 individual use.

829 (e) Inpatient and outpatient rehabilitative care.

830 (f) Emergency care services.

831 (g) Emergency transportation.

832 (h) Necessary transportation for health care services for
833 persons with disabilities or who may qualify as low income.

834 (i) Child and adult immunizations and preventive care.

835 (j) Health and wellness education.

836 (k) Hospice care.

837 (l) Care in a skilled nursing facility.

838 (m) Home health care, including health care provided in an
839 assisted living facility.

840 (n) Mental health services.

841 (o) Substance abuse treatment.

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842 (p) Dental care.
843 (q) Vision care.
844 (r) Prescription drugs.
845 (s) Pediatric care.
846 (t) Prenatal and postnatal care.
847 (u) Podiatric care.
848 (v) Chiropractic care.
849 (w) Acupuncture.
850 (x) Therapies that are shown by the National Center for
851 Complementary and Integrative Health, National Institutes of
852 Health, to be safe and effective.
853 (y) Blood and blood products.
854 (z) Dialysis.
855 (aa) Adult day care.
856 (bb) Rehabilitative services.
857 (cc) Ancillary health care or social services previously
858 covered by county primary care programs under part I of chapter
859 154.
860 (dd) Ancillary health care or social services for persons
861 with developmental disabilities which were previously
862 administered by the Developmental Disabilities Council under
863 chapter 393.
864 (ee) Case management and care coordination.
865 (ff) Language interpretation and translation for health
866 care services, including sign language and Braille or other
867 services needed for individuals to overcome communication
868 barriers.
869 (gg) Health care and long-term supportive services
870 currently covered under Medicaid or the Florida Kidcare Act.

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871 (3) Covered benefits for members must also include all
872 health care services required to be covered under any of the
873 following provisions, without regard to whether the member would
874 otherwise be eligible for or covered by the program or source
875 referred to:
876 (a) The Florida Kidcare Act.
877 (b) The state Medicaid program.
878 (c) The Medicare program pursuant to Title XVIII of the
879 Social Security Act, 42 U.S.C. ss. 1395 et seq.
880 (d) Chapter 641.
881 (e) Parts II, VI, and VII of chapter 627, relating to
882 health insurers.
883 (f) Any additional health care services authorized to be
884 added to the program's benefits by the program.
885 (g) All essential health benefits mandated by the
886 Affordable Care Act as of July 1, 2019.
887 Section 11. Section 408.96, Florida Statutes, is created to
888 read:
889 408.96 Delivery of care; health care providers.—
890 (1)(a) Any health care provider who is licensed to practice
891 in this state and is otherwise in good standing is qualified to
892 participate in the program as long as the health care provider's
893 services are performed within this state.
894 (b) The board shall establish and maintain procedures and
895 standards for recognizing health care providers located out of
896 this state for purposes of providing coverage under the program
897 for a member who requires out-of-state health care services
898 while he or she is temporarily located out of this state.
899 (2) Any health care provider qualified to participate under

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900 this section may provide covered health care services under the
901 program as long as the health care provider is legally
902 authorized to perform the health care service for the individual
903 and under the circumstances involved.
904 (3) A member may choose to receive health care services
905 under the program from any participating provider, consistent
906 with this part and the willingness or availability of the
907 provider, subject to provisions of this part relating to
908 discrimination and the appropriate clinically relevant
909 circumstances.
910 (4) A person who chooses to enroll with an integrated
911 health care delivery system, group medical practice, or
912 essential community provider that offers comprehensive services
913 shall retain membership for at least 1 year after an initial 3-
914 month evaluation period, during which time the person may
915 withdraw for any reason.
916 (a) The 3-month period must commence on the date when a
917 member first sees a primary care provider.
918 (b) A person who wishes to withdraw after the initial 3-
919 month period shall request a withdrawal pursuant to the dispute
920 resolution procedures established by the board and may request
921 assistance from the patient advocate, which must be provided for
922 in the dispute resolution procedures, in resolving the dispute.
923 The dispute must be resolved in a timely fashion and may not
924 have an adverse effect on the care a patient receives.
925 Section 12. Section 408.961, Florida Statutes, is created
926 to read:
927 408.961 Care coordination.—
928 (1) Care coordination must be provided to the member by his

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929 or her care coordinator. A care coordinator may employ or use
930 the services of other individuals or entities to assist in
931 providing care coordination for the member, consistent with
932 regulations of the board and with the statutory requirements and
933 regulations of the care coordinator's licensure.
934 (2) Care coordination includes administrative tracking and
935 medical recordkeeping services for members, except as otherwise
936 specified for integrated health care delivery systems.
937 (3) Care coordination administrative tracking and medical
938 recordkeeping services for members are not required in order to
939 use a certified electronic health record, meet any other
940 requirements of the federal Health Information Technology for
941 Economic and Clinical Health Act enacted under the federal
942 American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-
943 5, or meet certification requirements of the federal Centers for
944 Medicare and Medicaid Services' Electronic Health Records
945 Incentive Programs, including meaningful use requirements.
946 (4) The care coordinator shall comply with all state and
947 federal privacy laws, including, but not limited to, s. 381.004,
948 s. 395.3025, s. 456.057, and the Health Insurance Portability
949 and Accountability Act, 42 U.S.C. ss. 1320d et seq., and its
950 implementing regulations.
951 (5) Referrals from a care coordinator are not required for
952 a member to see any eligible provider.
953 (6) A care coordinator may be an individual or entity that
954 is approved under the program and that is any of the following:
955 (a) A health care practitioner that is any of the
956 following:
957 1. The member's primary care provider.

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958 2. The member's provider of primary gynecological care.
959 3. At the option of a member who has a chronic condition
960 that requires specialty care, a specialist health care
961 practitioner who regularly and continually provides treatment to
962 the member for that condition.
963 (b) An entity authorized by law to provide:
964 1. Hospital services in accordance with chapter 395;
965 2. Nursing home care services in accordance with chapter
966 400;
967 3. Life care services in accordance with chapter 651;
968 4. Services for the developmentally disabled under chapter
969 393;
970 5. Mental health services under chapter 394;
971 6. Assisted living services in accordance with chapter 429;
972 or
973 7. Hospice services in accordance with chapter 400.
974 (c) A health care organization.
975 (d) A Taft-Hartley health and welfare fund, with respect to
976 its members and their family members. This paragraph does not
977 preclude a Taft-Hartley health and welfare fund from becoming a
978 care coordinator under paragraph (e) or a health care
979 organization under s. 408.963.
980 (e) Any nonprofit or governmental entity approved under the
981 program.
982 (7)(a) A health care provider may be reimbursed for a
983 health care service only if the member is enrolled with a care
984 coordinator at the time the service is provided.
985 (b) Every member is encouraged to enroll with a care
986 coordinator that agrees to provide care coordination before the

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987 member receives health care services to be paid for under the
988 program. If a member receives health care services before
989 choosing a care coordinator, the program shall assist the
990 member, when appropriate, with choosing a care coordinator.
991 (c) The member must remain enrolled with his or her care
992 coordinator until the member enrolls with a different care
993 coordinator or ceases to be a member. A member has the right to
994 change his or her care coordinators on terms at least as
995 permissive as provided in part III or part IV of chapter 409.
996 (8) A health care organization may establish rules relating
997 to care coordination for members in the health care organization
998 which are different from this section but otherwise consistent
999 with this part and other applicable laws.
1000 (9) This section does not authorize any individual to
1001 engage in any act in violation of the applicable chapter under
1002 which he or she is licensed to practice.
1003 (10) An individual or entity may not be a care coordinator
1004 unless the services included in care coordination are within the
1005 individual's professional scope of practice or the entity's
1006 legal authority.
1007 (11)(a) The board shall develop by rule and implement
1008 procedures and standards for an individual or entity to be
1009 approved as a care coordinator in the program, including, but
1010 not limited to, procedures and standards relating to the
1011 revocation, suspension, or limitation of approval on a
1012 determination that the individual or entity is incompetent to be
1013 a care coordinator or has exhibited conduct that is inconsistent
1014 with program standards and regulations, or that exhibits an
1015 unwillingness to meet those standards and regulations, or is a

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1016 potential threat to the public health or safety.
1017 (b) The procedures and standards the board adopts must be
1018 consistent with established professional practice, licensure
1019 standards, and regulations for health care practitioners and
1020 providers.
1021 (c) In developing and implementing standards of approval of
1022 care coordinators for individuals receiving chronic mental
1023 health care services, the board shall consult with the Substance
1024 Abuse and Mental Health Program Office within the Department of
1025 Children and Families.
1026 (12) To maintain approval under the program, a care
1027 coordinator must do all of the following:
1028 (a) Renew the approval every 3 years pursuant to rules the
1029 board adopts.
1030 (b) Provide to the program any data required by the
1031 Department of Health which would enable the board to evaluate
1032 the impact of care coordinators on quality, outcomes, and cost
1033 of health care.
1034 Section 13. Section 408.962, Florida Statutes, is created
1035 to read:
1036 408.962 Payment for health care services and care
1037 coordination.—
1038 (1) The board shall adopt rules regarding contracting for,
1039 and establishing payment methodologies for, covered health care
1040 services and care coordination provided to members under the
1041 program by participating providers, care coordinators, and
1042 health care organizations. There may be a variety of different
1043 payment methodologies, including those established on a
1044 demonstration basis. All payment rates under the program must be

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1045 reasonable and reasonably related to the cost of efficiently
1046 providing the health care services and ensuring an adequate and
1047 accessible supply of health care services.
1048 (2) Health care services provided to members under the
1049 program, except for care coordination, must be paid for on a
1050 fee-for-service basis unless and until another payment
1051 methodology is established by the board.
1052 (3) Notwithstanding subsection (2), integrated health care
1053 delivery systems, essential community providers, and group
1054 medical practices that provide comprehensive, coordinated
1055 services may choose to be reimbursed on the basis of a capitated
1056 system operating budget or a noncapitated system operating
1057 budget that covers all costs of providing health care services.
1058 (4) The program shall engage in good faith negotiations
1059 with health care providers' representatives under s. 408.98,
1060 including, but not limited to, in relation to rates of payment
1061 for health care services, rates of payment for prescription and
1062 nonprescription drugs, and payment methodologies. For
1063 prescription and nonprescription drugs, the negotiations must be
1064 conducted through a single entity on behalf of the entire
1065 program.
1066 (5)(a) Payments for health care services established under
1067 this part are considered payment in full.
1068 (b) A participating provider may not charge any rate in
1069 excess of the payment established under this part for any health
1070 care service provided to a member under the program and may not
1071 solicit or accept payment from any member or third party for any
1072 health care service, except as provided under a federal program.
1073 (c) However, this section does not preclude the program

1074 from acting as a primary or secondary payer in conjunction with
1075 another third-party payer when permitted by a federal program.
1076 (6) The board may adopt by rule payment methodologies for
1077 the payment of capital-related expenses for specifically
1078 identified capital expenditures incurred by a nonprofit or
1079 governmental entity that is a health facility. As used in this
1080 subsection, the term "health facility" has the same meaning as
1081 in s. 154.205(8). Any capital-related expense generated by a
1082 capital expenditure that requires prior approval must have
1083 received that approval in order to be paid by the program. That
1084 approval must be based on achievement of the program standards
1085 described in s. 408.964.
1086 (7) Payment methodologies and payment rates must include a
1087 distinct component for reimbursement of direct and indirect
1088 graduate medical education expenses.
1089 (8) The board shall adopt by rule payment methodologies and
1090 procedures for paying for health care services provided to a
1091 member while he or she is located out of this state.
1092 Section 14. Section 408.963, Florida Statutes, is created
1093 to read:
1094 408.963 Health care organizations.—
1095 (1) A member may choose to enroll with and receive program
1096 care coordination and ancillary health care services from a
1097 health care organization.
1098 (2) A health care organization must be a nonprofit or
1099 governmental entity that is approved by the board and that is
1100 either of the following:
1101 (a) The county health department delivery system
1102 established by the Department of Health under s. 154.01.

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1103 (b) A facility licensed by the Agency for Persons with
1104 Disabilities which provides developmental disabilities services
1105 under chapter 393.
1106 (3)(a) The board shall by rule develop and implement
1107 procedures and standards for an entity to be approved as a
1108 health care organization in the program, including, but not
1109 limited to, procedures and standards relating to the revocation,
1110 suspension, or limitation of approval on a determination that
1111 the entity is incompetent to be a health care organization or
1112 has exhibited a course of conduct that is inconsistent with
1113 program standards and regulations, or that exhibits an
1114 unwillingness to meet those standards and regulations, or is a
1115 potential threat to the public health or safety.
1116 (b) The procedures and standards adopted by the board must
1117 be consistent with established professional practice, licensure
1118 standards, and regulations for health care practitioners and
1119 providers.
1120 (c) In developing and implementing standards of approval of
1121 health care organizations, the board shall consult with the
1122 Substance Abuse and Mental Health Program Office within the
1123 Department of Children and Families.
1124 (4) To maintain approval under the program, a health care
1125 organization must:
1126 (a) Renew its approval at a frequency determined by the
1127 board; and
1128 (b) Provide data to the Department of Health, as required
1129 by the board, to enable the board to evaluate the health care
1130 organization in relation to the quality of health care services
1131 provided, health care outcomes, and cost.

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1132 (5) The board may adopt rules relating specifically to
1133 health care organizations for the sole and specific purpose of
1134 ensuring compliance with this part.
1135 (6) This part may not be construed to alter in any way the
1136 professional practice of health care providers or their
1137 licensure standards.
1138 (7) Health care organizations may not use health
1139 information technology or clinical practice guidelines that
1140 limit the effective exercise of the professional judgment of
1141 physicians and registered nurses. Physicians and registered
1142 nurses are free to override health information technology and
1143 clinical practice guidelines if, in their professional judgment,
1144 it is in the best interest of the patient and consistent with
1145 the patient’s wishes.
1146 Section 15. Section 408.964, Florida Statutes, is created
1147 to read:
1148 408.964 Program standards.—The Healthy Florida Board shall
1149 establish a single standard of safe, therapeutic care for all
1150 residents of the state by the following means:
1151 (1) The board shall establish by rule requirements and
1152 standards for the program and for health care organizations,
1153 care coordinators, and health care providers consistent with
1154 this part and consistent with the applicable professional
1155 practice and licensure standards of health care providers and
1156 health care professionals, including requirements and standards
1157 for, as applicable:
1158 (a) The scope, quality, and accessibility of health care
1159 services.
1160 (b) Relations between health care organizations or health

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1161 care providers and members.
1162 (c) Relations between health care organizations and health
1163 care providers, including credentialing and participation in the
1164 health care organization, and terms, methods, and rates of
1165 payment.
1166 (2) The board shall establish by rule requirements and
1167 standards under the program which include, but are not limited
1168 to, provisions to promote all of the following:
1169 (a) Simplification of, transparency in, uniformity in, and
1170 fairness in health care provider credentialing and participation
1171 in health care organization networks, referrals, payment
1172 procedures and rates, claims processing, and approval of health
1173 care services, as applicable.
1174 (b) In-person primary and preventive care, care
1175 coordination, efficient and effective health care services,
1176 quality assurance, and promotion of public, environmental, and
1177 occupational health.
1178 (c) Elimination of health care disparities.
1179 (d) Nondiscrimination with respect to members and health
1180 care providers on the basis of race, color, ancestry, national
1181 origin, religion, citizenship, immigration status, primary
1182 language, mental or physical disability, age, sex, gender,
1183 sexual orientation, gender identity or expression, medical
1184 condition, genetic information, marital status, familial status,
1185 military or veteran status, or source of income; however, health
1186 care services provided under the program must be appropriate to
1187 the patient's clinically relevant circumstances.
1188 (e) Accessibility of care coordination, health care
1189 organization services, and health care services, including

1190 accessibility for people with disabilities and people with
1191 limited ability to speak or understand English.
1192 (f) Providing care coordination, health care organization
1193 services, and health care services in a culturally competent
1194 manner.
1195 (3) The board shall establish by rule requirements and
1196 standards, to the extent authorized by federal law, for
1197 replacing and merging with the Healthy Florida program health
1198 care services and ancillary services currently provided by other
1199 programs, including, but not limited to, Medicare, the
1200 Affordable Care Act, and federally matched public health
1201 programs.
1202 (4) Any participating provider or care coordinator that is
1203 organized as a for-profit entity shall be required to meet the
1204 same requirements and standards as entities organized as
1205 nonprofits, and payments under the program paid to those
1206 entities may not be calculated to accommodate the generation of
1207 profit, revenue for dividends, or other return on investment or
1208 the payment of taxes that would not be paid by a nonprofit
1209 entity.
1210 (5) Every participating provider shall furnish information
1211 as required by the Department of Health and allow the
1212 examination of that information by the program as may be
1213 reasonably required for purposes of reviewing accessibility and
1214 utilization of health care services, quality assurance, cost
1215 containment, the making of payments, and statistical or other
1216 studies of the operation of the program or for protection and
1217 promotion of public, environmental, and occupational health.
1218 (6) In developing requirements and standards and making

1219 other policy determinations under this section, the board shall
1220 consult with representatives of members, health care providers,
1221 care coordinators, health care organizations, labor
1222 organizations representing health care employees, and other
1223 interested parties.
1224 Section 16. Section 408.97, Florida Statutes, is created to
1225 read:
1226 408.97 Federal health programs and funding.—
1227 (1) The board shall seek all federal waivers and other
1228 federal approvals and arrangements and submit state plan
1229 amendments as necessary to operate the Healthy Florida program
1230 consistent with this part.
1231 (2)(a) The board shall apply to the United States Secretary
1232 of Health and Human Services or other appropriate federal
1233 official for all waivers of requirements, and shall make other
1234 arrangements necessary, under Medicare, any federally matched
1235 public health program, the Affordable Care Act, and any other
1236 federal program that provides federal funds for payment of
1237 health care services, to enable all Healthy Florida members to
1238 receive all benefits under the program, to enable the state to
1239 implement this part, and to allow the state to receive and
1240 deposit all federal payments under those programs, including
1241 funds that may be provided in lieu of premium tax credits, cost-
1242 sharing subsidies, and small business tax credits, in the State
1243 Treasury to the credit of the Healthy Florida Trust Fund,
1244 created under s. 408.971, and to use those funds for the program
1245 and other provisions under this part.
1246 (b) To the fullest extent possible, the board shall
1247 negotiate arrangements with the Federal Government to ensure

1248 that federal payments are paid to Healthy Florida in place of
1249 federal funding of, or tax benefits for, federally matched
1250 public health programs or federal health programs.
1251 (c) The board may require members or applicants to provide
1252 information necessary for the program to comply with any waiver
1253 or arrangement under this part. Information provided by members
1254 to the board for the purposes of this paragraph may not be used
1255 for any other purpose.
1256 (d) The board may take any additional actions necessary to
1257 effectively implement Healthy Florida to the maximum extent
1258 possible as a single-payer program consistent with this part.
1259 (3) The board may take actions consistent with this part to
1260 enable the program to administer Medicare in this state. The
1261 program must be a provider of supplemental insurance coverage
1262 under Medicare Part B and must provide premium assistance for
1263 drug coverage under Medicare Part D for eligible members of the
1264 program.
1265 (4) The board may waive or modify the applicability of any
1266 provision of this section relating to any federally matched
1267 public health program or Medicare, as necessary, to implement
1268 any waiver or arrangement under this section or to maximize the
1269 federal benefits to the program under this section, if the
1270 board, in consultation with the Chief Financial Officer,
1271 determines that the waiver or modification is in the best
1272 interest of this state and members affected by the action.
1273 (5) The board may apply for coverage for, and enroll, any
1274 eligible member under any federally matched public health
1275 program or Medicare. Enrollment in a federally matched public
1276 health program or Medicare may not cause any member to lose any

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1277 health care service provided by the program or diminish any
1278 right the member would otherwise have.
1279 (6)(a) Notwithstanding any other law, the board shall
1280 increase by rule the income eligibility level, increase or
1281 eliminate the resource test for eligibility, simplify any
1282 procedural or documentation requirement for enrollment, and
1283 increase the benefits for any federally matched public health
1284 program and for any program in order to reduce or eliminate an
1285 individual's coinsurance, cost-sharing, or premium obligations
1286 or increase an individual's eligibility for any federal
1287 financial support related to Medicare or the Affordable Care
1288 Act.
1289 (b) The board may act under this subsection upon a finding
1290 approved by the Chief Financial Officer and the board that the
1291 action:
1292 1. Will help to increase the number of members who are
1293 eligible for and enrolled in federally matched public health
1294 programs; or, for any program, to reduce or eliminate an
1295 individual's coinsurance, cost-sharing, or premium obligations
1296 or increase an individual's eligibility for any federal
1297 financial support related to Medicare or the Affordable Care
1298 Act;
1299 2. Will not diminish any individual's access to any health
1300 care service or any right the individual would otherwise have;
1301 3. Is in the interest of the program; and
1302 4. Has received any necessary federal waivers or approvals
1303 to ensure federal financial participation, or does not require
1304 any such waiver or approval.
1305 (c) Actions under this subsection do not apply to

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1306 eligibility for payment for long-term care.
1307 (7) To enable the board to apply for coverage for, and
1308 enroll, any eligible member under any federally matched public
1309 health program or Medicare, the board may require that every
1310 member or applicant provide the information necessary to enable
1311 the board to determine whether the applicant is eligible for a
1312 federally matched public health program or for Medicare, or any
1313 program or benefit under Medicare.
1314 (8) As a condition of continued eligibility for health care
1315 services under the program, a member who is eligible for
1316 benefits under Medicare must enroll in Medicare, including Parts
1317 A, B, and D.
1318 (9) The program shall provide premium assistance for all
1319 members enrolling in a Medicare Part D drug coverage plan under
1320 s. 1860D of Title XVIII of the Social Security Act, 42 U.S.C.
1321 ss. 1395w-101 et seq., limited to the low-income benchmark
1322 premium amount established by the federal Centers for Medicare
1323 and Medicaid Services and any other amount the federal agency
1324 establishes under its de minimis premium policy, except that
1325 those payments made on behalf of members enrolled in a Medicare
1326 advantage plan may exceed the low-income benchmark premium
1327 amount if determined to be cost effective to the program.
1328 (10) If the board has reasonable grounds to believe that a
1329 member may be eligible for an income-related subsidy under s.
1330 1860D-14 of Title XVIII of the Social Security Act, 42 U.S.C. s.
1331 1395w-114, the member must provide, and authorize the program to
1332 obtain, any information or documentation required to establish
1333 the member’s eligibility for that subsidy; however, the board
1334 shall attempt to obtain as much of the information and

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1335 documentation as possible from records that are available to it.
1336 (11) The program shall make a reasonable effort to notify
1337 members of their obligations under this section. After a
1338 reasonable effort has been made to contact the member, the
1339 member must be notified in writing that he or she has 60 days to
1340 provide the required information. If the required information is
1341 not provided within the 60-day period, the member’s coverage
1342 under the program may be terminated. Information members provide
1343 to the board for the purposes of this section may not be used
1344 for any other purpose.
1345 (12) The board shall assume responsibility for all benefits
1346 and services paid for by the Federal Government with federal
1347 funds.
1348 Section 17. Section 408.972, Florida Statutes, is created
1349 to read:
1350 408.972 Healthy Florida financing.—
1351 (1) It is the intent of the Legislature to enact
1352 legislation that would develop a revenue plan, taking into
1353 consideration anticipated federal revenue available for the
1354 Healthy Florida program. In developing the revenue plan, it is
1355 the intent of the Legislature to consult with appropriate
1356 officials and stakeholders.
1357 (2) It is the intent of the Legislature to enact
1358 legislation that would require all state revenues from the
1359 program to be deposited in an account within the Healthy Florida
1360 Trust Fund to be established and known as the Healthy Florida
1361 Trust Fund Account.
1362 Section 18. Section 408.98, Florida Statutes, is created to
1363 read:

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1364 408.98 Collective negotiation by health care providers with
1365 Healthy Florida; definitions; requirements and prohibited acts.—
1366 (1) DEFINITIONS.—As used in this section, the term:
1367 (a)“Health care provider” means a health care professional
1368 licensed under chapter 458, chapter 459, chapter 460, chapter
1369 461, chapter 463, chapter 464, chapter 465, chapter 466; part I,
1370 part III, part IV, part V, or part X of chapter 468; chapter
1371 483, chapter 484, chapter 486, chapter 490, or chapter 491, and
1372 who is any of the following:
1373 1. An individual who practices his or her profession as a
1374 health care provider or as an independent contractor.
1375 2. An owner, officer, shareholder, or proprietor of a
1376 health care provider.
1377 3. An entity that employs or uses health care providers to
1378 provide health care services, including, but not limited to, a
1379 facility authorized by law to provide services under chapter
1380 393, chapter 394, chapter 395, chapter 400, chapter 429, or
1381 chapter 651.
1382
1383 A health care provider who practices as an employee of a health
1384 care provider is not a health care provider for the purposes of
1385 this section.
1386 (b) “Health care providers’ representative” means a third
1387 party that is authorized by a group of health care providers to
1388 negotiate on the group’s behalf with Healthy Florida concerning
1389 terms and conditions affecting the health care providers.
1390 (2) COLLECTIVE NEGOTIATION REQUIREMENTS.—
1391 (a) Collective negotiation rights granted by this section
1392 must meet all of the following requirements:

1393 1. Health care providers may communicate with other health
1394 care providers regarding the terms and conditions to be
1395 negotiated with Healthy Florida.
1396 2. Health care providers may communicate with health care
1397 providers’ representatives.
1398 3. A health care providers’ representative is the only
1399 party authorized to negotiate with HF on behalf of the health
1400 care providers as a group.
1401 4. A health care provider may be bound by the terms and
1402 conditions negotiated by the health care providers’
1403 representatives.
1404 5. In communicating or negotiating with the health care
1405 providers’ representative, HF is entitled to offer and provide
1406 different terms and conditions to individual competing health
1407 care providers.
1408 (b) Before engaging in collective negotiations with HF on
1409 behalf of health care providers, a health care providers’
1410 representative must file with the board, in the manner
1411 prescribed by the board, information identifying the
1412 representative, the representative’s plan of operation, and the
1413 representative’s procedures to ensure compliance with this
1414 chapter.
1415 (c) Each person who acts as the representative of
1416 negotiating parties under this chapter shall pay a fee to the
1417 board to act as a representative. The board shall set by rule
1418 fees in amounts deemed reasonable and necessary to cover the
1419 costs the board incurs in administering this chapter.
1420 (3) PROHIBITED COLLECTIVE ACTION.—
1421 (a) This section does not authorize competing health care

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1422 providers to act in concert in response to a health care
1423 providers' representative's discussions or negotiations with HF,
1424 except as authorized by other law.
1425 (b) A health care providers' representative may not
1426 negotiate any agreement that excludes, limits the participation
1427 or reimbursement of, or otherwise limits the scope of services
1428 to be provided by any health care provider or group of health
1429 care providers with respect to the performance of services that
1430 are within the health care provider's scope of practice,
1431 license, registration, or certificate.
1432 (4) CONSTRUCTION.—
1433 (a) This section does not affect or limit the right of a
1434 health care provider or group of health care providers to
1435 collectively petition a governmental entity for a change in a
1436 law, rule, or regulation.
1437 (b) This section does not affect or limit collective action
1438 or collective bargaining on the part of a health care provider
1439 with his or her employer or any other lawful collective action
1440 or collective bargaining.
1441 Section 19. Section 408.99, Florida Statutes, is created to
1442 read:
1443 408.99 Effective date of operation.—
1444 (1) Notwithstanding any other law, this part may not become
1445 operative until the date the State Surgeon General of the
1446 Department of Health notifies the President of the Senate and
1447 the Speaker of the House of Representatives in writing that he
1448 or she has determined that the Healthy Florida Trust Fund has
1449 the revenues to fund the costs of implementing this part.
1450 (2) The Department of Health shall publish on its website a

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1451 copy of the notice described in subsection (1).
1452 Section 20. Section 408.991, Florida Statutes, is created
1453 to read:
1454 408.991 Severability.—The provisions of this part are
1455 severable. If any provision of this part or its application is
1456 held invalid, that invalidity may not affect other provisions or
1457 applications that can be given effect without the invalid
1458 provision or application.
1459 Section 21. This act shall take effect July 1, 2019.

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