A bill to be entitled

An act relating to the Healthy Florida Program; providing a directive to the Division of Law Revision to create chapter 638, F.S., entitled the "Healthy Florida Act"; creating part I of ch. 638, F.S., entitled "General Provisions"; creating s. 638.501, F.S.; providing legislative intent; creating s. 638.601, F.S.; establishing the Healthy Florida Program, to be administered by the Healthy Florida Board; creating s. 638.602, F.S.; providing definitions; creating s. 638.603, F.S.; providing that the act does not preempt any local government or political subdivision of the state from providing better coverages; creating s. 638.604, F.S.; providing construction; providing a directive to the Division of Law Revision to create part II of ch. 638, F.S., entitled "Governance"; creating s. 638.61, F.S.; providing membership of the Healthy Florida Board; providing membership requirements; authorizing reimbursement for per diem and travel expenses; authorizing the board to make rules; creating s. 638.611, F.S.; providing the powers and duties of the board; creating s. 638.612, F.S.; establishing a public advisory committee; providing the method of, and criteria for, appointment to the committee;

providing committee duties and requirements; authorizing reimbursement for travel expenses; creating s. 638.613, F.S.; authorizing the board to contract with not-for-profit organizations for certain purposes; creating s. 638.614, F.S.; requiring the board to provide grants from the Health Florida Trust Fund or other sources to health planning agencies; creating s. 638.615, F.S.; requiring the board to provide funds from the trust fund or other sources to the Department of Economic Opportunity for retraining and job transition for certain persons whose jobs become obsolete; creating s. 638.616, F.S.; requiring the board to provide for the collection and availability of data for specified purposes; providing that the data is open to the public; requiring the board to conduct programs using the data for specified purposes; creating s. 638.6161, F.S.; prohibiting law enforcement agencies from using any Healthy Florida Program personnel or property for specified purposes; providing a directive to the Division of Law Revision to create part III of ch. 638, F.S., entitled "Eligibility and Enrollment"; creating s. 638.62, F.S.; providing requirements for eligibility and enrollment of residents and of students, or students' dependents, who are nonresidents; providing a

directive to the Division of Law Revision to create part IV of ch. 638, F.S., entitled "Benefits"; creating s. 638.63, F.S.; providing covered health care benefits; providing a directive to the Division of Law Revision to create part V of ch. 638, F.S., entitled "Delivery of Care"; creating s. 638.635, F.S.; providing qualification standards for in-state and out-of-state providers; providing membership requirements for persons who are enrolled with specified health care providers; creating s. 638.637, F.S.; requiring that care coordination be provided to members for specified purposes; providing requirements and procedures related to care coordinators; requiring the board to adopt rules; creating s. 638.639, F.S.; requiring payment rates to be reasonable and cost-efficient; providing requirements related to payments; requiring the board to adopt rules; creating s. 638.64, F.S.; authorizing members to enroll with and receive specified services from a health care organization; providing requirements for a health care organization; requiring the board to adopt certain rules; providing construction; providing a directive to the Division of Law Revision to create part VI of ch. 638, F.S., entitled "Program Standards"; creating s. 638.645, F.S.; providing standards for the Healthy

Florida Program and related service entities; requiring the board to adopt certain rules; providing requirements for care coordinators; requiring a participating provider to furnish specified information; providing a directive to the Division of Law Revision to create part VII of ch. 638, F.S., entitled "Funding"; creating s. 638.65, F.S.; providing duties of the board; authorizing the board to take action to enable the program to operate as a Medicare Part B provider and to provide specified drug coverage under Medicare Part D; requiring the board to adopt certain rules; requiring members to provide specific information to obtain subsidies; creating s. 638.657, F.S.; providing legislative intent; providing a directive to the Division of Law Revision to create part VIII of ch. 638, F.S., entitled "Collective Bargaining"; creating s. 638.66, F.S.; providing definitions; creating s. 638.662, F.S.; authorizing health care providers to meet and communicate for purposes of collective bargaining with the Healthy Florida Program; providing construction; creating s. 638.664, F.S.; providing requirements for collective bargaining; providing construction; creating s. 638.666, F.S.; providing requirements for collective bargaining for health care providers' representatives;

creating s. 638.668, F.S.; prohibiting competing health care providers from acting in concert in response to certain discussions or negotiations; prohibiting health care providers' representatives from negotiating any agreement that excludes or reduces the participation or reimbursement of, or the scope of services by, a provider regarding the services performed by the provider; providing severability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. The Division of Law Revision is directed to create chapter 638, Florida Statutes, consisting of ss. 638.501-638.668, Florida Statutes, to be entitled the "Healthy Florida Act."

Section 2. Part I of chapter 638, Florida Statutes, consisting of ss. 638.501-638.604, Florida Statutes, is created and entitled "General Provisions."

Section 3. Section 638.501, Florida Statutes, is created to read:

638.501 Legislative intent.—

(1) The Legislature finds and declares all of the following:

(a) All residents of this state have the right to health

care. While the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, brought many improvements in health care and health care coverage, it still leaves many Floridians without coverage or with inadequate coverage.

(b) Floridians, as individuals, employers, and taxpayers, have experienced a rise in the cost of health care and health care coverage in recent years, including rising premiums, deductibles, and copayment, as well as restricted provider networks and high out-of-network charges.

(c) Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely.

(d) Individuals often find that they are deprived of affordable care and choice because of decisions by health benefit plans guided by the plans' economic needs rather than consumers' health care needs.

(e) To address the fiscal crisis facing the health care system and this state, and to ensure Floridians can exercise their right to health care, comprehensive health care coverage must be provided.

(f) It is the intent of the Legislature to establish a comprehensive universal single-payer health care coverage program and a health care cost control system for all residents of this state.

(2)(a) It is further the intent of the Legislature to establish the Healthy Florida Program to provide universal health coverage for every Floridian based on his or her ability to pay and funded by broad-based revenue.

(b) It is the intent of the Legislature to work to obtain waivers and other approvals relating to Medicaid, Florida's Children's Health Insurance Program, Medicare, the PPACA, and any other federal programs so that any federal funds and other subsidies that would otherwise be paid to this state, Floridians, and health care providers would be paid by the Federal Government to this state and deposited into the Healthy Florida Trust Fund.

(c) Under the waivers and approvals described in paragraph (b), the funds shall be used for health coverage that provides health benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums.

(d) Those programs shall be replaced and merged into the Healthy Florida Program, which will operate as a true single-payer program.

(e) If any necessary waivers or approvals are not obtained, it is the intent of the Legislature that this state use plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally matched public health programs and federal health programs in the

program.

(f) Thus, even if other programs such as Florida Medicaid or Medicare may contribute to paying for care, it is the goal of this chapter that the coverage be delivered by the program and, as much as possible, that the multiple sources of funding be pooled with other program funds and not be apparent to program members or participating providers.

(3) This chapter does not create any employment benefit, nor does it require, prohibit, or limit the providing of any employment benefit.

(4)(a) It is the intent of the Legislature not to change or impact the role or authority of any licensing board or state agency that regulates the standards for or provision of health care and the standards for health care providers as established under current general law.

(b) This chapter does not authorize the Healthy Florida Board, the Healthy Florida Program, or the Commissioner of Insurance to establish or revise licensure standards for health care providers.

(5) It is the intent of the Legislature that neither health information technology nor clinical practice guidelines limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses shall be free to override health information technology and clinical practice guidelines if, in their professional

judgment, it is in the best interest of the patient and consistent with the patient's wishes.

(6)(a) It is the intent of the Legislature to prohibit the program, a state agency, a local agency, or a public employee acting under color of law from providing or disclosing to anyone, including, but not limited to, the Federal Government, any personally identifying information obtained, including, but not limited to, a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

(b) This chapter prohibits law enforcement agencies from using the program's funds, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the Federal Government or any federal agency based on religion, national origin, ethnicity, or immigration status.

(7) It is the further intent of the Legislature to address the high cost of prescription drugs and ensure they are affordable for patients.

Section 4. Section 638.601, Florida Statutes, is created to read:

638.601 Healthy Florida Program.—There is hereby established the Healthy Florida Program, to be administered by

the Healthy Florida Board pursuant to part II of this chapter.

Section 5. Section 638.602, Florida Statutes, is created to read:

638.602 Definitions.—For the purposes of this chapter, the term:

(1) "Affordable Care Act" or "PPACA" has the same meaning as provided in s. 627.402.

(2) "Allied health practitioner" means a group of health professionals who apply their expertise to prevent disease transmission and to diagnose, treat, and rehabilitate people of all ages and in all specialties. Together with a range of technical and support staff, they may deliver direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions. Examples include, but are not limited to, audiologists, occupational therapists, social workers, and radiographers.

(3) "Board" means the Healthy Florida Board described in s. 638.61.

(4) "Care coordination" means services provided by a care coordinator under s. 638.637.

(5) "Care coordinator" means an individual or entity approved by the board to provide care coordination under s. 638.637.

(6) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the commissioner or other authorized provider, pursuant to general law.

(7) "Commissioner" means the commissioner of the Office of Insurance Regulation.

(8) "Committee" means the public advisory committee established pursuant to s. 638.612.

(9) "Essential community providers" means individuals or entities acting as safety net clinics, safety net health care providers, or rural hospitals.

(10) "Federally matched public health program" means the Florida Medicaid program under Title XIX of the Social Security Act, 42 U.S.C. ss. 1396 et seq., and Florida's Children's Health Insurance Program under Title XXI of the Social Security Act, 42 U.S.C. ss. 1397aa et seq.

(11) "Health care organization" means an entity that is approved by the board under s. 638.64 to provide health care services to members under the program.

(12) "Health care service" means any health care service, including care coordination, that is included as a benefit under the program.

(13) "Healthy Florida" or "program" means the Healthy Florida Program established under s. 638.601.

(14) "Implementation period" means the period under s.

638.611(6) during which the program is subject to special eligibility and financing provisions until it is fully implemented under that subsection.

(15) "Integrated health care delivery system" means a provider organization that meets all of the following criteria:

(a) Is fully integrated operationally and clinically to provide a broad range of health care services, including preventive care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services.

(b) Is compensated by Healthy Florida using capitation or facility budgets for the provision of health care services.

(16) "Long-term care" means long-term care, treatment, maintenance, or services not covered under this state's Children's Health Insurance Program, as appropriate, with the exception of short-term rehabilitation, and as defined by the board.

(17) "Medicaid" means a program that is one of the following:

(a) The Florida Medicaid program under Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq.

(b) Florida's Children's Health Insurance Program under Title XXI of the Social Security Act, 42 U.S.C. s. 1397aa et seq.

(18) "Medicare" means Title XVIII of the Social Security

Act, 42 U.S.C. ss. 1395 et seq., and the programs thereunder.

(19) "Out-of-state health care service" means a health care service provided in person to a member while the member is physically located out of this state and:

(a) It is medically necessary that the health care service be provided while the member physically is out of this state; or

(b) It is clinically appropriate and necessary, and cannot be provided in this state because the health care service can be provided only by a particular health care provider physically located out of this state. However, any health care service provided to a member by a health care provider qualified under s. 638.635 that is located outside this state is not an out-of-state health care service and is covered as otherwise provided in this chapter.

(20) "Participating provider" means any individual or entity that is a health care provider qualified under s. 638.635 that provides health care services to members under the program, or a health care organization.

(21) "Prescription drugs" means prescription drugs as defined under general law.

(22) "Resident" means an individual who has his or her principal place of domicile in this state, without regard to the individual's immigration status.

Section 6. Section 638.603, Florida Statutes, is created to read:

638.603 Preemption.—This chapter does not preempt any municipality, county, or other political subdivision of the state from adopting additional health care coverage for residents in that municipality, county, or other political subdivision that provides more protections and benefits to Florida residents than this chapter.

Section 7. Section 638.604, Florida Statutes, is created to read:

638.604 Conflicts.—To the extent any provision of general law is inconsistent with this chapter or the legislative intent of the Healthy Florida Act, this chapter applies and prevails, except when explicitly provided otherwise by this chapter.

Section 8. Part II of chapter 638, Florida Statutes, consisting of ss. 638.61-638.617, Florida Statutes, is created and entitled "Governance."

Section 9. Section 638.61, Florida Statutes, is created to read:

638.61 The Healthy Florida Board.—

(1) The Healthy Florida Board is established and must be an independent public entity not affiliated with an agency or department. The board shall be governed by an executive board consisting of nine members who are residents. Of the members of the board, four shall be appointed by the Governor, two shall be appointed by the President of the Senate, and two shall be appointed by the Speaker of the House of Representatives. The

commissioner or his or her designee shall serve as a voting ex officio member of the board.

(2) Members of the board, other than the ex officio member, shall be appointed for a term of 4 years. Appointments by the Governor are subject to confirmation by the Senate. A member of the board may continue to serve until the appointment and qualification of his or her successor. Vacancies shall be filled by appointment for the unexpired term. The board shall annually elect a chair.

(3)(a) Each person appointed to the board must have demonstrated and acknowledged expertise in health care.

(b) Appointing authorities must also consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise in the various aspects of health care.

(c) Appointments to the board by the Governor, the President of the Senate, and the Speaker of the House of Representatives must be composed of at least one representative from each of the following:

1. A labor organization representing registered nurses.

2. The general public.

3. A labor organization.

4. The medical provider community.

(4) Each member of the board has the responsibility and duty to meet the requirements of this chapter, the Affordable

Care Act, and all applicable state and federal laws and regulations, to serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through the program, and to ensure the operational well-being and fiscal solvency of the program.

(5) In making appointments to the board, the appointing authorities must take into consideration the cultural, ethnic, and geographical diversity of this state so that the board's composition reflects the communities of this state.

(6)(a) A member of the board or of the staff of the board may not be employed by, serve as a consultant to, be a member of the board of directors of, be affiliated with, or be otherwise a representative of, a health care provider, a health care facility, or a health clinic while serving on the board or on the staff of the board. A member of the board or of the staff of the board may not be a member, a board member, or an employee of a trade association of health facilities, health clinics, or health care providers while serving on the board or on the staff of the board. A member of the board or of the staff of the board may not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a health care practice.

(b) A board member must serve without additional compensation or honorarium, but may receive per diem and

reimbursement for travel expenses as provided in s. 112.061.

(c) For purposes of this subsection, "health care provider" means a means a physician licensed under chapter 458, chapter 459, or chapter 461.

(7) A member of the board may not make or participate in making a decision, or attempt to use his or her official position to influence the making of a decision, that he or she knows, or has reason to know, will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on either of the following:

(a) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status, aggregating $250 or more in value provided to, received by, or promised to the member within 12 months before the decision is made.

(b) Any business entity in which the member is a director, officer, partner, trustee, or employee or holds any position of management.

(8) There is no liability in a private capacity on the part of the board or a member of the board, or an officer or employee of the board, related to an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the

administration, management, or conduct under this chapter or affairs related to this chapter.

(9) The board must hire an executive director to organize, administer, and manage the operations of the board. The executive director serves at the pleasure of the board without civil service protection.

(10) The board may adopt rules to implement and administer this chapter.

Section 10. Section 638.611, Florida Statutes, is created to read:

638.611 Powers and duties of the board.—

(1) The board has all powers and duties necessary to establish and implement Healthy Florida. The program must provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents.

(2) The board must, to the maximum extent possible, organize, administer, and market the program and services as a single-payer program under the name "Healthy Florida," or any other name as the board determines, regardless of which general law or source the definition of a benefit is found, including, on a voluntary basis, retiree health benefits. In implementing this chapter, the board must avoid jeopardizing federal financial participation in the programs that are incorporated into Healthy Florida and must take care to promote public

understanding and awareness of available benefits and programs.

(3) The board must consider any matter to implement this chapter, and may have no executive, administrative, or appointive duties except as otherwise provided by general law.

(4) The board must employ necessary staff and authorize reasonable expenditures, as necessary, from the Healthy Florida Trust Fund to pay program expenses and to administer the program.

(5) The board may:

(a) Negotiate and enter into any necessary contracts, including, but not limited to, contracts with health care providers, integrated health care delivery systems, and care coordinators.

(b) Sue and be sued.

(c) Receive and accept gifts, grants, or donations of moneys from any agency of the Federal Government, any agency of this state, and any municipality, county, or other political subdivision of this state.

(d) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict-of-interest provisions adopted by the board by rule.

(e) Share information with relevant state departments, consistent with the confidentiality provisions in this chapter, necessary for the administration of the program.

(6) The board must determine when individuals may begin enrolling in the program. The implementation period begins on the date that individuals may begin enrolling in the program and ends on a date determined by the board.

(7) A carrier may not offer benefits or cover any services for which coverage is offered to individuals under the program, but may, if otherwise authorized, offer benefits to cover health care services that are not offered to individuals under the program. However, this chapter does not prohibit a carrier from offering either of the following:

(a) Any benefits to or for individuals, including their families, who are employed or self-employed in this state but who are not residents.

(b) Any benefits during the implementation period to individuals who enrolled or may enroll as members of the program.

(8) After the end of the implementation period, a person may not be a board member unless he or she is a member of the program, except the ex officio member.

(9) By July 1, 2021, the board must develop the following:

(a) A proposal, consistent with the principles of this chapter, for provision by the program of long-term care coverage, including the development of a proposal, consistent with the principles of this chapter, for its funding. In developing the proposal, the board must consult with an advisory

committee, appointed by the chair of the board, including representatives of consumers and potential consumers of long-term care, providers of long-term care, members of organized labor, and other interested parties.

(b) Proposals for all of the following:

1. Accommodating employer retiree health benefits for people who have been members of Healthy Florida but live as retirees out of this state.

2. Accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in this state before the implementation of Healthy Florida and live as retirees out of this state.

(c) A proposal for Healthy Florida coverage of health care services currently covered under the workers' compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.

Section 11. Section 638.612, Florida Statutes, is created to read:

638.612 Public advisory committee.—

(1) The commissioner must establish a public advisory committee to advise the board on all matters of policy for the program.

(2) The members of the committee must include all of the following:

(a) Four physicians, all of whom must be board certified in their fields, and at least one of whom must be a psychiatrist. The President of the Senate and the Governor shall each appoint one member. The Speaker of the House of Representatives shall appoint two members, both of whom must be primary care providers.

(b) Two registered nurses, appointed by the President of the Senate.

(c) One licensed allied health practitioner, appointed by the Speaker of the House of Representatives.

(d) One mental health care provider, appointed by the President of the Senate.

(e) One dentist, appointed by the Governor.

(f) One representative of private hospitals, appointed by the Governor.

(g) One representative of public hospitals, appointed by the Governor.

(h) One representative of an integrated health care delivery system, appointed by the Governor.

(i) Four consumers of health care. The Governor shall appoint two members, one of whom must be a member of the disabled community. The President of the Senate shall appoint one member who is 65 years of age or older. The Speaker of the House of Representatives shall appoint one member.

(j) One representative of labor organizations, appointed

by the Speaker of the House of Representatives.

(k) One representative of essential community providers, appointed by the President of the Senate.

(l) One representative of labor organizations, appointed by the President of the Senate.

(m) One representative of businesses that each employ fewer than 25 people, appointed by the Governor.

(n) One representative of businesses that each employ more than 250 people, appointed by the Speaker of the House of Representatives.

(o) One pharmacist, appointed by the Speaker of the House of Representatives.

(3) In making appointments pursuant to this section, the Governor, the President of the Senate, and the Speaker of the House of Representatives shall make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of this state.

(4) Each member appointed shall serve a 4-year term and may be reappointed for succeeding 4-year terms.

(5) Vacancies that occur must be filled within 30 days after the occurrence of the vacancy, and must be filled in the same manner in which the vacating member was initially selected or appointed. The commissioner must notify the appropriate appointing authority of any expected vacancies on the committee.

(6) Members of the committee must serve without compensation, but shall be reimbursed for travel expenses as provided in s. 112.061 for each full day of attending meetings of the committee. For purposes of this section, "full day of attending meetings" means being present at and participating in at least 75 percent of the total meeting time of the committee during any 24-hour period.

(7) The committee must meet at least six times annually in a place convenient to the public. All meetings of the committee are open to the public, pursuant to s. 286.011.

(8) The committee must elect a chair, who must serve for 2 years and who may be reelected for an additional 2 years.

(9) Appointed committee members must have worked in the field they represent on the committee for a period of at least 2 years before being appointed to the committee.

(10) A committee member or his or her assistant, clerk, or deputy may not use for personal benefit any information that is filed with, or obtained by, the committee and that is not generally available to the public.

Section 12. Section 638.613, Florida Statutes, is created to read:

638.613 Board's authority to contract.—The board may contract with not-for-profit organizations to provide any of the following:

(1) Assistance to consumers with respect to selection of a

care coordinator or health care organization, enrollment, obtaining health care services, disenrollment, and other matters relating to the program.

(2) Assistance to health care providers providing, seeking, or considering whether to provide health care services under the program, with respect to participating in a health care organization and interacting with a health care organization.

Section 13. Section 638.614, Florida Statutes, is created to read:

638.614 Funding for health planning agencies.—The board must provide grants from funds in the Healthy Florida Trust Fund or from funds otherwise appropriated for this purpose to health planning agencies to support the operation of those agencies.

Section 14. Section 638.615, Florida Statutes, is created to read:

638.615 Funding for job transition.—The board must provide funds from the Healthy Florida Trust Fund or funds otherwise appropriated for this purpose to the executive director of the Department of Economic Opportunity for a program for retraining and assisting job transition for individuals employed or previously employed in the fields of health insurance, health care service plans, and other third-party payments for health care, or those individuals providing services to health care providers to deal with third-party payers for health care, whose

jobs may be or have been ended as a result of the implementation of the program, consistent with otherwise applicable general law.

Section 15. Section 638.616, Florida Statutes, is created to read:

638.616 Collection of data.—

(1) The board must provide for the collection and availability of all of the following data to promote transparency, assess adherence to patient care standards, compare patient outcomes, and review the use of health care services paid for by the program:

(a) Inpatient discharge data, including acuity and risk of mortality.

(b) Emergency department and ambulatory surgery data, including charge data, length of stay, and patients' unit of observation.

(c) Hospital annual financial data, including all of the following:

1. Community benefits by hospital in dollar value.

2. Number of employees and classification by hospital unit.

3. Number of hours worked by hospital unit.

4. Employee wage information by job title and hospital unit.

5. Number of registered nurses per staffed bed by hospital

unit.

6. Type and value of healthy information technology.

7. Annual spending on health information technology, including purchases, upgrades, and maintenance.

(2) The board must make all disclosed data collected under subsection (1) publicly available and searchable through a website and through the Department of Health public data sets.

(3) The board must, directly and through grants to not-for-profit entities, conduct programs using data collected through the Healthy Florida Program to promote and protect public, environmental, and occupational health, including cooperation with other data collection and research programs of the Department of Health and the Office of Insurance Regulation, consistent with this chapter and otherwise applicable general law.

(4) Before full implementation of the program, the board must provide for the collection and availability of data on the number of patients served by hospitals and the dollar value of the care provided, at cost, for all of the following categories of Department of Health data items:

(a) Patients receiving charity care.

(b) Contractual adjustments of county and indigent programs, including traditional and managed care.

(c) Bad debts.

Section 16. Section 638.6161, Florida Statutes, is created

to read:

638.6161 Investigations and enforcement.—Notwithstanding any other law, law enforcement agencies may not use Healthy Florida moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the Federal Government or any federal agency based on religion, national origin, ethnicity, or immigration status.

Section 17. Part III of chapter 638, Florida Statutes, consisting of s. 638.62, Florida Statutes, is created and entitled "Eligibility and Enrollment."

Section 18. Section 638.62, Florida Statutes, is created to read:

638.62 Eligibility and enrollment.—

(1) Every resident may enroll as a member under the program.

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

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

(3) A college, university, or other institution of higher education in this state may purchase coverage under the program

for a student, or a student's dependent, who is not a resident.

Section 19. Part IV of chapter 638, Florida Statutes, consisting of s. 638.63, Florida Statutes, is created and entitled "Benefits."

Section 20. Section 638.63, Florida Statutes, is created to read:

638.63 Covered health care benefits.—

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

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

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

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

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

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

(e) Inpatient and outpatient rehabilitative care.

(f) Emergency care services.

(g) Emergency transportation.

(h) Necessary transportation for health care services for persons who have a disability or who may qualify as low income.

(i) Child and adult immunizations and preventive care.

(j) Health and wellness education.

(k) Hospice care.

(l) Care in a skilled nursing facility.

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

(n) Mental health services.

(o) Substance abuse treatment.

(p) Dental care.

(q) Vision care.

(r) Prescription drugs.

(s) Pediatric care.

(t) Prenatal and postnatal care.

(u) Podiatric care.

(v) Chiropractic care.

(w) Acupuncture.

(x) Therapies that are shown by the National Institutes of Health National Center for Complementary and Integrative Health to be safe and effective.

(y) Blood and blood products.

(z) Dialysis.

(aa) Adult day care.

(bb) Rehabilitative and habilitative services.

(cc) Ancillary health care or social services previously covered by county integrated health and human services programs, if any.

(dd) Ancillary health care or social services previously covered by a regional center for persons with developmental disabilities, if any.

(ee) Case management and care coordination.

(ff) Language interpretation and translation for health care services, including sign language and braille or other services needed for individuals with communication barriers.

(gg) Health care and long-term supportive services currently covered under Medicaid.

(hh) All health care services required to be covered under any of the following provisions, without regard to whether the member is eligible for or covered by the program or source referred to:

1. Medicaid.

2. Medicare.

3. Health care service plans pursuant to general law.

4. Health insurers, as defined under general law.

5. Any additional health care services authorized to be added to the program's benefits by the program.

6. All essential health benefits mandated by the Affordable Care Act as of January 1, 2017.

Section 21. Part V of chapter 638, Florida Statutes,

consisting of ss. 638.635-638.64, Florida Statutes, is created and entitled "Delivery of Care."

Section 22. Section 638.635, Florida Statutes, is created to read:

638.635 Health care providers.—

(1)(a) Any health care provider who is licensed to practice in this state and is otherwise in good standing may participate in the program if the health care provider's services are performed in this state.

(b) The board must establish and maintain procedures and standards for recognizing health care providers located out of this state for purposes of providing coverage under the program for members who require out-of-state health care services while the member is temporarily located out of this state.

(2) Any qualified health care provider may provide covered health care services under the program, as long as the health care provider is legally authorized to perform the health care service for the individual and under the circumstances involved.

(3) A member may choose to receive health care services under the program from any participating provider, consistent with this chapter, the willingness or availability of the provider, subject to this chapter relating to discrimination, and the appropriate clinically relevant circumstances.

(4) A person who chooses to enroll with an integrated health care delivery system, group medical practice, or

essential community provider that offers comprehensive services, must retain membership for at least 1 year after an initial 3-month evaluation period during which time the person may withdraw for any reason.

(a) The 3-month period must commence on the date when a member first sees a primary care provider.

(b) A person who wants to withdraw after the initial 3-month period must request a withdrawal pursuant to the dispute resolution procedures established by the board and may request assistance from the patient advocate, which is provided for in the dispute resolution procedures, in resolving the dispute. The dispute shall be resolved in a timely manner and may not have an adverse effect on the care a patient receives.

Section 23. Section 638.637, Florida Statutes, is created to read:

638.637 Care coordination.—

(1) Care coordination must be provided to the member by his or her care coordinator. A care coordinator may employ or use the services of other individuals or entities to assist in providing care coordination for the member, consistent with rules of the board and with general law and rules of the care coordinator's licensure.

(2) Care coordination includes administrative tracking and medical recordkeeping services for members, except as otherwise specified for integrated health care delivery systems.

(3) Care coordination administrative tracking and medical recordkeeping services for members may not be required to use a certified electronic health record, meet any other requirements of the federal Health Information Technology for Economic and Clinical Health Act, enacted under the federal American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, or meet certification requirements of the federal Centers for Medicare and Medicaid Services' Electronic Health Records Incentive Programs, including meaningful use requirements.

(4) The care coordinator must comply with all federal and state privacy laws, including, but not limited to, the federal Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. ss. 1320d et seq., and its implementing regulations.

(5) Referrals from a care coordinator are not required for a member to see any eligible provider.

(6) A care coordinator may be an individual or entity that is approved by the program that is any of the following:

(a) A health care practitioner that is any of the following:

1. The member's primary care provider.

2. The member's provider of primary gynecological care.

3. At the option of a member who has a chronic condition that requires specialty care, a specialist health care practitioner who regularly and continually provides treatment to the member for that condition.

(b) An entity that is a licensed:

1. Health facility.

2. Health care service plan.

3. Long-term health care facility or a program developed pursuant to s. 638.611(9)(a), or a long-term health care facility with respect to a member who receives mental health care services.

4. County medical facility.

5. Residential care facility for persons with chronic, life-threatening illness.

6. Alzheimer's day care resource center.

7. Residential care facility for the elderly.

8. Home health agency.

9. Private duty nursing agency.

10. Hospice.

11. Pediatric day health and respite care facility.

12. Home care service.

13. Mental health care provider.

(c) A health care organization.

(d) An authorized health and welfare fund, with respect to its members and their family members. This paragraph does not preclude an authorized health and welfare fund from becoming a care coordinator under paragraph (e) or a health care organization under s. 638.64.

(e) Any not-for-profit or governmental entity approved by

the program.

(7)(a) A health care provider may be reimbursed only for services if the member is enrolled with a care coordinator when the health care service is provided.

(b) Each member must be encouraged to enroll with a care coordinator that agrees to provide care coordination before receiving health care services paid for under the program. If a member receives health care services before choosing a care coordinator, the program must assist the member, when appropriate, with choosing a care coordinator.

(c) The member must remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. Members have the right to change their care coordinators on terms at least as permissive as Medicaid relating to an individual changing his or her primary care provider or managed care provider.

(8) A health care organization may establish rules relating to care coordination for members in the health care organization that are different from this section but otherwise consistent with this chapter and other applicable general laws.

(9) An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual's professional scope of practice or the entity's legal authority.

(10)(a) The board must develop and implement procedures

and standards, by rule, for an individual or entity to be approved as a care coordinator in the program, including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity:

1. Is incompetent to be a care coordinator;

2. Has exhibited a course of conduct that is inconsistent with program standards and rules, or that shows an unwillingness to meet those standards and rules; or

3. Is a potential threat to the public health or safety.

(b) The procedures and standards adopted by the board must be consistent with professional practice and licensure standards, and their implementing rules as applicable.

(c) In developing and implementing standards of approval of care coordinators for individuals receiving chronic mental health care services, the board must consult with the Department of Health.

(11) To maintain approval under the program, a care coordinator must do the following:

(a) Renew its status every 3 years pursuant to rules adopted by the board.

(b) Provide to the program any data required by the Department of Health pursuant to general law that enables the board to evaluate the impact of care coordinators on quality, outcomes, and cost of health care.

(12) This section does not authorize any individual to engage in any violation of general law.

Section 24. Section 638.639, Florida Statutes, is created to read:

638.639 Payment for health care services and care coordination.—

(1) The board must adopt rules regarding contracting for, and establishing payment methodologies for, covered health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. Different payment methodologies may be provided, including those established on a demonstration basis. All payment rates under the program must be reasonable and reasonably related to the cost of efficiently providing the health care service and ensuring an adequate and accessible supply of health care services.

(2) Health care services provided to members under the program, except for care coordination, must be paid for on a fee-for-service basis unless another payment methodology is established by the board.

(3) Notwithstanding subsection (2), integrated health care delivery systems, essential community providers, and group medical practices that provide comprehensive and coordinated services may choose to be reimbursed on the basis of a capitated-system operating budget or a noncapitated-system

operating budget that covers all costs of providing health care services.

(4) The program must engage in good faith negotiations with health care providers' representatives under part VIII of this chapter, including, but not limited to, in relation to rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies. Those negotiations must be through a single entity on behalf of the entire program for prescription and nonprescription drugs.

(5)(a) Payment for health care services established under this chapter are considered payment in full.

(b) A participating provider may not charge any rate in excess of the payment established under this chapter for any health care service provided to a member under the program and may not solicit or accept payment from any member or third party for any health care service, except as provided under a federal program.

(c) This section does not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

(6) The program may adopt, by rule, payment methodologies for the payment of capital-related expenses for specifically identified capital expenditures incurred by not-for-profit or governmental entities that are health facilities. Any capital-

related expense generated by a capital expenditure that requires prior approval must have received that approval in order to be paid by the program. That approval must be based on achievement of the program standards described in part VI of this chapter.

(7) Payment methodologies and payment rates must include a distinct component of reimbursement for direct and indirect graduate medical education.

(8) The board must adopt, by rule, payment methodologies and procedures for paying for health care services provided to a member while the member is located out of this state.

Section 25. Section 638.64, Florida Statutes, is created to read:

638.64 Health care organizations.—

(1) A member may enroll with and receive program care coordination and ancillary health care services from a health care organization.

(2) A health care organization must be a not-for-profit or governmental entity that is approved by the board and that is either of the following:

(a) A county integrated health and human services program.

(b) A regional center for persons with developmental disabilities.

(3)(a) The board must develop and implement procedures and standards, by rule, for an entity to be approved as a health care organization in the program, including, but not limited to,

procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the entity:

1. Is incompetent to be a health care organization;

2. Has exhibited a course of conduct that is inconsistent with program standards and rules, or that shows an unwillingness to meet those standards and rules; or

3. Is a potential threat to the public health or safety.

(b) The procedures and standards adopted by the board must be consistent with professional practice and licensure standards established pursuant to general law.

(c) In developing and implementing standards of approval of health care organizations, the board must consult with the Department of Health.

(4) To maintain approval under the program, a health care organization must do the following:

(a) Renew its status at a frequency determined by the board.

(b) Provide data to the Office of Insurance Regulation, as required by the board, to enable the board to evaluate the health care organization in relation to the quality of health care services, health care outcomes, and cost.

(5) The board may adopt narrowly focused rules relating solely to health care organizations for the sole and specific purpose of ensuring consistent compliance with this chapter.

(6) This chapter does not alter the professional practice of health care providers or their licensure standards established pursuant to general law.

(7) Health care organizations may not use health information technology or clinical practice guidelines that limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses may override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient's wishes.

Section 26. Part VI of chapter 638, Florida Statutes, consisting of s. 638.645, Florida Statutes, is created and entitled "Program Standards."

Section 27. Section 638.645, Florida Statutes, is created to read:

638.645 Program standards.—Healthy Florida must establish a single standard of safe therapeutic care for all residents by the following means:

(1) The board must establish requirements and standards, by rule, for the program and for health care organizations, care coordinators, and health care providers, consistent with this chapter and consistent with the applicable professional practice and licensure standards of health care providers and health care professionals established pursuant to general law:

(a) The scope, quality, and accessibility of health care services.

(b) Relations between health care organizations or health care providers and members.

(c) Relations between health care organizations and health care providers, including credentialing and participation in the health care organization, and terms, methods, and rates of payment.

(2) The board must establish requirements and standards, by rule, under the program that include, but are not limited to, provisions to promote the following:

(a) Simplification, transparency, uniformity, and fairness in health care provider credentialing and participation in health care organization networks, referrals, payment procedures and rates, claims processing, and approval of health care services, as applicable.

(b) In-person primary and preventive care, care coordination, efficient and effective health care services, quality assurance, and promotion of public, environmental, and occupational health.

(c) Elimination of health care disparities.

(d) Nondiscrimination with respect to members and health care providers on the basis of race, color, ancestry, national origin, religion, citizenship, immigration status, primary language, mental or physical disability, age, sex, gender,

sexual orientation, gender identity or expression, medical condition, genetic information, marital status, familial status, military or veteran status, or source of income; however, health care services provided under the program must be appropriate to the patient's clinically relevant circumstances.

(e) Accessibility of care coordination, health care organization services, and health care services, including accessibility for people with disabilities and people with limited ability to speak or understand English.

(f) Providing care coordination, health care organization services, and health care services in a culturally competent manner.

(3) The board must establish requirements and standards, to the extent authorized by federal law, by rule, for replacing and merging with the Healthy Florida Program health care services and ancillary services currently provided by other programs, including, but not limited to, Medicare, the Affordable Care Act, and federally matched public health programs.

(4) Any participating provider or care coordinator that is organized as a for-profit entity must meet the same requirements and standards as entities organized as not-for-profit entities, and payments under the program made to those entities may not be calculated to accommodate the generation of profit, revenue for dividends, or other return on investment or the payment of taxes

that would not be paid by a not-for-profit entity.

(5) Every participating provider must furnish information as required by the Department of Health pursuant to general law and permit examination of that information by the program as may be reasonably required for purposes of reviewing the accessibility and use of health care services, quality assurance, cost containment, making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental, and occupational health.

(6) In developing requirements and standards and making other policy determinations under this part, the board must consult with representatives of members, health care providers, care coordinators, health care organizations, labor organizations representing health care employees, and other interested parties.

Section 28. Part VII of chapter 638, Florida Statutes, consisting of ss. 638.65-638.657, Florida Statutes, is created and entitled "Funding."

Section 29. Section 638.65, Florida Statutes, is created to read:

638.65 Federal health programs and funding.—

(1) The board must seek all federal waivers and other federal approvals and arrangements and submit plan amendments as necessary to operate the program consistent with this chapter.

(2)(a) The board must apply to the United States Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the Affordable Care Act, and any other federal programs that provide federal funds, for payment for health care services that are necessary to enable all Healthy Florida members to receive all benefits under the program, to enable this state to implement this chapter, and to allow this state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, into the State Treasury to the credit of the Healthy Florida Trust Fund, created pursuant to s. 638.655, and to use those funds for the program and other provisions under this chapter.

(b) To the fullest extent possible, the board must negotiate arrangements with the Federal Government to make sure that federal payments are paid to Healthy Florida in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs.

(c) The board may require members or applicants to provide information necessary for the program to comply with any waiver or arrangement under this chapter. Information provided by members to the board for the purposes of this subsection may not be used for any other purpose.

(d) The board may take any additional actions necessary to effectively implement Healthy Florida to the maximum extent possible as a single-payer program consistent with this chapter.

(3) The board may take actions consistent with this section to enable the program to administer Medicare in this state, and the program must be a provider of supplemental insurance coverage, Medicare Part B, and must provide premium assistance drug coverage under Medicare Part D for eligible members of the program.

(4) The board may waive or modify the applicability of this section relating to any federally matched public health program or Medicare to implement any waiver or arrangement under this section or to maximize the federal benefits to the program under this section, if the board, in consultation with the Department of Financial Services, determines that the waiver or modification is in the best interest of this state and members affected by the action.

(5) The board may apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare. Enrollment in a federally matched public health program or Medicare may not cause any member to lose any health care service provided by the program or diminish any right of the member.

(6)(a) Notwithstanding any other law, the board, by rule, must increase the income eligibility level, increase or

eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program, and for any program in order to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(b) The board may act under this subsection, upon a finding approved by the Department of Financial Services and the board that the action does the following:

1. Will help to increase the number of members who are eligible for and enrolled in federally matched public health programs or for any program to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

2. Will not diminish an individual's access to any health care service or right of the individual.

3. Is in the interest of the program.

4. Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

(c) Actions under this subsection do not apply to eligibility for payment for long-term care.

(7) To enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare, the board may require that each member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

(8) As a condition of continued eligibility for health care services under the program, a member who is eligible for benefits under Medicare must enroll in Medicare, including Parts A, B, and D.

(9) The program must provide premium assistance for all members enrolling in a Medicare Part D drug coverage plan under Section 1860D of Title XVIII of the Social Security Act, 42 U.S.C. ss. 1395w-101 et seq., limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

(10) If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under Section 1860D-14 of Title XVIII of the Social Security Act, 42

U.S.C. s. 1395w-114, the member must provide, and authorize the program to obtain, any information or documentation required to establish the member's eligibility for that subsidy. However, the board must attempt to obtain as much of the information and documentation as possible from records that are available to it.

(11) The program must make a reasonable effort to notify members of their obligations under this section. After a reasonable effort has been made to contact the member, the member must be notified in writing that he or she has 60 days to provide the required information. If the required information is not provided within the 60-day period, the member's coverage under the program may be terminated. Information provided by members to the board for the purposes of this section may not be used for any other purpose.

(12) The board must assume responsibility for all benefits and services paid for by the Federal Government with those funds.

Section 30. Section 638.657, Florida Statutes, is created to read:

638.657 Legislative intent.—

(1) It is the intent of the Legislature to enact legislation that develops a revenue plan, taking into consideration anticipated federal revenue available for the program. In developing the revenue plan, it is the intent of the Legislature to consult with appropriate officials and

stakeholders.

(2) It is the intent of the Legislature to enact legislation that requires all state revenues from the program to be deposited into an account within the Healthy Florida Trust Fund to be established and known as the Healthy Florida Trust Fund Account.

Section 31. Part VIII of chapter 638, Florida Statutes, consisting of ss. 638.66-638.668, Florida Statutes, is created and entitled "Collective Bargaining."

Section 32. Section 638.66, Florida Statutes, is created to read:

638.66 Definitions.—For purposes of this part, the term:

(1)(a) "Health care provider" means a person who is licensed, certified, registered, or authorized to practice a health care profession and who is any of the following:

1. An individual who practices that profession as a health care provider or as an independent contractor.

2. An owner, officer, shareholder, or proprietor of a health care provider.

3. An entity that employs or uses health care providers to provide health care services, including, but not limited to, a licensed health facility.

(b) A health care provider who practices as an employee of a health care provider is not a health care provider for purposes of this part.

(2) "Health care providers' representative" means a third party that is authorized by health care providers to negotiate on their behalf with Healthy Florida over terms and conditions affecting those health care providers.

Section 33. Section 638.662, Florida Statutes, is created to read:

638.662 Collective bargaining authorized.—

(1) Health care providers may meet and communicate for the purpose of collectively negotiating with Healthy Florida on any matter relating to Healthy Florida, including, but not limited to, rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies.

(2) This part does not authorize an alteration of the terms of the internal and external review procedures set forth in general law.

(3) This part does not authorize a strike of Healthy Florida by health care providers related to the collective bargaining negotiations.

(4) This part does not authorize terms or conditions that impede the ability of Healthy Florida to obtain or retain accreditation by the National Committee for Quality Assurance or a similar body, or to comply with applicable state or federal law.

Section 34. Section 638.664, Florida Statutes, is created

to read:

638.664 Collective bargaining requirements.—

(1) Collective bargaining rights granted by this part must meet all of the following requirements:

(a) Health care providers may communicate with other health care providers regarding the terms and conditions to be negotiated with Healthy Florida.

(b) Health care providers may communicate with health care providers' representatives.

(c) A health care providers' representative is the only party authorized to negotiate with Healthy Florida on behalf of the health care providers as a group.

(d) A health care provider may be bound by the terms and conditions negotiated by the health care providers' representatives.

(e) In communicating or negotiating with the health care providers' representative, Healthy Florida may offer and provide different terms and conditions to individual competing health care providers.

(2) This part does not affect or limit the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a general law, rule, or regulation.

(3) This part does not affect or limit collective action or collective bargaining on the part of a health care provider

with his or her employer or any other lawful collective action or collective bargaining.

Section 35. Section 638.666, Florida Statutes, is created to read:

638.666 Collective bargaining.—Before engaging in collective bargaining with Healthy Florida on behalf of health care providers, a health care providers' representative must file with the board, in the manner prescribed by the board, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this part.

Section 36. Section 638.668, Florida Statutes, is created to read:

638.668 Prohibited collective action.—

(1) This part does not authorize competing health care providers to act in concert in response to health care providers' representative's discussions or negotiations with Healthy Florida, except as authorized by other general law.

(2) A health care providers' representative may not negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

Section 37. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity does not affect other provisions or applications that can be given effect without the invalid provision or application.

Section 38. This act shall take effect July 1, 2019.