A bill to be entitled

An act relating to medical debt protection and comprehensive health care for residents; providing a short title; creating s. 381.4011, F.S.; providing a short title; providing purpose; providing construction; providing definitions; requiring large health care facilities to develop written financial assistance policies; providing requirements for such policies; providing procedures for determining eligibility for financial assistance; providing eligibility criteria; providing publication and notice requirements relating to financial assistance policies; providing requirements for translations for notices relating to such policies; providing billing and collections rules and prohibitions; providing requirements for price information; providing liability for medical debt; providing requirements for itemized bills; prohibiting information relating to medical debt from being included in consumer reports, communicated with and reported to consumer reporting agencies, and used for certain decisions; prohibiting medical creditors and medical debt collectors from engaging in certain acts during health insurance appeals; limiting interest on medical debt under certain circumstances; providing applicability;

requiring written copies of payment plans under certain circumstances; providing requirements before payment plans may be declared terminated; requiring receipts of payment; providing violations; providing private remedies for patients; prohibiting waivers of patients' rights; providing for enforcement and complaint process; providing reporting requirements; requiring the Office of the Attorney General to post certain information in a database and publish an annual consolidated report; providing severability; creating part IV of ch. 641, F.S., entitled the "Florida Health Plan"; creating s. 641.71, F.S.; providing a short title; creating s. 641.72, F.S.; creating the Florida Health Plan; providing purpose of the plan; creating s. 641.73, F.S.; providing definitions; creating s. 641.74, F.S.; providing eligibility for and coverage of the plan; authorizing the Florida Health Board to establish financial arrangements with other states and foreign countries under certain circumstances; providing duties of the board relating to plan enrollment; providing enrollment requirements; creating s. 641.755, F.S.; authorizing plan enrollees to choose certain health care providers; providing covered health care benefits; authorizing the board to expand health care

benefits under certain circumstances; providing health care services that are excluded from the plan; requiring enrollees to have primary care providers and access to care coordination; authorizing enrollees to see health care specialists without referral; authorizing the board to establish a computerized registry; authorizing the plan to assist enrollees in choosing primary care providers; prohibiting cost-sharing requirements from being imposed on enrollees; creating s. 641.77, F.S.; requiring the board to secure repeals and waivers of certain provisions of federal law; requiring the Department of Health and the Agency for Health Care Administration to provide assistance to the board; requiring the board to adopt rules under certain circumstances; providing that the plan's responsibility for providing health care is secondary to existing federal programs under certain circumstances; creating s. 641.78, F.S.; defining the term "collateral source"; requiring the plan to collect health care costs from collateral sources under certain circumstances; requiring the board to negotiate waivers, seek federal legislation, and make arrangements to incorporate collateral sources into the plan; requiring plan enrollees to notify health care providers of collateral sources and health care

providers to forward such information to the board; authorizing the board to take appropriate actions to recover reimbursement from collateral sources; requiring collateral sources to pay for health care services under certain circumstances; providing specified authority and rights to the board relating to collateral sources; providing construction; creating s. 641.791, F.S.; providing that defaults, underpayments, and late payments of certain obligations shall result in remedies and penalties; prohibiting eligibility for health care benefits from being impaired by such defaults, underpayments, and late payments; creating s. 641.792, F.S.; providing eligibility of health care providers for the plan; prohibiting patient care from being affected by fee schedules and financial incentives; providing requirements for the payment system for noninstitutional providers; providing requirements for the annual budgets for institutional providers; prohibiting noninstitutional and institutional providers that accept payments from the plan from billing patients; providing requirements for capital expenditures by noninstitutional and institutional providers which exceed a specified amount; requiring the board to establish payment criteria and payment

methods for care coordination; creating s. 641.793, F.S.; establishing the Florida Health Board by a specified date; providing purpose of the board; providing board membership, terms, and compensation; providing duties of the board; providing reporting requirements; creating s. 641.794, F.S.; requiring the Secretary of Health Care Administration to designate health planning regions; providing considerations for such designations; providing requirements for regional planning boards; providing board membership, terms, and first meetings with the Florida Health Board; providing duties of the board; creating s. 641.795, F.S.; establishing the Office of Health Quality and Planning; providing purpose and duties of the office; authorizing the Florida Health Board to convene advisory panels under certain circumstances; creating s. 641.796, F.S.; creating the Ombudsman Office for Patient Advocacy; providing purpose of the office; providing appointment and qualifications of the ombudsman; providing duties and authority of the ombudsman; providing requirements for the office budget; creating s. 641.797, F.S.; creating the position of auditor for the plan; providing purpose, appointment, and duties of the auditor; creating s. 641.798, F.S.; providing applicability of the Code of

Ethics for Public Officers and Employees; providing disciplinary actions for failure to comply with the code of ethics; prohibiting certain persons from engaging in specified acts or from being employed by specified entities; creating the Conflict-of-Interest Committee; providing duties of the committee; creating s. 641.799, F.S.; providing that the plan policies and procedures are exempt from the Administrative Procedure Act; providing procedures and requirements for adoption of certain rules on plan policies and procedures; requiring specified persons to regularly update the Legislature on certain information; providing a timeline for the operation of the plan; prohibiting certain health insurance policies and contracts from being sold in this state on and after a specified date; requiring an analysis of specified capital expenditure needs; providing reporting requirements; providing a contingent effective date.

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

Section 1. This act may be cited as the "Healthy Florida Act."

Section 2. Section 381.4011, Florida Statutes, is created to read:

381.4011 Financial assistance for patients of large health care facilities.—

(1) SHORT TITLE.—This section may be cited as the "Medical Debt Protection Act."

(2) PURPOSE.—The purpose of this section is to reduce burdensome medical debt and to protect patients in their dealings with medical creditors, medical debt buyers, and medical debt collectors with respect to such debt. This section shall be construed as a consumer protection statute and shall be liberally and remedially construed to carry out its purposes.

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

(a) "Consumer" means a natural person.

(b) "Consumer reporting agency" means a person or entity that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(c) "External review" means a review of an adverse benefit determination, including, but not limited to, a final internal adverse benefit determination, conducted pursuant to an applicable state external review process, a federal external review process as described in 42 U.S.C. s. 300gg-19, a review pursuant to 29 U.S.C. s. 1133, a Medicare appeals process, a Medicaid appeals process, or another applicable appeals process.

(d) "Extraordinary collection action" means any of the following:

1. Selling a consumer's debt to another party, except if, before the sale, the medical creditor has entered into a legally binding written agreement with the medical debt buyer of the debt pursuant to which:

a. The medical debt buyer or medical debt collector is prohibited from engaging in any prohibited collection actions listed in subsection (8) to obtain payment for the care;

b. The medical debt buyer may not charge interest on the debt in excess of that described in subsection (14);

c. The debt is returnable to or recallable by the medical creditor upon a determination by the medical creditor or medical debt buyer that the consumer is eligible for financial assistance; and

d. If the consumer is determined to be eligible for financial assistance and the debt is not returned to or recalled by the medical creditor, the medical debt buyer is required to adhere to the procedures specified in the agreement that ensures that the consumer does not pay, and has no obligation to pay, the medical debt buyer and the medical creditor together more than the consumer is personally responsible for paying in compliance with this section.

2. Filing a debt collection lawsuit.

3. Any prohibited collection action.

(e) "Financial assistance policy" means a written financial assistance policy that includes:

1. Eligibility criteria for financial assistance, including when such assistance covers free or discounted care.

2. The basis for calculating amounts charged to patients.

3. The method for applying for financial assistance.

4. The billing and collections policy containing the actions the covered health care provider may take in the event of nonpayment, including collections action.

5. Measures to widely publicize the policy within the community to be served by the covered health care provider.

(f) "Gross charges" means a covered health care provider's full, established price for health care services that the covered health care provider charges uninsured patients before applying any contractual allowances, discounts, or deductions. Such price may be referred to elsewhere as standard charges, as provided in 42 U.S.C.A. s. 300gg-18, or chargemaster rates.

(g) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, dental, behavioral, substance use disorder, or mental health condition, illness, injury, or disease. These services include, but are not limited to, any procedures, products, devices, or medications.

(h) "Household income" or "income" means income calculated by using the methods used to calculate Medicaid eligibility, as

set forth at 42 C.F.R. s. 435.603, or a comparable method designated by the Department of Children and Families.

(i) "Internal review" or "internal appeal" means review by a health insurance plan or other insurer of an adverse benefit determination.

(j) "Large health care facility" means any the following entities:

1. A hospital licensed under chapter 395, whether a nonprofit entity subject to 26 U.S.C. s. 501(c)(3); a hospital owned by a county, a municipality, or this state; or a for-profit entity that provides health care services.

2. An outpatient clinic or facility affiliated with a hospital, as described in subparagraph 1., or operating under the license of a hospital, as described in subparagraph 1.

3. An ambulatory surgical center licensed under chapter 395.

4. A practice that provides outpatient medical, behavioral, optical, radiology, laboratory, dental, or other health care services with revenues of at least $20,000,000 annually, and that is licensed or permitted under chapter 395, chapter 408, chapter 483, chapter 484, chapter 466, or any other chapter that licenses or permits health care facilities.

5. A licensed health care professional who provides health care services in one or more of the settings listed in subparagraphs 1.-4., but bills patients independently.

(k) "Medical creditor" means an entity that provides health care services and to which the patient owes money for health care services, or an entity that provided health care services and to which the patient previously owed money if the medical debt has been purchased by one or more debt buyers.

(l) "Medical debt" means an obligation or alleged obligation of a patient to pay any amount related to the receipt of health care services, products, or devices. The term does not include debt charged to a credit card or other extension of credit unless the credit card or extension of credit is offered specifically for the payment of health care services, products, or devices.

(m) "Medical debt buyer" means a person or entity that is engaged in the business of purchasing medical debts for collection purposes, whether the person or entity collects the debt or hires a third party for collection or an attorney at law for litigation in order to collect such debt.

(n) "Medical debt collector" means a person or entity that regularly collects or attempts to collect, directly or indirectly, medical debts originally owed or due or asserted to be owed or due another. The term includes a medical debt buyer for all purposes.

(o) "Patient" means the person who received health care services. The term includes a parent if the patient is a minor, or a legal guardian if the patient is an adult under

guardianship.

(p) "Patient income" means the household income of the patient's family.

(q) "Prohibited collection actions" means any of the following activities when used by a medical creditor or medical debt collector to collect debts owed for health care services:

1. Causing or threatening to cause a consumer's arrest.

2. Causing or threatening to cause a consumer to be subject to a capias or similar warrant.

3. Obtaining or threatening to obtain a lien on a consumer's real property.

4. Foreclosing or threatening to foreclose on a consumer's real property.

5. Garnishing or threatening to garnish wages or state income tax refunds.

6. Using state or federal tax offsets to seize tax refunds or tax credits.

7. Attaching, seizing, or threatening to attach or seize a consumer's bank account.

8. Furnishing or threatening to furnish information about the medical debt to a consumer reporting agency.

(4) FINANCIAL ASSISTANCE POLICY FOR LARGE HEALTH CARE FACILITIES.—

(a)1. A large health care facility must develop a written financial assistance policy that complies with this section and

any implementing regulations.

2. The requirement under subparagraph 1. applies whether or not the large health care facility is required to develop a financial assistance policy under 26 U.S.C. s. 501(r)-(4) and implementing regulations.

(b) The financial assistance policy required under subparagraph (a)1. must, at a minimum, contain the following:

1. A written explanation of the financial assistance that is available for emergency and other medically necessary health care services offered by a covered health care provider.

2. A summary, in plain language, of the financial assistance policy which does not exceed two pages in length.

3. The eligibility criteria for financial assistance and a summary of the type of assistance that is available as set forth in this section.

4. The method and application process that patients are to use to apply for financial assistance.

5. The information and documentation the large health care facility may require patients to provide as part of the application.

6. The reasonable steps that a health care provider will take to determine whether a patient is eligible for financial assistance.

7. The billing and collections policy, including the actions that may be taken in the event of nonpayment, which must

comply with all applicable provisions of this section and other applicable municipal, county, state, or federal laws.

(c) The financial assistance policy must be approved by the owners or governing body of a health care provider. The financial assistance policy shall be reviewed and approved on an annual basis by the owners or governing board.

(d) The financial assistance policy must apply to all patients who are financially eligible based on income as provided in subsection (5). Patients may not be denied financial assistance on the basis of residency, health insurance coverage status, citizenship or immigration status, or assets or prospective assets.

(5) IMPLEMENTATION OF THE FINANCIAL ASSISTANCE POLICY.—

(a) In addition to any other actions required by applicable municipal, county, state, or federal law, a large health care facility must screen all patients for eligibility for financial assistance by taking all of the following steps before seeking payment for any emergency or medically necessary health care services:

1. Determine whether the patient has health insurance. If the patient is uninsured, offer to screen the patient for public or private insurance eligibility and offer assistance if the patient chooses to apply for public or private insurance. A patient's refusal to be screened is not grounds for denying financial assistance.

2. Offer to screen the patient for other public programs that may assist with health care costs. However, a patient's refusal to be screened is not grounds for denying financial assistance.

3. If the patient submits an application for financial assistance, determine the patient's eligibility for the financial assistance plan within 14 days after the patient applies for financial assistance, suspending any billing or collections actions while eligibility is being determined.

(b) The following patients qualify for financial assistance under the financial assistance plan, which applies to any charges for health care services that are not covered by insurance and would otherwise be billed to the patient:

1. Patients with household incomes at or below 300 percent of the federal poverty level shall receive free care.

2. Patients with household incomes above 300 percent, up to and including 400 percent, of the federal poverty level shall be charged no more than the amount calculated in the following manner:

a. The patient's bill shall be recalculated using the Medicare reimbursement rate applicable on the date of service; and

b. The patient shall be charged no more than 25 percent of the recalculated bill under sub-subparagraph a.

3. Patients with household incomes above 400 percent, up

to and including 600 percent, of the federal poverty level shall receive the same discounts as patients with household incomes above 300 percent, up to and including 400 percent, of the federal poverty level if the patient and the patient's household have incurred medical expenses from the current large health care facility's bill and all other medical bills for medically necessary health care services received during the previous 12 months which, in total, exceed 5 percent of the household's annual gross income.

4. In addition to other financial assistance provided under this section, patients with household incomes at or below 400 percent of the federal poverty level may not be required to pay more than $2,300 per year in cumulative medical bills to large health care facilities. Upon patient request and documentation, any health care services that have been delivered by one or more large health care facilities after the $2,300 limit has been met must be provided as free care.

(c)1. Household income shall be established by the most recent tax return, unless the patient chooses to submit pay stubs, documentation of public assistance, or documentation of household income that the Department of Children and Families has identified as a valid form of documentation for the purposes of this section. Additional documentation other than proof of income may not be required.

2. If a large health care facility uses a consumer report,

as defined in s. 603(d) of the Fair Credit Reporting Act, 15 U.S.C. s. 1681a(d), or any score or rating based on consumer report information, the facility must obtain the consumer's consent for such use and must comply with all applicable provisions of this section.

3. A large health care facility may grant financial assistance notwithstanding a patient's failure to provide one of the required forms of documentation described in the financial assistance policy or application form and may rely on, but not require, other evidence of eligibility. Proof that the patient receives a means-tested benefit from the federal, state, or local government is sufficient to establish eligibility for financial assistance without additional documentation of income.

4. A large health care facility must screen, under paragraph (a), a patient for presumptive eligibility for financial assistance as set forth in paragraph (b). The rules and process for screening a patient for presumptive eligibility for financial assistance must require a large health care facility to inform any patient who is deemed presumptively eligible for financial assistance that the large health care facility has reduced or eliminated the patient's medical bill, specify if any amount is currently outstanding, and explain how to apply for additional financial assistance for any remaining balance.

5. If a large health care provider chooses to use credit

reports or scores or similar screening tools when determining eligibility for financial assistance, the large health care provider may:

a. Use such tools only to make a positive eligibility determination, and not to deny financial assistance to any patient; and

b. Obtain credit reports or scores and use the reports or scores only for screening if the patient consents by signing a stand-alone document granting permission for the credit check, which shall be effective for no more than 30 days.

(d) If a large health care facility receives an application for financial assistance from a patient, the facility shall notify the patient in writing within 14 days as to whether the facility has approved or denied the application. The large health care facility shall provide a copy of any recalculated bill and calculation of financial assistance provided to the patient.

(e) A large health care facility shall accept and consider a patient's application for financial assistance when the application is submitted within 1 year after the date of the first bill for the provision of the health care services. However, if the patient is the subject of collection activity by the facility or a medical debt collector, including a lawsuit to collect a medical debt, and submits an application for financial assistance, the large health care facility shall accept and

process the application at any time. If the patient submits a financial assistance application to a medical debt collector, the medical debt collector shall forward the application to the large health care facility within 2 business days, and shall cease collection activity until notified by the large health care facility of the outcome of the application and any debt forgiven or new repayment terms.

(f) A large health care facility and medical debt collector may not charge any interest or late fees to patients who qualify for financial assistance.

(g) A large health care facility and medical debt collector shall offer to any patient who qualifies for financial assistance a payment plan of not less than 24 months, and may not require the patient to make monthly payments that exceed 5 percent of the household's gross monthly income. Prepayment penalties, early payment penalties, or fees are prohibited.

(h) For a patient who has been found to be eligible for financial assistance, the initial payment on a monthly payment plan may not be due within the first 90 days after the health care services are provided.

(6) FINANCIAL ASSISTANCE POLICY; PUBLIC EDUCATION AND INFORMATION.—

(a) A large health care facility must do all of the following to publicize its financial assistance policy:

1. Make the financial assistance policy and the financial

assistance application form easily accessible online, through the large health care facility's website and through any patient portal or other online communication portal used by patients of the health care provider.

2. In addition to any other requirements in this section, make paper copies of the financial assistance policy and the application form available upon request and without charge, both by mail and in the large health care facility's office. For hospitals, copies should be available, at a minimum, in the emergency room, if there is an emergency room, and admissions areas.

3. Notify and inform members of the community served by the large health care facility about the financial assistance policy in a manner reasonably calculated to reach those members who are most likely to require financial assistance with such efforts commensurate to the size and income of the facility.

4. Notify and inform patients who receive care from the large health care facility about the financial assistance policy by doing all of the following:

a. Offer a paper copy of the financial assistance policy to a patient as part of the patient's first visit or, in the case of a hospital facility, during the intake and discharge process.

b. Include a conspicuous written notice on all billing statements, whether sent by the large health care facility or a

medical debt collector, which notifies and informs patients about the availability of financial assistance and includes the telephone number of the large health care facility's office or department that can provide information about the financial assistance policy and application process and the direct website address where copies of the financial assistance policy and application form may be obtained.

c. Place conspicuous public displays, or other measures reasonably calculated to attract patients' attention, which notify and inform patients about the financial assistance policy in public locations in the large health care facility's office. For hospitals, displays should be posted in the emergency room, if there is an emergency room and admissions areas, at a minimum.

(b) In all attempts, whether written or oral, by a medical creditor or medical debt collector to collect a medical debt for health care services provided by a large health care facility, the medical creditor or medical debt collector must inform the patient of any financial assistance policy available through the large health care facility.

(7) FINANCIAL ASSISTANCE POLICIES; LANGUAGE ACCESS.—

(a) A financial assistance policy must include a notice that states the following or substantially similar language: "This document contains important information about financial assistance for your bill. Contact [insert name and telephone

number of large health care facility] for translation assistance." The statement must be translated in the 10 languages most frequently spoken by limited English proficient households in the large health care facility's service area, as determined by the United States Census Bureau data.

(b) A large health care facility must accommodate all significant populations that have limited English proficiency by translating the financial assistance policy and application form into the primary languages spoken by such populations. A large health care facility satisfies this translation requirement if it makes available translations of its financial assistance policy and application form in the language spoken by each limited English proficiency language group that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the large health care facility or the population likely to be affected or encountered by the large health care facility. A large health care facility may determine the percentage or number of limited English proficiency individuals in the large health care facility's community or likely to be affected or encountered by the large health care facility using any reasonable method.

(c) A large health care facility must accommodate any patient with limited English proficiency who is part of a population that falls below the numerical thresholds established in paragraph (b) by providing oral interpretation services to

the patient upon request and at no cost to the patient to explain the financial assistance policy and the application form.

(d) A large health care facility must accommodate any patient with limited English proficiency in answering questions from the patient regarding the financial assistance policy, the application form, any written determination of eligibility, and any other communication regarding financial assistance from the large health care facility. A large health care facility may accommodate these patients by providing oral interpretation services to the patient upon request and at no cost to the patient.

(8) BILLING AND COLLECTIONS RULES, LIMITS ON CREDITORS.—

(a) A medical creditor or medical debt collector may not engage in prohibited collection actions to collect medical debts owed for health care services.

(b) A medical creditor or medical debt collector may not engage in any extraordinary collection actions until 180 days after the first bill for a medical debt has been sent.

(c) At least 30 days before taking any permissible extraordinary collection actions, a medical creditor or medical debt collector must provide to the patient a notice that:

1. In the case of large health care facilities and medical debt collectors collecting debt for health care services provided by such facilities, states that financial assistance is

available for eligible patients and providing a summary, in plain language, of the financial assistance policy.

2. Identifies the extraordinary collection actions that will be initiated in order to obtain payment.

3. Provides a deadline after which such extraordinary collection actions will be initiated, which date is no earlier than 30 days after the date of the notice.

(d) A medical debt collector collecting debt for health care services provided by such a large health care facility may not engage in extraordinary collection actions during a declared state or federal emergency or a public health emergency.

(e) A large health care facility or a medical debt collector collecting debt for health care services provided by such a facility may not use any extraordinary collection actions unless these actions are described in the large health care facility's billing and collections policy.

(f) If a large health care facility or a medical debt collector collecting debt for health care services provided by such a facility bills or initiates collection activities and the patient is later found eligible for financial assistance, the large health care facility or medical debt collector shall reverse any permissible extraordinary collection actions or any collection activity that were previously permissible and have since become prohibited, including, but not limited to:

1. Deleting any negative reports to consumer reporting

agencies.

2. Dismissing or vacating any collection lawsuits over the medical debt.

3. Removing any wage garnishment orders or state tax refund interception requests.

(g) If the patient has paid any part of the medical debt or any of the patient's funds has been seized or levied in excess of the amount that the patient owes after application of financial assistance, the large health care facility or medical debt collector shall refund any excess amount to the patient.

(9) PRICE INFORMATION.—A large health care facility must post price information on its website. The price information must be accessible through a link from the website's homepage and, at a minimum, must include the following:

(a) A list of gross charges for all health care services.

(b) A list of the amount that Medicare would reimburse for the health care service, next to the relevant gross charge.

(c) The titles or descriptions of health care services, in plain language that can be understood by an average person.

(10) LIABILITY FOR MEDICAL DEBT.—

(a) Parents and legal guardians are jointly liable for any medical debt incurred by children under the age of 18.

(b) A spouse or person may not be held personally liable for the medical debt or nursing home debt of any other person age 18 or older, or other damages related to the collection of

the patient's bill.

(c) Any admission agreement must comply with applicable federal and state laws, including the Nursing Home Reform Law, 42 U.S.C. s. 1395i-3.

(11) VERIFICATION UPON WRITTEN OR ORAL REQUEST.—A medical creditor or medical debt collector shall provide an itemized bill to the patient within 60 days after a request. The itemized bill must state:

(a) The name and address of the medical creditor.

(b) The date of service.

(c) The date the medical debt was incurred, if different from the date of service.

(d) A detailed list of the specific health care services provided to the patient.

(e) A list of all health care professionals who treated the patient.

(f) The amount of principal for any medical debt incurred.

(g) Any adjustment to the bill, such as negotiated insurance rates or other discounts.

(h) The amount of any payments received, whether from the patient or any other party.

(i) Any interest or fees.

(j) Whether the patient was screened for financial assistance.

(k) Whether the patient was found eligible for financial

assistance and, if so, the amount due after all financial assistance has been applied to the itemized bill.

(12) MEDICAL DEBT AND CONSUMER REPORTING AGENCIES.—

(a) A consumer reporting agency may not make a consumer report containing an item of information that the consumer reporting agency knows or should know concerns medical debt.

(b) A person may not communicate with or report any information to any consumer reporting agency regarding a medical debt.

(c) A person who uses a consumer report may not use a medical debt listed on the report as a negative factor when making a credit, employment, or housing decision.

(d) A medical creditor shall include a provision in any contract entered into with a medical debt collect or for the purchase or collection of medical debt which prohibits the reporting of any portion of such medical debt to a consumer reporting agency.

(13) PROHIBITION AGAINST COLLECTION OF MEDICAL DEBT DURING HEALTH INSURANCE APPEALS.—

(a) A medical creditor or medical debt collector that knows or should have known about an internal review, external review, or other internal appeal of a health insurance decision that is pending or was pending within the previous 180 days may not:

1. Communicate with the patient regarding the unpaid

charges for health care services for the purpose of seeking to collect the charges; or

2. Initiate a lawsuit or arbitration proceeding against the patient relating to unpaid charges for health care services.

(b) A medical creditor that knows or should have known about an internal review, external review, or other internal appeal of a health insurance decision that is pending or was pending within the previous 180 days may not refer, place, or send the unpaid charges for health care services to a medical debt collector, including by selling the debt to a medical debt buyer.

(14) INTEREST ON MEDICAL DEBT.—

(a) Unless a patient is eligible for financial assistance under paragraph (5)(b), and notwithstanding any agreement to the contrary, interest on medical debt may not exceed 2 percent per annum. Patients eligible for financial assistance may not be charged any interest or late fees.

(b) The rate of interest provided in paragraph (a) also applies to any judgments on medical debt, notwithstanding any agreement to the contrary.

(15) MEDICAL DEBT PAYMENT PLANS.—

(a) A medical creditor or medical debt collector that agrees to a payment plan for a medical debt shall provide a written copy of the payment plan to the patient within 5 business days after entering into the payment plan. This plan

must prominently disclose the rate of any interest being applied to the debt in compliance with subsection (14), and the date by which the account will be paid off in full, assuming the payments set by the schedule are made without interruption.

(b) A consumer need not make a payment on the payment plan until the written copy has been provided.

(c)1. A medical debt payment plan may be accelerated or declared in default or terminated due to nonpayment only after the patient fails to make scheduled payments on the payment plan for at least 3 consecutive months.

2. Before declaring the payment plan terminated, the medical creditor or medical debt collector must do all of the following:

a. Make at least three reasonable attempts to contact the patient by telephone or by other method preferred by the patient.

b. Provide a written notice informing the patient that the payment plan may be terminated and that the patient has the opportunity to renegotiate the payment plan.

c. Attempt to renegotiate the terms of the defaulted payment plan, if requested by the patient.

3. The medical creditor or medical debt collector may not commence a civil action against the patient or responsible party for nonpayment until at least 90 days after the payment plan is declared to be terminated. For purposes of this section, the

notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

(16) RECEIPTS FOR PAYMENTS.—Within 10 business days after receipt of a payment on a medical debt, a medical creditor or medical debt collector, or any agents thereof, receiving the payment shall furnish a receipt to the person that made the payment. The receipt must show all of the following:

(a) The date of the provision of the health care service.

(b) The amount paid.

(c) The date payment was received.

(d) The account's balance before the most recent payment.

(e) The new balance after application of the payment.

(f) The interest rate and interest accrued since the patient's last payment.

(g) The patient's account number.

(h) The name of the current owner of the debt and, if different, the name of the medical creditor.

(i) Whether the payment is accepted as payment in full of the debt.

(17) DEBT FORGIVEN BY MEDICAL CREDITOR.—Forgiveness of any part of an insured patient's copayment, coinsurance, deductible, facility fees, out-of-network charges, or other cost sharing is not a breach of contract or other violation of an agreement between the medical creditor and the insurer or payor.

(18) PRIVATE REMEDY.—

(a) Collection activity against a patient who the large health care facility, medical creditor, or medical debt collector knew or should have known was, or should have been, eligible for financial assistance is an unfair or deceptive trade practice in violation of part II of chapter 501. Any other violation of this section by a medical creditor or medical debt collector is also an unfair or deceptive trade practice in violation of part II of chapter 501.

(b) A patient may sue for injunctive or other appropriate equitable relief to enforce this section.

(c) The remedies provided in this section are not intended to be the exclusive remedies available to a patient, and the patient is not required to exhaust any administrative remedies provided under this section or any other applicable law.

(d) A financial assistance policy or agreement between a patient and a large health care provider or medical debt collector may not contain a provision that, before a dispute arises, waives or has the practical effect of waiving the rights of the patient to resolve that dispute by obtaining:

1. Injunctive, declaratory, or other equitable relief;

2. Multiple or minimum damages as specified by law;

3. Attorney fees and costs as specified by law; or

4. A hearing at which a party can present evidence in person.

(e) Any provision in a financial assistance policy or

other written agreement violating paragraph (d) is void and unenforceable. A court may refuse to enforce other provisions of the financial assistance policy or other written agreement as equity may require.

(19) PROHIBITION OF WAIVER OF RIGHTS.—Any waiver by a patient of any protection provided by or any right of the patient or other person under this section is void and may not be enforced by any court or any other person. A large health care facility may not circumvent the responsibilities and protections of this section by requiring prepayment for medical care.

(20) ENFORCEMENT.—

(a) The Office of the Attorney General may enforce this section and may adopt any regulation or rules necessary or appropriate to carry out the purpose of this section, to provide for the protection of patients, and to assist market participants in interpreting this section.

(b) The Office of the Attorney General shall establish a complaint process whereby an aggrieved consumer or any member of the public may file a complaint against a medical creditor or medical debt collector who violates any provision of this section. All complaints shall be considered public records.

(21) ANNUAL REPORTS AND DATABASE.—

(a) On or before July 1 of each year, beginning July 1, 2028, each large health care provider shall file its financial

assistance policy and an annual report with the Legislature and the Office of the Attorney General pursuant to procedures that the Office of the Attorney General shall establish.

(b) The Office of the Attorney General shall post each report and financial assistance policy in a searchable database accessible on the Internet.

(c) The Office of the Attorney General shall prepare an annual consolidated report and shall make it available to the public. The report must include the following information for the time period of July 1 of the prior year to July of that year:

1. The total number of patients who applied for financial assistance.

2. The total number of patients who received financial assistance.

3. The total number of patients who were denied financial assistance.

4. Deidentified demographic information for patients who received financial assistance, including zip code, race, language, gender, and disability status, to the extent that such data is available from the large health care facility.

5. The total amount of financial assistance provided to patients.

6. The types of collection practices used.

7. The amounts of money collected with each of these

collection practices, in dollars and by percentage of the large health care facility's annual revenue.

(22) SEVERABILITY.—If any provision of this section or its application to any person or circumstance is held invalid, that provision or its application is severable and does not affect the validity of the other provisions or applications of this section.

Section 3. Part IV of chapter 641, Florida Statutes, consisting of ss. 641.71-641.799, Florida Statutes, is created and entitled the "Florida Health Plan."

Section 4. Section 641.71, Florida Statutes, is created to read:

641.71 Short title.—This part may be cited as the "Florida Health Plan."

Section 5. Section 641.72, Florida Statutes, is created to read:

641.72 Purpose.—There is created the Florida Health Plan. The purpose of the Florida Health Plan is to keep residents of this state healthy and to provide the best quality of health care by:

(1) Ensuring that all residents of this state, regardless of immigration status, are covered.

(2) Covering all necessary care, including dental; vision; hearing; mental health; reproductive care, including abortion services and prenatal and postpartum care; gender-affirming

health care, including medication and treatment; substance use disorder treatment; prescription drugs; durable medical equipment and supplies; and long-term care and home care, including long-term services and supports in home and community-based settings.

(3) Allowing patients to choose their health care providers.

(4) Reducing costs by negotiating fair prices and cutting administrative bureaucracy, through measures such as a global budget approach to institutional providers, and not by restricting or denying care.

(5) Being affordable to all patients through financing based on a patient's ability to pay and the elimination of premiums, copayments, deductibles, and out-of-pocket expenses at the point of service.

(6) Focusing on preventive care and early intervention to improve health.

(7) Ensuring that there are enough health care providers to guarantee timely access to care.

(8) Continuing this state's leadership in medical education, research, and technology.

(9) Providing adequate and timely payments to health care providers.

(10) Using a simple funding and payment system.

(11) Providing a just transition for a displaced workforce

affected by changes.

Section 6. Section 641.73, Florida Statutes, is created to read:

641.73 Definitions.—As used in this part, the term:

(1) "Board" means the Florida Health Board established in s. 641.793.

(2) "Institutional provider" means an inpatient hospital, nursing facility, rehabilitation facility, or any other health care facility that provides overnight care.

(3) "Medically necessary" means comprehensive services or supplies needed to promote health and to prevent, diagnose, or treat a particular patient's medical condition. The comprehensive services and supplies must meet accepted standards of medical practice within a health care provider's professional peer group.

(4) "Noninstitutional provider" means an individual provider, group practice, clinic, outpatient surgical center, imaging center, or any other health care facility that does not provide overnight care.

(5) "Plan" means the Florida Health Plan created in s. 641.72.

(6) "Resident of this state" means an individual who has had a principal place of domicile in this state for more than 6 consecutive months, who has registered to vote in this state, who has made a statement of domicile pursuant to s. 222.17, or

who has filed for homestead tax exemption on property in this state.

Section 7. Section 641.74, Florida Statutes, is created to read:

641.74 Eligibility for and enrollment in the Florida Health Plan.—

(1) ELIGIBILITY.—

(a) All residents of this state, regardless of immigration status, are eligible for the Florida Health Plan.

(b) Coverage for emergency care for a resident of this state which is obtained out of state must be at prevailing local rates where the care is provided. Coverage for nonemergency care obtained out of state must be according to rates and conditions established by the Florida Health Board. The board may require that a resident of this state be transported back to this state when prolonged treatment of an emergency condition is necessary and when that transport will not adversely affect the patient's care or condition.

(c) A nonresident visiting this state shall be billed by the board for all services received under the plan. The board may enter into intergovernmental arrangements or contracts with other states and foreign countries to provide reciprocal coverage for temporary visitors.

(d) The board shall extend eligibility to nonresidents employed in this state under a premium schedule set by the

board.

(e) For a business outside of this state which employs residents of this state, the board shall apply for a federal waiver to collect the employer contribution mandated by federal law.

(f) A retiree who is covered under the plan and who elects to reside outside of this state is eligible for benefits under the terms and conditions of the retiree's employer-employee contract.

(g) The board may establish financial arrangements with other states and foreign countries in order to facilitate meeting the terms of the contracts described in paragraph (f). Payments for care provided by non-Florida health care providers to retirees who are covered under the plan shall be reimbursed at rates established by the board. Health care providers who accept any payment from the plan for a covered service may not bill the patient for the covered service.

(h)1. A person is presumed eligible for coverage under the plan, and a health care provider shall provide health care services as if the person is eligible for coverage under the plan, if the person:

a. Is a minor;

b. Arrives at a health care facility unconscious, comatose, or otherwise unable to document eligibility or to act on the person's own behalf because of the person's physical or

mental condition; or

c. Is involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds which provides for involuntary commitment.

2. All health care facilities subject to state and federal provisions governing emergency medical treatment must comply with subparagraph 1.

(2) ENROLLMENT.—The board shall establish a procedure to enroll residents of this state and provide each with identification that may be used by health care providers to confirm eligibility for services. The application for enrollment may not be more than two pages.

Section 8. Section 641.755, Florida Statutes, is created to read:

641.755 Benefits.—

(1) A person covered under the Florida Health Plan may choose to receive services from any qualified, licensed health care provider that participates in the plan.

(2) Except for the exclusions provided in subsection (4), covered health care benefits under the plan include all prescribed medically necessary care, which includes:

(a) Inpatient and outpatient health care facility services.

(b) Inpatient and outpatient licensed health care provider services.

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

(d) Durable medical equipment, appliances, and assistive technology, including, but not limited to, prescribed prosthetics, eye care, and hearing aids and their repair, technical support, and customization required for individual use.

(e) Inpatient and outpatient rehabilitative care.

(f) Emergency care services.

(g) Necessary transportation for health care services:

1. As covered under Medicaid or Medicare; or

2. For persons with disabilities, older persons with functional limitations, and low-income persons.

(h) Child and adult immunizations and preventive care.

(i) Health and wellness education for chronic or preventative care as provided by licensed health care providers.

(j) Reproductive health care, including abortion services, contraceptives, and prenatal and postpartum care.

(k) Childbirth and maternity care, including doula services and care in freestanding childbirth centers.

(l) Gender-affirming health care, including medication and treatment.

(m) Holistic licensed health care services such as chiropractic, acupressure, acupuncture, massage, and nutritional services.

(n) Mental health services, including substance use disorder treatment, services in substance use disorder treatment facilities, and mental health care provided by licensed or certified mental health providers such as licensed psychologists, licensed mental health counselors, licensed professional counselors, licensed clinical social workers, certified master social workers, rehabilitation support service providers, and any providers that the board deems eligible.

(o) Dental care, including diagnostics and restoration and durable equipment such as braces and mouthguards.

(p) Vision care.

(q) Hearing care.

(r) Prescription drugs.

(s) Podiatric care.

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

(u) Blood and blood products.

(v) Dialysis.

(w) Licensed qualified adult day care.

(x) Rehabilitative and habilitative services.

(y) Ancillary health care or social services previously covered by this state's qualified public health programs.

(z) Case management and care coordination.

(aa) Language interpretation and translation for health

care services, including sign language and Braille or other services needed for persons with communication barriers.

(bb) Services provided by qualified community health workers.

(cc) Health care and long-term supportive services, including in a home or community-based setting, assisted living facility, and nursing home, with home health care providers, home health aides, and palliative and hospice care.

(dd) Any item or service described in this subsection which is furnished using telehealth, to the extent practicable.

(3) The Florida Health Board may expand health care benefits beyond the minimum benefits described in subsection (2) if the expansion meets the intent of this part and when there are sufficient funds to cover the expansion.

(4) The following health care services are excluded from coverage by the plan:

(a) Treatments and procedures primarily for cosmetic purposes, unless required to correct a congenital defect or to restore or correct a part of the body that has been altered as a result of an injury, a disease, or a surgery or unless determined to be medically necessary by a qualified, licensed health care provider in the plan.

(b) Services of a health care provider or facility that is not licensed, certified, or accredited by this state. The licensure, certification, or accreditation requirements do not

apply to health care providers or facilities that provide services to residents of this state who require medical attention while traveling out of state.

(5)(a) All plan enrollees must have a primary care provider and must have access to care coordination.

(b) A plan enrollee does not need a referral to see a health care specialist.

(c) The board may establish a computerized registry to assist enrollees in identifying appropriate providers, and the plan may assist an enrollee with choosing a primary care provider if the enrollee so chooses.

(6) The plan may not impose a deductible, copayment, coinsurance, or any other cost-sharing requirement on an enrollee with respect to a covered benefit.

Section 9. Section 641.77, Florida Statutes, is created to read:

641.77 Federal preemption.—

(1) The Florida Health Board shall secure a repeal or a waiver of any provision of federal law that preempts any provision of this part. The Department of Health and the Agency for Health Care Administration shall provide all necessary assistance to the board to secure any repeal or waiver.

(2)(a) The board shall, under the state innovation waivers under s. 1332 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, request to repeal or

waive any of the following provisions to the extent necessary to implement this part:

1. Title 42 of the United States Code, ss. 18021-18024.

2. Title 42 of the United States Code, ss. 18031-18033.

3. Title 42 of the United States Code, s. 18071.

4. Section 5000A of the Internal Revenue Code of 1986, as amended.

(b) If a repeal or a waiver of a federal law or regulation cannot be secured, the board shall adopt rules, or seek conforming state legislation, consistent with federal law, in an effort to best fulfill the purposes of this part.

(c) The Florida Health Plan's responsibility for providing health care is secondary to existing federal programs for health care services to the extent that funding for these programs is not transferred or that the transfer is delayed beyond the date on which initial benefits are provided under the plan.

Section 10. Section 641.78, Florida Statutes, is created to read:

641.78 Subrogation.—

(1)(a) As used in this section, the term "collateral source" includes:

1. A health insurance policy, health maintenance contract, continuing care contract, and prepaid health clinic contract, and the medical components of motor vehicle insurance, homeowner's insurance, and other forms of insurance.

2. The medical components of worker's compensation.

3. A pension plan and retiree health care benefits.

4. An employer plan.

5. An employee benefit contract.

6. A government benefit program.

7. A judgment for damages for personal injury.

8. The state of last domicile for individuals moving to Florida for medical care who have extraordinary medical needs.

9. Any third party who is or may be liable to an individual for health care services or costs.

(b) The term does not include:

1. A contract or plan that is subject to federal preemption.

2. Any governmental unit, agency, or service to the extent that subrogation is prohibited by law.

(2) When other payers for health care have been terminated, the plan shall collect health care costs from a collateral source if health care services provided to a patient are, or may be, covered services under the collateral source available to the patient, or if the patient has a right of action for compensation permitted under law.

(3) The board shall negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources into the plan.

(4) If a person who receives health care services under

the plan is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, the person must notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information. The health care provider shall forward this information to the board. The person entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source must provide additional information as requested by the board.

(a) The plan shall seek reimbursement from the collateral source for services provided to the person and may take appropriate action, including legal proceedings, to recover the reimbursement. Upon demand, the collateral source shall pay the sum that it would have paid or spent on behalf of the person for the health care services provided by the plan.

(b) In addition to any other right to recovery provided in this section, the board has the same right to recover the reasonable value of health care benefits from the collateral source.

(c) If the collateral source is exempt from subrogation or the obligation to reimburse the plan, the board may require that the person who is entitled to health care services from the collateral source first seek those services from the collateral source before seeking the services from the plan.

(5) To the extent permitted by federal law, the board has

the same right of subrogation over contractual retiree health care benefits provided by employers as other contracts allowing the plan to recover the cost of health care services provided to a person covered by the retiree health care benefits, unless arrangements are made to transfer the revenues of the health care benefits directly to the plan.

(6) A collateral source is not excluded from the obligations imposed by this section by virtue of a contract or relationship with a governmental unit, agency, or service.

Section 11. Section 641.791, Florida Statutes, is created to read:

641.791 Defaults, underpayments, and late payments.—

(1) Defaults, underpayments, or late payments of any premium or other obligation imposed by this part shall result in the remedies and penalties provided by law, except as provided in this part.

(2) Eligibility for health care benefits may not be impaired by any default, underpayment, or late payment of any premium or other obligation imposed by this part.

Section 12. Section 641.792, Florida Statutes, is created to read:

641.792 Provider payments.—

(1) All health care providers licensed to practice in this state may participate in the Florida Health Plan. The Florida Health Board may determine the eligibility of any other health

care providers to participate in the plan.

(a) A participating health care provider shall comply with all federal laws and regulations governing referral fees and fee splitting, including, but not limited to, 42 U.S.C. ss. 1320a-7b and 1395nn, whether reimbursed by federal funds or not.

(b) A fee schedule or financial incentive may not adversely affect the care a patient receives or the care a health provider recommends.

(2) The board shall establish and oversee a fair and efficient payment system for noninstitutional providers.

(a) The board shall pay noninstitutional providers based on rates negotiated with noninstitutional providers. The rates must take into account the need to address the shortage of noninstitutional providers.

(b) Noninstitutional providers that accept any payment from the plan for a covered health care service may not bill the patient for the covered health care service.

(c) Noninstitutional providers shall be paid within 30 business days for claims filed following procedures established by the board.

(3) The board shall set an annual budget for each institutional provider, which consists of an operating and a capital budget, to cover the institutional provider's anticipated health care services for the following year based on past performance and projected changes in prices and health care

service levels.

(a) The annual budget for each individual institutional provider must be set separately. The board may not set a joint budget for a group of more than one institutional provider nor for a parent corporation that owns or operates one or more institutional providers.

(b) Institutional providers that accept any payment from the plan for a covered health care service may not bill the patient for the covered health care service.

(4)(a) The board shall periodically develop a capital investment plan that will serve as a guide in determining the annual budgets of institutional providers and in deciding whether to approve applications for approval of capital expenditures by noninstitutional providers.

(b) Institutional and noninstitutional providers that propose to make capital purchases in excess of $500,000 must obtain board approval. The board may alter the threshold expenditure level that triggers the requirement to submit information on capital expenditures. Institutional providers must propose these expenditures and submit the required information as part of the annual budget they submit to the board. Noninstitutional providers must apply to the board for approval of these expenditures. The board must respond to capital expenditure applications in a timely manner.

(5) The board shall establish payment criteria and payment

methods for care coordination for patients, especially those with chronic illness and complex medical needs.

Section 13. Section 641.793, Florida Statutes, is created to read:

641.793 Florida Health Board.—

(1) By December 1, 2026, the Florida Health Board shall be established to promote the delivery of high-quality, coordinated health care services that enhance health; prevent illness, disease, and disability; slow the progression of chronic diseases; and improve personal health management. The board shall administer the Florida Health Plan. The board shall oversee the Office of Health Quality and Planning established in s. 641.795.

(2)(a) The board shall consist of at least 15 members, including the representatives selected by the regional planning boards established in s. 641.794. These representatives shall appoint the following additional members to serve on the board:

1. One patient member and one employer member.

2. Seven representatives of labor organizations who represent health care workers or social workers.

3. Five health care providers consisting of one physician, one registered nurse, one mental health provider, one dentist, and one health care facility director.

(b) Each member shall take the oath of office to uphold the Constitution of the United States and the Constitution of

the State of Florida and to operate the plan in the public interest by upholding the underlying principles of this part.

(c) Board members shall serve 4 years; however, for the purpose of providing staggered terms, of the initial appointments, those members appointed by the representatives of regional planning boards shall serve 2-year terms.

(d) The board shall set a board member's compensation, not to exceed the salary paid under state law to a commissioner on the Florida Public Service Commission. The board shall select the chair from among its membership.

(e)1. A board member may be removed by a two-thirds vote of the members voting on removal. After receiving notice and hearing, a member may be removed for malfeasance or nonfeasance in performance of the member's duties.

2. Conviction of any criminal behavior, regardless of how much time has lapsed, is grounds for immediate removal.

(3) The board shall:

(a) Ensure that all of the requirements of the plan are met.

(b) Hire a chief executive officer for the plan, who must take the oath described in paragraph (2)(b).

(c) Hire a director for the Office of Health Quality and Planning, who must take the oath described in paragraph (2)(b).

(d) Provide technical assistance to the regional planning boards.

(e) Conduct investigations and inquiries and require the submission of information, documents, and records that the board considers necessary to carry out the purposes of this part.

(f) Establish a process for the board to receive concerns, opinions, ideas, and recommendations of the public regarding all aspects of the plan and the means of addressing those concerns.

(g) Conduct activities the board considers necessary to carry out the purposes of this part.

(h) Collaborate with the Department of Health and with the Agency for Health Care Administration to ensure that each health care facility performance is monitored and deficient practices are recognized and corrected in a timely manner.

(i) Establish conflict-of-interest standards that prohibit health care providers from receiving financial benefit from their medical decisions outside of board reimbursement, including any financial benefit for referring a patient for a service, product, or health care provider or for prescribing, ordering, or recommending a drug, product, or service.

(j) Establish conflict-of-interest standards related to pharmaceuticals and medical equipment, supplies, and devices, and their marketing to a health care provider, so that the health care provider does not receive any incentive to prescribe, administer, or use a product or service.

(k) Require all electronic health records used by health care providers to be fully interoperable with the open source

electronic health records system used by the United States Department of Veterans Affairs.

(l) Provide financial help and assistance in retraining and job placement to workers in this state who may be displaced because of the administrative efficiencies of the plan.

(m) Ensure that assistance is provided to all workers and communities that may be affected by provisions in this part.

(n) Work with the Department of Commerce to ensure that funding and program services are promptly and efficiently provided to all affected workers. The Department of Commerce shall monitor and report on a regular basis on the status of displaced workers.

(o) Adopt rules, policies, and procedures as necessary to carry out the duties assigned under this part.

(4) Before submitting a state innovation waivers application under s. 1332 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the board must do all of the following, as required by federal law:

(a) Conduct, or contract for, any actuarial analyses and actuarial certifications necessary to support the board's estimates that the waiver will comply with the comprehensive coverage, affordability, and scope of coverage requirements in federal law.

(b) Conduct or contract for any necessary economic analyses needed to support the board's estimates that the waiver

will comply with the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements in federal law. These analyses must include:

1. A detailed 10-year budget plan.

2. A detailed analysis regarding the estimated impact of the waiver on health insurance coverage in this state.

(c) Establish a detailed draft implementation timeline for the waiver plan.

(d) Establish quarterly, annual, and cumulative targets for the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements in federal law.

(5) The board has the following financial duties:

(a) Approve statewide and regional budgets.

(b) Negotiate and establish payment rates for health care providers through their professional associations.

(c) Monitor compliance with all budgets and payment rates and take action to achieve compliance to the extent authorized by law.

(d) Pay claims for medical products or services as negotiated and, if deemed necessary, issue requests for proposals from nonprofit business corporations in this state for a contract to process claims.

(e) Seek federal approval to bill another state for health care coverage provided to a patient from out of state who comes to this state for long-term care or other costly treatment when

the patient's home state fails to provide such coverage, unless a reciprocal agreement with the patient's home state to provide similar coverage to residents of this state relocating to that state can be negotiated.

(f) Implement fraud prevention measures necessary to protect the operation of the plan.

(g) Work to ensure appropriate cost control by:

1. Instituting aggressive public health measures, early intervention and preventive care, health and wellness education, and promotion of personal health improvement.

2. Making changes in the delivery of health care services and administration that improve efficiency and care quality.

3. Minimizing administrative costs.

4. Ensuring that the delivery system does not contain excess capacity.

5. Negotiating the lowest possible prices for prescription drugs, medical equipment, and health care services.

(6) The board has the following management duties:

(a) Develop and implement enrollment procedures for the plan.

(b) Implement and review eligibility standards for the plan.

(c) Arrange for health care services to be provided at convenient locations to serve communities in need in the same manner as federally qualified health centers, including ensuring

the availability of school nurses so that all students have access to health care, immunizations, and preventive care at public schools and encouraging health care providers to provide services at easily accessible locations.

(d) Make recommendations, when needed, to the Legislature about changes in the geographic boundaries of the health planning regions.

(e) Establish an electronic claim and payment system for the plan.

(f) Monitor the operation of the plan through consumer surveys and regular data collection and evaluation activities, including evaluations of the adequacy and quality of services provided under the plan, the need for changes in the benefit package, the cost of each type of service, and the effectiveness of cost control measures under the plan.

(g) Disseminate information and establish a health care website to provide information to the public about the plan, including health care providers and facilities, and state and regional planning board meetings and activities.

(h) Collaborate with public health agencies, schools, and community clinics.

(i) Ensure that plan policies and health care providers, including public health care providers, support all residents of this state in achieving and maintaining maximum physical and mental health.

(7) The board, in conjunction with the office and administrative staff of the plan's chief executive officer, has the following policy duties:

(a) Develop and implement cost control and quality assurance procedures.

(b) Ensure strong public health services, including education and community prevention and clinical services.

(c) Ensure a continuum of coordinated high-quality primary to tertiary care to all residents of this state.

(d) Implement policies to ensure that all residents of this state receive culturally and linguistically competent care.

(8) The board shall determine the feasibility of self-insuring health care providers for malpractice and shall establish a self-insurance system and create a special fund for payment of losses incurred if the board determines self-insuring health care providers would reduce costs.

(9) By July 1 of each year, the board shall report to the President of the Senate, the Speaker of the House of Representatives, and ranking members of the committees having cognizance over health care issues on:

(a) The performance of the plan.

(b) The fiscal condition and need for payment adjustment.

(c) Any needed changes in geographic boundaries of the health planning regions.

(d) Any recommendations for statutory changes.

(e) Receipts of revenues from all sources.

(f) Whether current year goals and priorities are met.

(g) Future goals and priorities.

(h) Major new technology and prescription drugs.

(i) Other circumstances that may affect the cost or quality of health care.

Section 14. Section 641.794, Florida Statutes, is created to read:

641.794 Health planning regions.—

(1) By August 1, 2026, the Secretary of Health Care Administration shall designate health planning regions within this state which are composed of geographically contiguous areas grouped on the basis of the following considerations:

(a) Patterns of use of health care services.

(b) Health care resources, including workforce resources.

(c) Health care needs of the population, including public health needs.

(d) Geography.

(e) Population and demographic characteristics.

(f) Other considerations the board deems appropriate.

(2) Each health planning region is administered by a regional planning board. A minimum of eight regional planning boards shall be created, and all regional planning boards shall be created by October 1, 2026.

(a) Each regional planning board shall consist of:

1. One county commissioner per county, selected by the county commission for each health planning region consisting of at least five counties; or

2. Three county commissioners per county, selected by the county commission for each health planning region consisting of four counties or less.

(b) A county commission may designate a representative to act as a member of the regional planning board in the member's absence.

(c) Each regional planning board shall select the chair from among its membership.

(d) Regional planning board members shall serve for 4-year terms; however, for the purpose of providing staggered terms, of the initial appointments, at least half of the board members shall be appointed to 2-year terms. Board members may receive per diem for meetings.

(e) The Secretary of Health Care Administration, or his or her designee, shall convene the first meeting of each regional planning board with the Florida Health Board within 30 days after the regional planning board is established.

(3) A regional planning board's duties shall consist of:

(a) Recommending health standards, goals, priorities, and guidelines for the health planning region.

(b) Preparing an operating and capital budget for the health planning region to recommend to the Florida Health Board.

(c) Collaborating with local public health care agencies to:

1. Educate consumers and health care providers on public health programs, goals, and the means of reaching those goals.

2. Implement public health and wellness initiatives.

(d) Hiring a regional health planning director.

(e) Ensuring that all parts of the health planning region have access to a 24-hour nurse hotline and to 24-hour urgent care clinics.

Section 15. Section 641.795, Florida Statutes, is created to read:

641.795 Office of Health Quality and Planning.—The Florida Health Board shall establish the Office of Health Quality and Planning to assess the quality, access, and funding adequacy of the Florida Health Plan. The Office of Health Quality and Planning shall:

(1) Make annual recommendations to the board on the overall direction of the plan on the following subjects:

(a) Overall effectiveness of the plan in addressing public health and wellness.

(b) Access to health care.

(c) Quality improvement.

(d) Efficiency of administration.

(e) Adequacy of the budget and funding.

(f) Appropriateness of payments to health care providers.

(g) Capital expenditure needs.

(h) Long-term health care.

(i) Mental health and substance abuse services.

(j) Staffing levels and working conditions in health care facilities.

(k) Identification of the number and mix of health care facilities and providers necessary to meet the needs of the plan.

(l) Care for chronically ill patients.

(m) Health care provider training on promoting the use of advance directives with patients to enable patients to obtain the health care of their choice.

(n) Research needs.

(o) Integration of disease management programs into health care delivery.

(2) Analyze shortages in the health care workforce that is required to meet the needs of the population and develop plans to meet those needs in collaboration with regional planners and educational institutions.

(3) Analyze methods of paying health care providers and make recommendations to improve the quality of health care services and to control costs.

(4) Assist in coordination of the plan and public health programs.

(5) Assess and evaluate health care benefits by:

(a) Considering health care benefit additions to the plan and evaluating the additions based on evidence of clinical efficacy.

(b) Establishing a process and criteria by which health care providers may request authorization to provide health care services and treatments that are not included in the plan benefit set, such as experimental health care treatments.

(c) Evaluating proposals to increase the efficiency and effectiveness of the health delivery system, and making recommendations to the board based on the cost-effectiveness of the proposals.

(d) Identifying complementary and alternative health care modalities that have been shown to be safe and effective.

(6) The board may convene advisory panels as needed to assess the quality, access, and funding adequacy of the plan.

Section 16. Section 641.796, Florida Statutes, is created to read:

641.796 Ombudsman Office for Patient Advocacy.—

(1) The Ombudsman Office for Patient Advocacy is created to represent the interests of consumers of health care and to help residents of this state secure the health care services and health care benefits to which they are entitled under this part. The Ombudsman Office for Patient Advocacy shall also advocate on behalf of enrollees of the Florida Health Plan.

(2) The Ombudsman Office for Patient Advocacy shall be

headed by the ombudsman, who shall be appointed by the Secretary of Health Care Administration. The ombudsman shall serve in the unclassified service and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be knowledgeable about and have experience in health care services and administration. A person may not serve as ombudsman while holding another public office.

(a) The ombudsman may gather information about decisions and acts of the Florida Health Board and about any matters related to the board, health care providers, and health care programs.

(b) The ombudsman shall:

1. Ensure that patient advocacy services are available to all residents of this state.

2. Establish and maintain the grievance system according to subsection (3).

3. Receive, evaluate, and respond to consumer complaints about the plan.

4. Establish a process to receive recommendations from the public about ways to improve the plan.

5. Develop educational and informational guides that describe consumer rights and responsibilities.

6. Ensure that the guides described in subparagraph 5. are widely available to consumers and available in health care provider offices and facilities.

7. Prepare an annual report about the consumer's perspective on the performance of the plan, including recommendations for needed improvements.

(3) The ombudsman shall establish a grievance system for complaints. The system must provide a process that ensures adequate consideration of plan enrollee grievances and appropriate remedies.

(a) The ombudsman may refer any complaint that does not pertain to compliance with this part to the federal Centers for Medicare and Medicaid Services or any other appropriate local, state, and federal government entity for investigation and resolution.

(b) A health care provider or an employee of a health care provider may join with, or otherwise assist, a complainant in submitting a complaint to the ombudsman. A health care provider or an employee of a health care provider who, in good faith, joins with or assists a complainant in submitting a complaint is subject to protections and remedies under this part or under general law.

(c) In reviewing a complaint, the ombudsman may require a health care provider or the board to submit any information the ombudsman deems necessary.

(d)1. The ombudsman shall send a written notice of the final disposition of the complaint and the reasons for the decision to:

a. The complainant;

b. Any health care provider or employee of a health care provider who joins with or assists the complainant in submitting the complaint; and

c. The board,

within 30 calendar days after receipt of the complaint, unless the ombudsman determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance.

2. The ombudsman's order of corrective action is binding on the plan. A decision of the ombudsman is subject to de novo review by the district court.

(4) The budget for the Ombudsman Office for Patient Advocacy shall be determined by the Legislature and shall be independent from the board.

(5) The ombudsman shall establish offices to provide convenient access to residents of this state.

Section 17. Section 641.797, Florida Statutes, is created to read:

641.797 Auditor for the Florida Health Plan.—

(1) There is created in the Office of the Auditor General the position of auditor for the Florida Health Plan to prevent health care fraud and abuse of the plan. The auditor for the Florida Health Plan shall be appointed by the Auditor General.

(2) The auditor for the Florida Health Plan shall:

(a) Investigate, audit, and review the financial and business records of the plan.

(b) Investigate, audit, and review the financial and business records of individuals, public and private agencies and institutions, and private corporations that provide services or products to the plan which are reimbursed by the plan.

(c) Investigate allegations of misconduct on the part of an employee or appointee of the Florida Health Board and on the part of any health care provider that is reimbursed by the plan, and report any findings of misconduct to the Attorney General.

(d) Investigate fraud and abuse.

(e) Arrange for the collection and analysis of data needed to investigate inappropriate use of a product or service that is reimbursed by the plan.

(f) Annually report recommendations for improvements to the plan to the board.

Section 18. Section 641.798, Florida Statutes, is created to read:

641.798 Ethics and conflicts of interest; Conflict of Interest Committee.—

(1) The Code of Ethics for Public Officers and Employees under part III of chapter 112 applies to the employees and the chief executive officer of the Florida Health Plan, the employees and members of the Florida Health Board, the employees and members of the regional planning boards and the regional

health planning directors, the employees and the director of the Office of Health Quality and Planning, the employees and the ombudsman of the Ombudsman Office for Patient Advocacy, and the auditor for the Florida Health Plan. Failure to comply with the code of ethics under part III of chapter 112 is grounds for disciplinary action, which may include termination of employment or removal from the board.

(2) In order to avoid the appearance of political bias or impropriety, the chief executive officer of the plan may not:

(a) Engage in leadership of, or employment by, a political party or political organization.

(b) Publicly endorse a political candidate.

(c) Contribute to a political candidate, political party, or political organization.

(d) Attempt to avoid compliance with this subsection by making a contribution through a spouse or other family member.

(3) In order to avoid a conflict of interest, a person specified in subsection (1) may not be employed by a health care provider or a pharmaceutical, health insurance, or medical supply company while holding the position specified in subsection (1), except for the five health care provider members appointed to the Florida Health Board by the representatives of regional planning boards under s. 641.793(2)(a)2. These five members may be employed by a health care provider, but not by a pharmaceutical, health insurance, or medical supply company

while serving on the board.

(4) The board shall establish a Conflict-of-Interest Committee to develop standards of practice for persons or entities doing business with the plan, including, but not limited to, board members, health care providers, and medical suppliers.

(a) The committee shall establish guidelines on the duty to disclose to the committee the existence of any financial interest and all material facts related to a financial interest.

(b) The committee shall review all proposed transactions and arrangements that involve the plan. In considering a proposed transaction or arrangement, if the committee determines a conflict of interest exists, the committee must investigate alternatives to the proposed transaction or arrangement. After exercising due diligence, the committee shall determine whether the plan can obtain with reasonable efforts a more advantageous transaction or arrangement with a person or entity which would not give rise to a conflict of interest. If the committee determines that a more advantageous transaction or arrangement is not reasonably possible under the circumstances, the committee shall make a recommendation to the board on whether the transaction or arrangement is in the best interest of the plan, and whether the transaction is fair and reasonable. The committee shall provide to the board all material information used to make the recommendation. After reviewing all relevant

information, the board shall decide whether to approve the transaction or arrangement.

Section 19. Section 641.799, Florida Statutes, is created to read:

641.799 Florida Health Plan policies and procedures; rulemaking.—

(1) The Florida Health Plan policies and procedures are exempt from the Administrative Procedure Act.

(2)(a) If the board determines that a rule should be adopted under this part to establish, modify, or revoke a policy or procedure, the board must publish in the state register the proposed rule and must afford interested persons a period of 30 days after publication to submit written data or comments.

(b) On or before the last day of the 30-day period provided for the submission of written data or comments under paragraph (a), any interested person may file with the board written objections to the proposed rule, stating the grounds for objection and requesting a public hearing on those objections. Within 30 days after the last day for submitting written data or comments, the board shall publish in the state register a notice specifying the rule to which objections have been filed and a hearing requested and specifying a time and place for the hearing.

(c) Within 60 days after the expiration of the period provided for the submission of written data or comments, or

within 60 days after the completion of any hearing, the board shall issue a rule adopting, modifying, or revoking a policy or procedure, or make a determination that a rule should not be adopted. The rule may contain a provision delaying its effective date for such period as the board determines is necessary.

Section 20. (1) The Director of the Office of Financial Regulation of the Department of Financial Services and the chief executive officer of the Florida Health Plan shall regularly update the Legislature on the status of the planning, implementation, and financing of this act.

(2) The Florida Health Plan must be operational by July 1, 2028.

(3) On and after the day the Florida Health Plan becomes operational, a health insurance policy, a health maintenance contract, a continuing care contract, a prepaid health clinic contract, or any policy or contract that offers coverage for services covered by the Florida Health Plan may not be sold in this state.

(4) The Office of the Inspector General of the Agency for Health Care Administration shall prepare an analysis of this state's capital expenditure needs for the purpose of assisting the Florida Health Board in adopting the statewide capital budget for the year following implementation. The Office of the Inspector General shall submit this analysis to the board.

(5) By July 1, 2027, the Department of Commerce shall

provide to the Florida Health Board, the Governor, and the chairs and ranking members of the legislative committees with jurisdiction over health, human services, and commerce a report determining the appropriations and legislation necessary to assist all affected individuals and communities through the transition to the Florida Health Plan.

Section 21. This act shall take effect July 1, 2026, but only if HB 1491 or similar legislation is adopted in the same legislative session or an extension thereof and becomes a law.