By Senator Torres

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

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

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

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

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

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

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

204 to notify members of certain obligations; providing
205 procedures for notifying members and for the
206 termination of coverage; prohibiting certain uses of
207 member information by the board; providing that the
208 board assumes responsibility for certain benefits and
209 services; creating s. 408.972, F.S.; providing
210 legislative intent regarding a revenue plan for the
211 program; creating s. 408.98, F.S.; defining terms;
212 specifying requirements for collective negotiation
213 rights between health care providers and the program;
214 requiring representatives of negotiating parties to
215 pay a fee to the board; requiring the board to set
216 certain fees by rule; prohibiting certain collective
217 actions; providing construction; creating s. 408.99,
218 F.S.; providing that the act does not become operative
219 until the State Surgeon General of the Department of
220 Health provides a specified notice to the Legislature;
221 requiring the Department of Health to publish the
222 notice on its website; creating s. 408.991, F.S.;
223 providing for severability; providing an effective
224 date.
225
226 Be It Enacted by the Legislature of the State of Florida:
227
228 Section 1. The Division of Law Revision and Information is
229 directed to create part V of chapter 408, Florida Statutes,
230 consisting of ss. 408.95-408.991, Florida Statutes, to be
231 entitled the "Healthy Florida Act."
232 Section 2. Section 408.95, Florida Statutes, is created to

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

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

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

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

349 prevent disease transmission and diagnose, treat, and
350 rehabilitate people of all ages. Together with a range of
351 technical and support staff, they may deliver direct patient
352 care, rehabilitation, treatment, diagnostics, and health
353 improvement interventions to restore and maintain optimal
354 physical, sensory, psychological, cognitive, and social
355 functions. As used in this subsection, the term "health
356 professional" includes, but is not limited to, an audiologist,
357 an occupational therapist, a social worker, or a radiographer.
358 (3) "Board" means the Healthy Florida Board created in s.
359 408.953.
360 (4) "Care coordination" means services provided by a care
361 coordinator under s. 408.961.
362 (5) "Care coordinator" means an individual or entity
363 approved by the board to provide care coordination under s.
364 408.961.
365 (6) "Carrier" means a private health insurer holding a
366 valid certificate of authority under chapter 624, or a health
367 maintenance organization holding a valid certificate of
368 authority under chapter 641, issued by the Office of Insurance
369 Regulation.
370 (7) "Committee" means the public advisory committee
371 established under s. 408.954.
372 (8) "Essential community providers" means persons or
373 entities acting as safety net clinics, safety net health care
374 providers, or rural hospitals.
375 (9) "Federally matched public health program" means the
376 state's Medicaid program under Title XIX of the Social Security
377 Act, 42 U.S.C. ss. 1396 et seq., and the Florida Kidcare Act,

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378 the state’s Children’s Health Insurance Program under Title XXI
379 of the Social Security Act, 42 U.S.C. ss. 1397aa et seq.
380 (10) “Fund” means the Healthy Florida Trust Fund created
381 under s. 408.971.
382 (11) “Health care organization” means an entity that is
383 approved by the board under s. 408.963 to provide health care
384 services to members under the program.
385 (12) “Health care service” means any health care service,
386 including care coordination, which is included as a benefit
387 under the program.
388 (13) “Healthy Florida,” “HF,” or “program” means the
389 Healthy Florida program created in s. 408.953.
390 (14) “Implementation period” means the period under s.
391 408.955(6) during which the program is subject to special
392 eligibility and financing provisions until it is fully
393 implemented under that subsection.
394 (15) “Integrated health care delivery system” means a
395 provider organization that:
396 (a) Is fully integrated, operationally and clinically, in
397 order to provide a broad range of health care services,
398 including preventive care, prenatal and well-baby care,
399 immunizations, screening diagnostics, emergency services,
400 hospital and medical services, surgical services, and ancillary
401 services; and
402 (b) Is compensated by Healthy Florida using capitation or
403 facility budgets for the provision of health care services.
404 (16) “Long-term care” means long-term care, treatment,
405 maintenance, or services not covered under the Florida Kidcare
406 Act, as appropriate, with the exception of short-term

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

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

465 elect a chair on an annual basis.
466 (4)(a) Each person appointed to the board must have
467 demonstrated and acknowledged expertise in health care.
468 (b) Appointing authorities shall also consider the
469 expertise of the other members of the board and attempt to make
470 appointments so that the board's composition reflects a
471 diversity of expertise in the various aspects of health care.
472 (c) Appointments to the board by the Governor, the
473 President of the Senate, and the Speaker of the House of
474 Representatives must consist of:
475 1. At least one representative of a labor organization
476 representing registered nurses.
477 2. At least one representative of the general public.
478 3. At least one representative of a labor organization.
479 4. At least one representative of the medical provider
480 community.
481 (5) Each member of the board shall have the responsibility
482 and duty to meet the requirements of this part, the Affordable
483 Care Act, and all applicable state and federal laws and
484 regulations, to serve the public interest of the individuals,
485 employers, and taxpayers seeking health care coverage through
486 the program, and to ensure the operational well-being and fiscal
487 solvency of the program.
488 (6) In making appointments to the board, the appointing
489 authorities shall take into consideration the cultural, ethnic,
490 and geographical diversity of the state so that the board's
491 composition reflects the communities of this state.
492 (7)(a) A member of the board or of its staff may not be
493 employed by, a consultant to, a member of the board of directors

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494 of, affiliated with, or otherwise be a representative of a
495 health care provider, a health care facility, or a health clinic
496 while serving on the board or on the board staff. A member of
497 the board or of its staff may not be a member, a board member,
498 or an employee of a trade association of health facilities,
499 health clinics, or health care providers while serving on the
500 board or on the staff of the board. A member of the board or of
501 its staff may not be a health care provider unless he or she
502 receives no compensation for rendering services as a health care
503 provider and does not have an ownership interest in a health
504 care practice.
505 (b) A board member may not receive compensation for his or
506 her service on the board, but may be reimbursed for per diem and
507 travel expenses in accordance with s. 112.061 while engaged in
508 the performance of official duties of the board.
509 (c) For purposes of this subsection, the term "health care
510 provider" means a health care professional licensed under
511 chapter 458, chapter 459, chapter 460, chapter 461, chapter 463,
512 chapter 464, chapter 465, chapter 466, part I, part III, part
513 IV, part V, or part X of chapter 468, chapter 483, chapter 484,
514 chapter 486, chapter 490, or chapter 491.
515 (8) A member of the board may not make, participate in
516 making, or in any way attempt to use his or her official
517 position to influence the making of a decision that he or she
518 knows, or has reason to know, will have a reasonably foreseeable
519 material financial effect, distinguishable from its effect on
520 the public generally, on him or her or a member of his or her
521 immediate family, or on either of the following:
522 (a) Any source of income aggregating $250 or more in value

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

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

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581 President of the Senate.
582 (l) One representative of essential community providers, to
583 be appointed by the President of the Senate.
584 (m) One representative of small business, which is a
585 business that employs less than 25 people, to be appointed by
586 the Governor.
587 (n) One representative of large business, which is a
588 business that employs more than 250 people, to be appointed by
589 the Speaker of the House of Representatives.
590 (o) One pharmacist, to be appointed by the Speaker of the
591 House of Representatives.
592 (3) In making appointments pursuant to this section, the
593 Governor, the President of the Senate, and the Speaker of the
594 House of Representatives shall make good faith efforts to ensure
595 that their appointments, as a whole, reflect, to the greatest
596 extent feasible, the social and geographic diversity of the
597 state.
598 (4) Any member appointed by the Governor, the President of
599 the Senate, or the Speaker of the House of Representatives shall
600 serve a 4-year term. These members may be reappointed for
601 succeeding 4-year terms.
602 (5) A vacancy that occurs must be filled within 30 days
603 after it occurs and in the same manner in which the vacating
604 member was initially selected or appointed. The State Surgeon
605 General of the Department of Health shall notify the appropriate
606 appointing authority of any expected vacancy on the public
607 advisory committee.
608 (6) Members of the committee shall serve without
609 compensation, but shall be reimbursed for per diem and travel

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610 expenses in accordance with s. 112.061, and except that a member
611 shall receive $100 for each full day of attending meetings of
612 the committee. As used in this subsection, the term "full day of
613 attending a meeting" means presence at, and participation in,
614 not less than 75 percent of the total meeting time of the
615 committee during any particular 24-hour period.
616 (7) The public advisory committee shall meet at least 6
617 times per year in a place convenient to the public. All meetings
618 of the committee must be open to the public pursuant to s.
619 286.011.
620 (8) The public advisory committee shall elect a chair who
621 shall serve for 2 years and who may be reelected for an
622 additional 2 years.
623 (9) Appointed committee members must have worked in the
624 field they represent on the committee for a period of at least 2
625 years before being appointed to the committee.
626 (10) It is unlawful for the committee members or any of
627 their assistants, clerks, or deputies to use for personal
628 benefit any information that is filed with, or obtained by, the
629 committee and that is not generally available to the public.
630 Section 7. Section 408.955, Florida Statutes, is created to
631 read:
632 408.955 Board powers and duties.—
633 (1) The board has all powers and duties necessary to
634 establish and implement the Healthy Florida program under this
635 part. The program must provide comprehensive universal single-
636 payer health care coverage and a health care cost control system
637 for the benefit of all residents of this state.
638 (2) The board shall, to the maximum extent possible,

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

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

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

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

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755 b. Number of employees and classification by hospital unit.
756 c. Number of hours worked by hospital unit.
757 d. Employee wage information by job title and hospital
758 unit.
759 e. Number of registered nurses per staffed bed by hospital
760 unit.
761 f. Type and value of healthy information technology.
762 g. Annual spending on health information technology,
763 including purchases, upgrades, and maintenance.
764 (b) The board shall make all disclosed data collected under
765 paragraph (a) publicly available and searchable through a
766 website and through the Department of Health’s public data sets.
767 (c) The board shall, directly and through grants to
768 nonprofit entities, conduct programs using data collected
769 through the Healthy Florida program to promote and protect
770 public, environmental, and occupational health, including
771 cooperation with other data collection and research programs of
772 the Department of Health, consistent with this part and
773 otherwise applicable law.
774 (d) Before full implementation of the program, the board
775 shall provide for the collection and availability of data on the
776 number of patients served by hospitals and the dollar value of
777 the care provided, at cost, for all of the following categories
778 of Department of Health data items:
779 1. Patients receiving charity care.
780 2. Contractual adjustments of county and indigent programs,
781 including traditional and managed care.
782 3. Bad debts.
783 Section 8. Section 408.956, Florida Statutes, is created to

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784 read:
785 408.956 Law enforcement agencies; prohibited acts relating
786 to Healthy Florida.—Notwithstanding any other law, a law
787 enforcement agency may not use Healthy Florida moneys,
788 facilities, property, equipment, or personnel to investigate,
789 enforce, or assist in the investigation or enforcement of any
790 criminal, civil, or administrative violation or warrant for a
791 violation of any requirement that individuals register with the
792 Federal Government or any federal agency based on religion,
793 national origin, ethnicity, or immigration status.
794 Section 9. Section 408.957, Florida Statutes, is created to
795 read:
796 408.957 Eligibility and enrollment.—
797 (1) Every resident of this state is eligible and entitled
798 to enroll as a member under the program.
799 (2)(a) A member may not be required to pay any fee,
800 payment, or other charge for enrolling in or being a member
801 under the program.
802 (b) A member may not be required to pay any premium,
803 copayment, coinsurance, deductible, or any other form of cost
804 sharing for all covered benefits.
805 (3) A college, university, or other institution of higher
806 education in this state may purchase coverage under the program
807 for a student, or a student's dependent, who is not a resident
808 of the state.
809 Section 10. Section 408.958, Florida Statutes, is created
810 to read:
811 408.958 Benefits.—
812 (1) Covered health care benefits under the program include

813 all medical care determined to be medically appropriate by the
814 member's health care provider.
815 (2) Covered health care benefits for members must include,
816 but are not limited to, all of the following:
817 (a) Licensed inpatient and licensed outpatient medical and
818 health facility services.
819 (b) Inpatient and outpatient professional health care
820 provider medical services.
821 (c) Diagnostic imaging, laboratory services, and other
822 diagnostic and evaluative services.
823 (d) Medical equipment, appliances, and assistive
824 technology, including prosthetics, eyeglasses, and hearing aids
825 and the repair, technical support, and customization needed for
826 individual use.
827 (e) Inpatient and outpatient rehabilitative care.
828 (f) Emergency care services.
829 (g) Emergency transportation.
830 (h) Necessary transportation for health care services for
831 persons with disabilities or who may qualify as low income.
832 (i) Child and adult immunizations and preventive care.
833 (j) Health and wellness education.
834 (k) Hospice care.
835 (l) Care in a skilled nursing facility.
836 (m) Home health care, including health care provided in an
837 assisted living facility.
838 (n) Mental health services.
839 (o) Substance abuse treatment.
840 (p) Dental care.
841 (q) Vision care.

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

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871 following provisions, without regard to whether the member would
872 otherwise be eligible for or covered by the program or source
873 referred to:
874 (a) The Florida Kidcare Act.
875 (b) The state Medicaid program.
876 (c) The Medicare program pursuant to Title XVIII of the
877 Social Security Act, 42 U.S.C. ss. 1395 et seq.
878 (d) Chapter 641.
879 (e) Parts II, VI, and VII of chapter 627, relating to
880 health insurers.
881 (f) Any additional health care services authorized to be
882 added to the program's benefits by the program.
883 (g) All essential health benefits mandated by the
884 Affordable Care Act as of July 1, 2018.
885 Section 11. Section 408.96, Florida Statutes, is created to
886 read:
887 408.96 Delivery of care; health care providers.—
888 (1)(a) Any health care provider who is licensed to practice
889 in this state and is otherwise in good standing is qualified to
890 participate in the program as long as the health care provider's
891 services are performed within this state.
892 (b) The board shall establish and maintain procedures and
893 standards for recognizing health care providers located out of
894 this state for purposes of providing coverage under the program
895 for a member who requires out-of-state health care services
896 while he or she is temporarily located out of this state.
897 (2) Any health care provider qualified to participate under
898 this section may provide covered health care services under the
899 program as long as the health care provider is legally

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

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929 providing care coordination for the member, consistent with
930 regulations of the board and with the statutory requirements and
931 regulations of the care coordinator’s licensure.
932 (2) Care coordination includes administrative tracking and
933 medical recordkeeping services for members, except as otherwise
934 specified for integrated health care delivery systems.
935 (3) Care coordination administrative tracking and medical
936 recordkeeping services for members are not required in order to
937 use a certified electronic health record, meet any other
938 requirements of the federal Health Information Technology for
939 Economic and Clinical Health Act enacted under the federal
940 American Recovery and Reinvestment Act of 2009, Pub. L. 111-5,
941 or meet certification requirements of the federal Centers for
942 Medicare and Medicaid Services’ Electronic Health Records
943 Incentive Programs, including meaningful use requirements.
944 (4) The care coordinator shall comply with all state and
945 federal privacy laws, including, but not limited to, s. 381.004,
946 s. 395.3025, s. 456.057, and the Health Insurance Portability
947 and Accountability Act, 42 U.S.C. ss. 1320d et seq., and its
948 implementing regulations.
949 (5) Referrals from a care coordinator are not required for
950 a member to see any eligible provider.
951 (6) A care coordinator may be an individual or entity that
952 is approved under the program and that is any of the following:
953 (a) A health care practitioner that is any of the
954 following:
955 1. The member’s primary care provider.
956 2. The member’s provider of primary gynecological care.
957 3. At the option of a member who has a chronic condition

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

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

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

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1045 accessible supply of health care services.

1046 (2) Health care services provided to members under the
1047 program, except for care coordination, must be paid for on a
1048 fee-for-service basis unless and until another payment
1049 methodology is established by the board.

1050 (3) Notwithstanding subsection (2), integrated health care
1051 delivery systems, essential community providers, and group
1052 medical practices that provide comprehensive, coordinated
1053 services may choose to be reimbursed on the basis of a capitated
1054 system operating budget or a noncapitated system operating
1055 budget that covers all costs of providing health care services.

1056 (4) The program shall engage in good faith negotiations
1057 with health care providers' representatives under s. 408.98,
1058 including, but not limited to, in relation to rates of payment
1059 for health care services, rates of payment for prescription and
1060 nonprescription drugs, and payment methodologies. For
1061 prescription and nonprescription drugs, the negotiations must be
1062 conducted through a single entity on behalf of the entire
1063 program.

1064 (5)(a) Payments for health care services established under
1065 this part are considered payment in full.

1066 (b) A participating provider may not charge any rate in
1067 excess of the payment established under this part for any health
1068 care service provided to a member under the program and may not
1069 solicit or accept payment from any member or third party for any
1070 health care service, except as provided under a federal program.

1071 (c) However, this section does not preclude the program
1072 from acting as a primary or secondary payer in conjunction with
1073 another third-party payer when permitted by a federal program.

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

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1103 under chapter 393.
1104 (3)(a) The board shall by rule develop and implement
1105 procedures and standards for an entity to be approved as a
1106 health care organization in the program, including, but not
1107 limited to, procedures and standards relating to the revocation,
1108 suspension, or limitation of approval on a determination that
1109 the entity is incompetent to be a health care organization or
1110 has exhibited a course of conduct that is inconsistent with
1111 program standards and regulations, or that exhibits an
1112 unwillingness to meet those standards and regulations, or is a
1113 potential threat to the public health or safety.
1114 (b) The procedures and standards adopted by the board must
1115 be consistent with established professional practice, licensure
1116 standards, and regulations for health care practitioners and
1117 providers.
1118 (c) In developing and implementing standards of approval of
1119 health care organizations, the board shall consult with the
1120 Substance Abuse and Mental Health Program Office within the
1121 Department of Children and Families.
1122 (4) To maintain approval under the program, a health care
1123 organization must:
1124 (a) Renew its approval at a frequency determined by the
1125 board; and
1126 (b) Provide data to the Department of Health, as required
1127 by the board, to enable the board to evaluate the health care
1128 organization in relation to the quality of health care services
1129 provided, health care outcomes, and cost.
1130 (5) The board may adopt rules relating specifically to
1131 health care organizations for the sole and specific purpose of

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

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

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

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

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

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1277 (6)(a) Notwithstanding any other law, the board shall
1278 increase by rule the income eligibility level, increase or
1279 eliminate the resource test for eligibility, simplify any
1280 procedural or documentation requirement for enrollment, and
1281 increase the benefits for any federally matched public health
1282 program and for any program in order to reduce or eliminate an
1283 individual's coinsurance, cost-sharing, or premium obligations
1284 or increase an individual's eligibility for any federal
1285 financial support related to Medicare or the Affordable Care
1286 Act.
1287 (b) The board may act under this subsection upon a finding
1288 approved by the Chief Financial Officer and the board that the
1289 action:
1290 1. Will help to increase the number of members who are
1291 eligible for and enrolled in federally matched public health
1292 programs; or, for any program, to reduce or eliminate an
1293 individual's coinsurance, cost-sharing, or premium obligations;
1294 or increase an individual's eligibility for any federal
1295 financial support related to Medicare or the Affordable Care
1296 Act;
1297 2. Will not diminish any individual's access to any health
1298 care service or any right the individual would otherwise have;
1299 3. Is in the interest of the program; and
1300 4. Has received any necessary federal waivers or approvals
1301 to ensure federal financial participation, or does not require
1302 any such waiver or approval.
1303 (c) Actions under this subsection do not apply to
1304 eligibility for payment for long-term care.
1305 (7) To enable the board to apply for coverage for, and

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1306 enroll, any eligible member under any federally matched public
1307 health program or Medicare, the board may require that every
1308 member or applicant provide the information necessary to enable
1309 the board to determine whether the applicant is eligible for a
1310 federally matched public health program or for Medicare, or any
1311 program or benefit under Medicare.
1312 (8) As a condition of continued eligibility for health care
1313 services under the program, a member who is eligible for
1314 benefits under Medicare must enroll in Medicare, including Parts
1315 A, B, and D.
1316 (9) The program shall provide premium assistance for all
1317 members enrolling in a Medicare Part D drug coverage plan under
1318 s. 1860D of Title XVIII of the Social Security Act, 42 U.S.C.
1319 ss. 1395w-101 et seq., limited to the low-income benchmark
1320 premium amount established by the federal Centers for Medicare
1321 and Medicaid Services and any other amount the federal agency
1322 establishes under its de minimis premium policy, except that
1323 those payments made on behalf of members enrolled in a Medicare
1324 advantage plan may exceed the low-income benchmark premium
1325 amount if determined to be cost effective to the program.
1326 (10) If the board has reasonable grounds to believe that a
1327 member may be eligible for an income-related subsidy under s.
1328 1860D-14 of Title XVIII of the Social Security Act, 42 U.S.C. s.
1329 1395w-114, the member must provide, and authorize the program to
1330 obtain, any information or documentation required to establish
1331 the member's eligibility for that subsidy; however, the board
1332 shall attempt to obtain as much of the information and
1333 documentation as possible from records that are available to it.
1334 (11) The program shall make a reasonable effort to notify

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

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

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

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1422 except as authorized by other law.
1423 (b) A health care providers' representative may not
1424 negotiate any agreement that excludes, limits the participation
1425 or reimbursement of, or otherwise limits the scope of services
1426 to be provided by any health care provider or group of health
1427 care providers with respect to the performance of services that
1428 are within the health care provider's scope of practice,
1429 license, registration, or certificate.
1430 (4) CONSTRUCTION.—
1431 (a) This section does not affect or limit the right of a
1432 health care provider or group of health care providers to
1433 collectively petition a governmental entity for a change in a
1434 law, rule, or regulation.
1435 (b) This section does not affect or limit collective action
1436 or collective bargaining on the part of a health care provider
1437 with his or her employer or any other lawful collective action
1438 or collective bargaining.
1439 Section 19. Section 408.99, Florida Statutes, is created to
1440 read:
1441 408.99 Effective date of operation.—
1442 (1) Notwithstanding any other law, this part may not become
1443 operative until the date the State Surgeon General of the
1444 Department of Health notifies the President of the Senate and
1445 the Speaker of the House of Representatives in writing that he
1446 or she has determined that the Healthy Florida Trust Fund has
1447 the revenues to fund the costs of implementing this part.
1448 (2) The Department of Health shall publish on its website a
1449 copy of the notice described in subsection (1).
1450 Section 20. Section 408.991, Florida Statutes, is created

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1451 to read:
1452 408.991 Severability.—The provisions of this part are
1453 severable. If any provision of this part or its application is
1454 held invalid, that invalidity may not affect other provisions or
1455 applications that can be given effect without the invalid
1456 provision or application.
1457 Section 21. This act shall take effect July 1, 2018.

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