Tab 1	**SB 428** by **Yarborough (CO-INTRODUCERS) Smith;** Identical to H 00085 Swimming Lesson Voucher Program

Tab 2	**SB 606** by **Smith (CO-INTRODUCERS) Yarborough;** Identical to H 00503 Drowning Prevention Education

126596	A	S		HP, Smith	Delete L.50 - 51:	01/16 02:50 PM

Tab 3	**SB 192** by **Martin;** Identical to H 00259 Patient Funds Held in Trust by Chiropractic Physicians

Tab 4	**SB 162** by **Davis;** Identical to H 00093 Protection from Surgical Smoke

Tab 5	**SB 340** by **Harrell;** Similar to H 00303 Human Trafficking Training for Nursing Students

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The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Harrell, Vice Chair

MEETING DATE: Tuesday, January 20, 2026
TIME: 3:30—5:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Burton, Chair; Senator Harrell, Vice Chair; Senators Berman, Calatayud, Davis, Gaetz, Leek, Massullo, Osgood, Passidomo, and Trumbull

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 428** Yarborough (Identical H 85)	Swimming Lesson Voucher Program; Revising the age requirements for children receiving a voucher through the Swimming Lesson Voucher Program, etc. HP 01/20/2026 AHS FP	
2	**SB 606** Smith (Identical H 503)	Drowning Prevention Education; Requiring the Department of Health to develop educational materials on drowning prevention safety measures and safe bathing practices for specified purposes; providing requirements for such materials; requiring hospitals, birth centers, and home birth providers to provide the educational materials to new parents and caregivers as part of their postpartum education and care, etc. HP 01/20/2026 AHS FP	
3	**SB 192** Martin (Identical H 259)	Patient Funds Held in Trust by Chiropractic Physicians; Deleting the limitation on the amount of patient funds a chiropractic physician may hold in trust for specified purposes, etc. HP 01/20/2026 JU RC	
4	**SB 162** Davis (Identical H 93)	Protection from Surgical Smoke; Defining the terms “smoke evacuation system” and “surgical smoke”; requiring hospitals and ambulatory surgical centers, by a specified date, to adopt and implement policies requiring the use of smoke evacuation systems during certain surgical procedures, etc. HP 01/20/2026 AHS RC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
5	**SB 340** Harrell (Similar H 303)	Human Trafficking Training for Nursing Students; Requiring nursing education programs to include a course on human trafficking meeting specified criteria as part of their core curriculum; requiring that the course be approved by the Board of Nursing; requiring the board, in coordination with the Department of Health, to oversee implementation and enforcement of the new education requirements, etc. HP 01/20/2026 AHS FP	
6	Review of Health Care Practitioner Regulation in Florida and Other States by the Office of Program Policy Analysis and Government Accountability (OPPAGA)		
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 428
INTRODUCER:	Senators Yarborough and Smith
SUBJECT:	Swimming Lesson Voucher Program
DATE:	January 16, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 428 amends the Swimming Lesson Voucher Program (SLVP) established by s. 514.073, F.S., to require that children who participate in the program must be between the ages of one and seven, rather than the current-law requirement of four years of age or younger.

The bill provides an effective date of July 1, 2026.

II. Present Situation:

The Danger of Drowning

Drowning is one of the leading causes of accidental death among children. For all ages, the current annual global estimate is 295,000 drowning deaths, although this figure is thought to underreport fatal drownings, in particular boating and disaster related drowning mortality.

Drowning disproportionately impacts children and young people, with over half of all drowning deaths occurring among people younger than 25 years old. In many countries, children under five years of age record the highest rate of fatal and non-fatal drowning, with incidents commonly occurring in swimming pools and bathtubs in high income countries and in bodies of water in and around a home in low income contexts.[1]

Drowning Deaths in Florida

Drowning deaths in Florida have consistently ranged between 350 and 500 deaths per year in the state from 2005 to present at an average rate of approximately two deaths per

[1] Peden AE, Franklin RC. Learning to Swim: An Exploration of Negative Prior Aquatic Experiences among Children. Int J Environ Res Public Health, May 19, 2020, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7277817/ (last visited Jan. 14, 2026).

100,000 population.[2] Children aged four and under, however, drown nearly three times as often with a rate of approximately six per 100,000 population.[3] Comparably, children between the ages of one and seven drown at a rate of approximately five per 100,000 population and made up 87 out of 452, or nearly 20 percent, of the drowning deaths in Florida in 2024.[4]

Formal Swimming Lessons and Drowning Prevention

Learning to swim has been found to be an effective drowning prevention strategy and has been proposed by the World Health Organization as one of ten key strategies for global drowning prevention. Participation in formal swimming lessons has been shown to reduce drowning risk among children aged 1-19 years, and a recent review of evidence suggests that teaching aquatic competencies to young children causes no increased risk, particularly when combined with the additional drowning prevention strategies of supervision, restricting access to water, and caregiver training in cardiopulmonary resuscitation (CPR).[5] Swimming lessons have been found to be particularly effective in protecting children age 0-4 from drowning with one study showing that formal swimming lessons were associated with an 88 percent reduction in the risk for drowning for that population.[6]

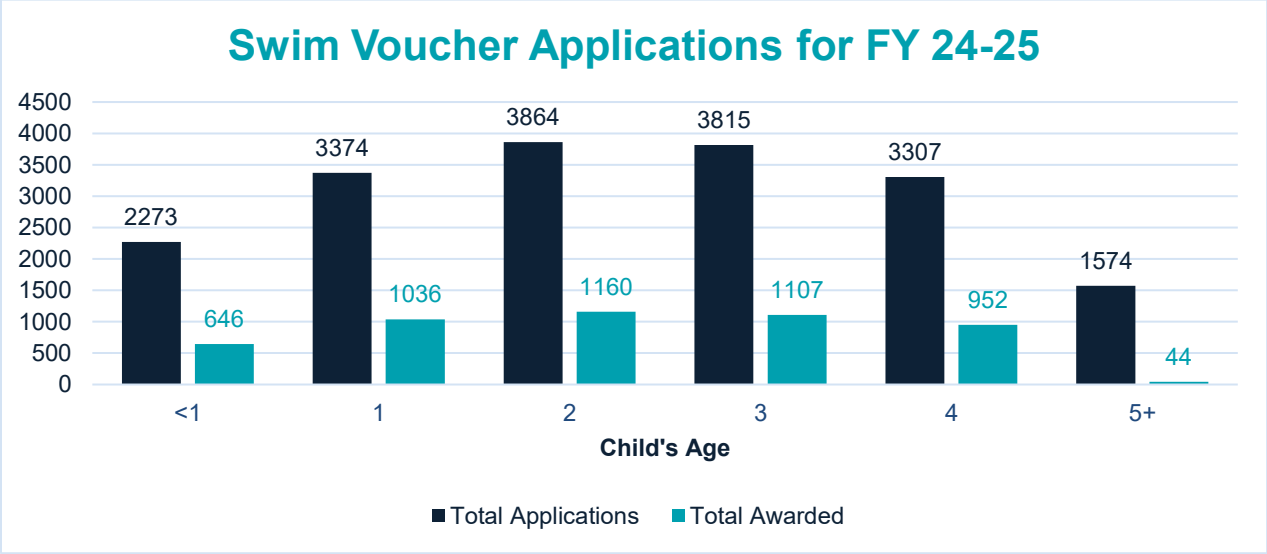
Florida's Swimming Lesson Voucher Program

In 2024, the Florida Legislature passed SB 544[7] which created the SLVP in s. 514.073, F.S. The SLVP is administered by the Department of Health (DOH) and provides vouchers for swimming lessons to families who have an income of 200 percent of federal poverty level or lower, who are Florida residents, and have one or more children aged four and under. To ensure that the vouchers are accepted, the SLVP also requires the DOH to establish a network of swimming lesson providers where the vouchers may be used. Eligible families who apply for, and receive, a voucher through the SLVP can exchange the voucher for swimming lessons through any swimming lesson provider who is part of the DOH's network.[8]

The SLVP initially received $500,000 in funds appropriated by the Legislature for state fiscal year 2024-2025. Additionally, the DOH was able to secure an additional $200,000 in grant funding from the Consumer Product Safety Commission, and several county health departments contributed $143,400 in discretionary funds to supplement the appropriation, bringing the total funding to $843,400 for lessons provided through June 30, 2025.[9] For state fiscal year 2024-2025, the DOH received 16,663 applications for and awarded 4,945 swimming

[2] Florida Health Charts, Deaths from Unintentional Drowning, available at https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=Death.DataViewer&cid=0105, (last visited Jan. 14, 2026).
[3] *Id.* (Rate type changed to "crude" and age range selected from "0 to 4").
[4] *Id.*
[5] *Supra,* note 2.
[6] Brenner RA, Taneja GS, Haynie DL, Trumble AC, Qian C, Klinger RM, Klebanoff MA. Association between swimming lessons and drowning in childhood: a case-control study. Arch Pediatr Adolesc Med. 2009 Mar;163(3):203-10. doi: 10.1001/archpediatrics.2008.563. PMID: 19255386; PMCID: PMC4151293.
[7] Chapter 2024-89, L.O.F.
[8] A list of swimming lesson providers who are part of the network, and the requirements that such providers must meet, are available at WaterSmartFL, (last visited Jan. 14, 2026).
[9] Swimming Lesson Voucher Program Legislative Report 2025, p. 8, on file with Senate Health Policy Committee staff.

lesson vouchers.[10] See below for a chart of the distribution of voucher applications and awards by age:



For state fiscal year 2025-2026, the Legislature increased the funding for the SLVP to $1 million and required the DOH to prioritize the dissemination of vouchers to eligible families who are active military or whose eligible child has autism.[11]

III. Effect of Proposed Changes:

SB 428 amends the SLVP established by s. 514.073, F.S., to require that children who participate in the program must be between the ages of one and seven, rather than the current-law requirement of four years of age or younger.

The bill provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[10] *Id.* at p. 10.
[11] *Supra* n. 9 at p. 12.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 428 may have a positive fiscal impact on families seeking swimming lessons for children ages five to seven who will qualify for a voucher under the changes made by the bill. The bill may have a negative fiscal impact on families with children not yet one year old who will no longer qualify for a voucher.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 514.073 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Yarborough

4-00451-26 2026428__

A bill to be entitled

An act relating to the Swimming Lesson Voucher Program; amending s. 514.073, F.S.; revising the age requirements for children receiving a voucher through the Swimming Lesson Voucher Program; providing an effective date.

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

Section 1. Subsection (1) and paragraph (b) of subsection (2) of section 514.073, Florida Statutes, are amended to read:

514.073 Swimming Lesson Voucher Program.—

(1) There is created within the department the Swimming Lesson Voucher Program. The purpose of the program is to increase water safety in this state by offering vouchers for swimming lessons at no cost to families with an income of no more than 200 percent of the federal poverty level who have one or more children between 1 and 7 ~~4~~ years of age ~~or younger~~.

(2) The department shall do all of the following to implement the program:

(b) Establish a method for members of the public to apply for swimming lesson vouchers and for determining an applicant's eligibility. The department shall establish eligibility criteria necessary for a family to receive one or more vouchers from the program, including, but not limited to, the following:

1. The age of each child for whom a voucher is being sought, who must be between 1 and 7 ~~may be no more than 4~~ years of age.

2. The family income level, which may be up to 200 percent

of the federal poverty level.

3. The family's address of residency in this state.

Section 2. This act shall take effect July 1, 2026.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 606
INTRODUCER:	Senators Smith and Yarborough
SUBJECT:	Drowning Prevention Education
DATE:	January 16, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 606 creates s. 383.3363, F.S., to require the Department of Health (DOH) to develop educational materials on drowning prevention safety measures and safe bathing practices and provides minimum requirements for what must be included in such materials. The bill requires hospitals, birth centers, and home birth providers to provide the educational materials to parents and caregivers of newborns as part of their postpartum education and care and requires childbirth educators to provide the materials to parents and caregivers receiving childbirth education. Hospitals, birth centers, and home birth providers are required to maintain proof of compliance and make such records available to the Agency for Health Care Administration (AHCA) upon request. The bill also amends several sections of the Florida statutes to provide conforming changes.

The bill provides an effective date of July 1, 2026.

II. Present Situation:

The Danger of Drowning

Drowning is one of the leading causes of accidental death among children. For all ages, the current annual global estimate is 295,000 drowning deaths, although this figure is thought to underreport fatal drownings, in particular boating and disaster-related drowning mortality.

Drowning disproportionately impacts children and young people, with over half of all drowning deaths occurring among people younger than 25 years old. In many countries, children under five years of age record the highest rate of fatal and non-fatal drowning, with incidents commonly

occurring in swimming pools and bathtubs in high income countries and in bodies of water in and around a home in low income contexts.[1]

Drowning Deaths in Florida

Drowning deaths in Florida have consistently ranged between 350 and 500 deaths per year in the state from 2005 to present at an average rate of approximately two deaths per 100,000 population.[2] Children aged four and under, however, drown nearly three times as often with a rate of approximately six per 100,000 population.[3] Comparably, children between the ages of one and seven drown at a rate of approximately five per 100,000 population and made up 87 out of 452, or nearly 20 percent, of the drowning deaths in Florida in 2024.[4]

Drowning Prevention

The National Drowning Prevention Alliance (NDPA) recommends five steps for protecting children from drowning, which the NDPA refers to as "5 layers of protection."[5] These layers are: barriers and alarms, supervision, water competency, life jackets, and emergency preparation.

Barriers and Alarms

The NDPA cites that 70 percent of child drownings happen during non-swim times.[6] Many types of fences can help prevent children from accessing a pool area when the children are not being supervised. Additionally, certain covers and safety nets can prevent children from falling into a pool. Lastly, many types of alarms exist that can alert parents when the pool area or the pool itself has been accessed without permission and supervision.[7]

Supervision

The NDPA provides several recommendations for supervision of children around pools and bodies of water. These include having general house rules about not leaving children unattended and reminding guests, babysitters, and caregivers about pool hazards and the need for constant supervision. Lastly, the NDPA recommends active supervision while swimming and participating in water activities and using a water watcher, i.e. a person whose sole responsibility is watching over the children in and near the water, or a lifeguard during water-centered gatherings.[8]

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[1] Peden AE, Franklin RC. Learning to Swim: An Exploration of Negative Prior Aquatic Experiences among Children. Int J Environ Res Public Health, May 19, 2020, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7277817/ (last visited Jan. 14, 2026).
[2] Florida Health Charts, Deaths from Unintentional Drowning, available at https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=Death.DataViewer&cid=0105, (last visited Jan. 14, 2026).
[3] *Id.* (To see this result, change "rate type" to "crude" and select the age range from "0 to 4").
[4] *Id.*
[5] National Drowning Prevention Alliance, Learn the 5 Layers of Protection, available at https://ndpa.org/layers/, (last visited Jan. 15, 2026)
[6] The Five Layers of Protection brochure, National Drowning Prevention Alliance, p. 2, available at https://ndpa.org/wp-content/uploads/2022/09/FINAL-LOP-Brochure.pdf, (last visited Jan. 15, 2026).
[7] *Id*. at pp. 3-6.
[8] *Id.* at p. 7

Water Competency

The American Academy of Pediatrics recommends starting swim lessons as early as age one. Research shows that children ages one through four can reduce their drowning risk up to 88 percent if enrolled in formal lessons. The NDPA recommends making sure that the swim instruction includes water safety and survival education at the appropriate developmental level.[9]

Life Jackets

The NDPA recommends that everyone wear a life jacket or personal flotation device (PFD) approved by the U.S. Coast Guard (USCG) whenever boating or in a natural or open body of water. The NDPA indicates it is important that the life jacket is USCG approved and fitted for the individual. Not all devices sold by retailers are tested and approved flotation devices. Devices that are not tested and approved cannot be considered a safe layer of protection and should not be part of a family's water safety plan, according to the NDPA.[10]

Emergency Readiness

The NDPA recommends that adults participating in water activities when children are involved have an emergency plan, including keeping a phone near the pool or swimming area with the ability to call 911 for help if needed. Additionally, parents and others who live in homes with pools should learn and practice cardiopulmonary resuscitation (CPR) and there should be at least one person who knows CPR at any large gathering where water is involved. Lastly, pool owners and operators may enroll in water safety courses that teach proper rescue techniques.[11]

III. Effect of Proposed Changes:

SB 606 creates s. 383.3363, F.S., to require the DOH to develop educational materials on drowning prevention safety measures and safe bathing practices to be distributed to parents and caregivers as part of postpartum or childbirth education provided by hospitals, birth centers, home birth providers, and childbirth educators. The materials, at a minimum, must include:

- The increased risk of drowning for infants and toddlers in bathtubs, pools, and other water sources, citing available data on such drownings;
- Water safety measures parents can employ to prevent drowning, emphasizing the importance of constant supervision of infants and children while they are around water and the benefits of early childhood swimming lessons and water competency programs as an added layer of protection from drownings; and
- Additional safety hazards in the home setting and evidence-based safe bathing practices.

The bill requires each hospital, birth center, and home birth provider providing maternity, prenatal, and newborn services to provide the educational materials to the parents or caregivers of a newborn as part of its postpartum education and care. Hospitals, birth centers, and home birth providers are required to maintain proof of compliance and make records available to the AHCA upon request. Additionally, childbirth educators must provide the educational materials to parents or caregivers who receive childbirth education from the educator.

[9] *Supra* n. 6 at p. 8
[10] National Drowning Prevention Alliance, Life Jackets, available at https://ndpa.org/life-jackets/, (last visited Jan. 15, 2026).
[11] *Supra* n. 6 at p. 10.

The bill also amends ss. 383.318 and 395.1053, F.S., to include the educational and compliance requirements established by the bill in the licensure acts for birth centers and hospitals, respectively.

The bill provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill references "home birth providers" and creates requirements for such providers, subject to regulation by the AHCA. However, the bill does not define that term, and there is no definition in existing law. Given the plain meaning of the term, it could potentially include licensed health care practitioners, who are regulated by the DOH and their respective regulatory boards, or anyone providing unregulated services during a home birth.

The bill requires hospitals, birth centers, and home birth providers to "maintain proof of compliance with [the requirements of the bill] and make such records available to the Agency for Health Care Administration upon request." While the AHCA is the regulatory agency for hospitals and birth centers, the AHCA is not charged with regulating licensed practitioners or unlicensed persons or entities providing unregulated services during a home birth. It is unclear what regulatory authority the AHCA would have over such providers should those providers not comply with the bill's documentation requirements.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 383.318 and 395.1053.

This bill creates section 383.3363 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

126596

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Health Policy (Smith) recommended the following:

Senate Amendment (with title amendment)

Delete lines 50 - 51

and insert:

postpartum education and care. Hospitals and birth centers shall maintain proof of compliance with

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete line 11

126596

and insert:

hospitals and birth centers to

By Senator Smith

17-00670A-26 2026606__

A bill to be entitled

An act relating to drowning prevention education; creating s. 383.3363, F.S.; requiring the Department of Health to develop educational materials on drowning prevention safety measures and safe bathing practices for specified purposes; providing requirements for such materials; requiring hospitals, birth centers, and home birth providers to provide the educational materials to new parents and caregivers as part of their postpartum education and care; requiring hospitals, birth centers, and home health providers to maintain proof of compliance with the required distribution of the educational materials and make such records available to the Agency for Health Care Administration upon request; requiring childbirth educators to provide the informational materials to parents or caregivers receiving childbirth education from them; amending ss. 383.318 and 395.1053, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Section 383.3363, Florida Statutes, is created to read:

383.3363 Education on drowning prevention safety measures and safe bathing practices.—

(1) The Department of Health shall develop educational materials on drowning prevention safety measures and safe

bathing practices to be distributed to parents or caregivers as part of postpartum or childbirth education provided by hospitals, birth centers, home birth providers, and childbirth educators in this state. The materials must include, but need not be limited to, instruction on all of the following:

(a) The increased risk of drowning for infants and toddlers in bathtubs, pools, and other water sources, citing available data on such drownings.

(b) Water safety measures parents can employ to prevent drowning, emphasizing the importance of constant supervision of infants and children while they are around water and the benefits of early childhood swimming lessons and water competency programs as an added layer of protection from drownings.

(c) Additional safety hazards in the home setting and evidence-based safe bathing practices.

(2) Each hospital, birth center, and home birth provider providing maternity, prenatal, and newborn services shall provide the educational materials developed under subsection (1) to the parents or caregivers of a newborn as part of its postpartum education and care. Hospitals, birth centers, and home birth providers shall maintain proof of compliance with this subsection and make such records available to the Agency for Health Care Administration upon request.

(3) Childbirth educators shall provide the educational materials developed under subsection (1) to the parents or caregivers receiving childbirth education.

Section 2. Paragraph (j) is added to subsection (4) of section 383.318, Florida Statutes, to read:

383.318 Postpartum care for birth center clients and infants.—

(4) The birth center shall provide a postpartum evaluation and followup care that includes all of the following:

(j) Provision of the educational materials on drowning prevention safety measures and safe bathing practices developed by the Department of Health under s. 383.3363. Birth centers shall maintain proof of compliance with the requirements of this paragraph and make such records available to the Agency for Health Care Administration upon request.

Section 3. Section 395.1053, Florida Statutes, is amended to read:

395.1053 Postpartum education.—

(1) A hospital that provides birthing services shall provide each parent with postpartum education on the care of newborns, which must include all of the following:

(a) ~~incorporate~~ Information on safe sleep practices and the possible causes of Sudden Unexpected Infant Death. ~~into the hospital's postpartum instruction on the care of newborns and provide to each parent~~

(b) Provision of the informational pamphlet on infant and childhood eye and vision disorders created by the department pursuant to s. 383.14(3)(h).

(c) Provision of the educational materials on drowning prevention safety measures and safe bathing practices developed by the department under s. 383.3363.

(2) Hospitals shall maintain proof of compliance with the requirements of this section and make such records available to the agency upon request.

Section 4. This act shall take effect July 1, 2026.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 192
INTRODUCER:	Senator Martin
SUBJECT:	Patient Funds Held in Trust by Chiropractic Physicians
DATE:	January 16, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Pre-meeting**
2.			JU	
3.			RC	

I. Summary:

SB 192 deletes the $1,500 cap on advances a chiropractic physician may collect for examination or treatment. The bill provides an effective date of July 1, 2026.

II. Present Situation:

Regulation of Chiropractic Physicians

The Department of Health (DOH) reports that, as of July 1, 2025, Florida had 8,994 licensed chiropractic practitioners.[1] Chiropractic physicians are licensed health care practitioners regulated by the DOH through the Board of Chiropractic Medicine (Board), which is created within the DOH.[2]

Under the chiropractic practice act (chapter 460, F.S.), the practice of chiropractic medicine consists of the adjustment, manipulation, and treatment of vertebral subluxations and other malpositioned articulations and structures that interfere with the normal generation, transmission, and expression of nerve impulse, thereby restoring the normal flow of nerve impulse which produces normal function and consequent health.[3] Licensed chiropractic physicians are subject to discipline under ch. 456, F.S., and the chiropractic-specific grounds in ch. 460, F.S., and the DOH and the Board may take action for rule violations, fraud, and other enumerated misconduct. The Board's implementing rules are codified in Rule Chapter 64B2, F.A.C., addressing matters such as licensure and renewal, continuing education, advertising, and disciplinary guidelines.

[1] Department of Health, Senate Bill 192 Legislative Analysis (Oct. 17, 2025) (on file with the Senate Committee on Health Policy).
[2] Section 460.404, F.S.
[3] Section 460.403(9), F.S.

Patient Funds Held in Trust

Section 460.413(1)(y), F.S., makes it a disciplinary violation for a chiropractic physician to fail to preserve the identity of patient funds or property valued at more than $501. The statute provides that, as specified by Board rule, money or property entrusted to a chiropractic physician for a specific purpose, including advances for costs and expenses of examination or treatment, is to be held in trust and applied only to that purpose. In 2012, the Legislature imposed a statutory cap on advances that remains in effect today.[4] Such advances may not exceed the value of $1,500.[5]

Accordingly, because the $1,500 limitation is stated within paragraph (y)'s description of the trust obligation, collecting an advance for examination or treatment exceeding $1,500 constitutes conduct encompassed by the disciplinary ground. Since 2012, the DOH has received 12 complaints alleging violations of s. 460.413(1)(y), F.S., nine of which involved collecting amounts greater than $1,500.[6]

Rule 64B2-14.001, F.A.C., applies to trust funds received or disbursed by chiropractors and defines "trust funds" as unearned fees received before services are rendered or goods sold. The rule specifies minimum trust accounting records (e.g., separate trust account, journals, receipts, ledgers, cancelled checks) and procedures, including:

- Reconciliation at least quarterly with retention for six years; and
- Annual filing (between June 1 and August 15) of a certificate of substantial compliance with s. 460.413(1)(y), F.S., and the rule.

Patient Overpayment Refund Requirement

Effective January 1, 2026, s. 456.0625, F.S., requires health care practitioners (including chiropractic physicians) who accept payment from insurance for services rendered to refund any overpayment made by the patient no later than 30 days after determining that the patient made an overpayment. [7] A violation of this requirement to refund an overpayment constitutes grounds for discipline under s. 456.072, F.S. The DOH notes that this requirement will include monies held in trust and reports that the Board proposed disciplinary rule amendments in August 2025 to address such violations (citations and penalty ranges).[8]

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[4] Chapter 2012-17, Laws of Fla.

[5] Based on U.S. Bureau of Labor Statistics Consumer Price Index for All Urban Consumers (CPI-U) data, $1,500 in 2012 is approximately equivalent to $2,120 in December 2025 dollars.
Calculation: $1,500 × (CPI-U Dec. 2025 / CPI-U 2012 annual average) = $1,500 × (324.054 / 229.594) ≈ $2,117. Source: U.S. Bureau of Labor Statistics, CPI-U Index.

[6] *See* supra note 1.

[7] Chapter 2025-48, Laws of Fla.

[8] *See* supra note 1. *Notices of Proposed Rule, Department of Health, Board of Chiropractic Medicine:* Rule 64B2-16.0075, F.A.C. (*Citations*), published in the *Florida Administrative Register*, vol. 51, no. 220 (Nov. 12, 2025), available at https://www.flrules.org/gateway/View_Notice.asp?id=64B2-16.0075; and Rule 64B2-16.003, F.A.C. (*Guidelines for the Disposition of Disciplinary Cases*), published in the *Florida Administrative Register*, vol. 51, no. 220 (Nov. 12, 2025), available at https://www.flrules.org/gateway/View_Notice.asp?id=30213577.

III. Effect of Proposed Changes:

Section 1 of the bill deletes the phrase limiting patient advances for examination or treatment to amounts that "may not exceed the value of $1,500." This change repeals the maximum monetary amount chiropractic physicians may collect in advance and hold in trust for examination or treatment, effectively allowing any amount to be collected in advance. If enacted, chiropractic physicians will no longer be subject to Board discipline for collecting advanced payments in excess of $1,500 for costs and expenses of examination and treatment. The DOH states it would review any pending complaints involving collection of more than $1,500, and such complaints "would likely be closed" if the only alleged violation is collecting above the cap.[9]

The bill retains the current law relating to patient trusts accounts. If a chiropractic physician is entrusted with patient funds and property exceeding $501 in value, those monies remain subject to trust status, must be applied only to the specified patient and purpose, and remain subject to existing accounting requirements in rule.

Along with other health care practitioners, chiropractic physicians who accept payment from insurance for services rendered remain subject to the new requirement in s. 456.0625, F.S., to refund patient overpayments within 30 days after determining an overpayment occurred, with disciplinary consequences for noncompliance. The DOH indicates this includes monies held in trust and reports proposed Board disciplinary guidance for violations.[10]

Section 2 of the bill provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

[9] *See* supra note 1.
[10] *Id*.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 460.413 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Martin

33-00484-26 2026192__

A bill to be entitled

An act relating to patient funds held in trust by chiropractic physicians; amending s. 460.413, F.S.; deleting the limitation on the amount of patient funds a chiropractic physician may hold in trust for specified purposes; providing an effective date.

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

Section 1. Paragraph (y) of subsection (1) of section 460.413, Florida Statutes, is amended to read:

460.413 Grounds for disciplinary action; action by board or department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(y) Failing to preserve identity of funds and property of a patient, the value of which is greater than $501. As provided by rule of the board, money or other property entrusted to a chiropractic physician for a specific purpose, including advances for costs and expenses of examination or treatment ~~which may not exceed the value of $1,500~~, is to be held in trust and must be applied only to that purpose. Money and other property of patients coming into the hands of a chiropractic physician are not subject to counterclaim or setoff for chiropractic physician’s fees, and a refusal to account for and deliver over such money and property upon demand shall be deemed a conversion. This is not to preclude the retention of money or other property upon which the chiropractic physician has a valid lien for services or to preclude the payment of agreed fees from

the proceeds of transactions for examinations or treatments. Controversies as to the amount of the fees are not grounds for disciplinary proceedings unless the amount demanded is clearly excessive or extortionate, or the demand is fraudulent. All funds of patients paid to a chiropractic physician, other than advances for costs and expenses, shall be deposited into one or more identifiable bank accounts maintained in the state in which the chiropractic physician's office is situated, and funds belonging to the chiropractic physician may not be deposited therein except as follows:

1. Funds reasonably sufficient to pay bank charges may be deposited therein.

2. Funds belonging in part to a patient and in part presently or potentially to the physician must be deposited therein, but the portion belonging to the physician may be withdrawn when due unless the right of the physician to receive it is disputed by the patient, in which event the disputed portion may not be withdrawn until the dispute is finally resolved.

Every chiropractic physician shall maintain complete records of all funds, securities, and other properties of a patient coming into the possession of the physician and render appropriate accounts to the patient regarding them. In addition, every chiropractic physician shall promptly pay or deliver to the patient, as requested by the patient, the funds, securities, or other properties in the possession of the physician which the patient is entitled to receive.

Section 2. This act shall take effect July 1, 2026.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 162
INTRODUCER:	Senator Davis
SUBJECT:	Protection from Surgical Smoke
DATE:	January 16, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			RC	

I. Summary:

SB 162 requires hospitals and ambulatory surgical centers to, by January 1, 2027, adopt and implement policies that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke.

The bill provides an effective date of July 1, 2026.

II. Present Situation:

Surgical smoke is produced by the thermal destruction of tissue using lasers or electrosurgical devices.[1] Surgical smoke has been shown to contain toxic gases, vapors and particulates, dead and live cellular material, and viruses.[2] The chemical contents of surgical smoke may include such substances denoted in the following chart:[3]

[1] The National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention, *Control of Smoke From Laser/Electric Surgical Procedures*, last updated June 30, 2017, available at https://www.cdc.gov/niosh/docs/hazardcontrol/hc11.html (last visited Jan. 13, 2026).
[2] *Id.*
[3] Centers for Disease Control and Prevention, *Surgical Smoke Inhalation: Dangerous Consequences for the Surgical Team,* June 18, 2020, available at https://blogs.cdc.gov/niosh-science-blog/2020/06/18/surgical-smoke/, (last visited Jan. 13, 2026).

Chemical Contents of Surgical Smoke				
Acetonitrile	Acetylene	Acroloin	Acrylonitrile	Alkyl benzene
Benzaldehyde	Benzene	Benzonitrile	Butadiene	Butene
3-Butenenitrile	Carbon monoxide	Creosol	1-Decene	2,3-Dihydro indene
Ethane	Ethyl benzene	Ethylene	Formaldehyde	Furfural
Hexadecanoic acid	Hydrogen cyanide	Indole	Methane	3-Methyl butenal
6-Methyl indole	4-Methyl phenol	2-Methyl propanol	Methyl pyrazine	Phenol
Propene	2-Propylene nitrile	Pyridine	Pyrrole	Styrene
Toluene	1-Undecene	Xylene		

At high concentrations, such smoke can cause ocular and upper respiratory tract irritation in health care personnel and can obstruct a surgeon's view. The smoke has been shown to have mutagenic potential.[4] Studies have shown that surgical smoke may be associated with complications such as carcinogenicity, toxicity, mutagenicity, irritants, respiratory diseases, spread of pathogenic microorganisms, Human Papillomavirus DNA transfer, Hepatitis B transfer, tumor cell transmission, headache, dizziness, drowsiness, bad hair odor, and runny eyes.[5] Some researchers have suggested that surgical smoke may act as a vector for cancerous cells that may be inhaled.[6]

According to the federal Occupational Safety and Health Administration, recognized controls and work practices for surgical smoke include:

- Using portable local smoke evacuators and room suction systems with in-line filters.
- Keeping the smoke evacuator or room suction hose nozzle inlet within two inches of the surgical site to effectively capture airborne contaminants.
- Having a smoke evacuator available for every operating room where plume is generated.
- Evacuating all smoke, no matter how much is generated.
- Keeping the smoke evacuator "ON" (activated) at all times when airborne particles are produced during all surgical or other procedures.
- Considering all tubing, filters, and absorbers as infectious waste and dispose of them appropriately.

[4] The National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention, *Control of Smoke From Laser/Electric Surgical Procedures: Engineering Controls Database,* last updated Nov. 16, 2018, available at https://www.cdc.gov/niosh/engcontrols/ecd/detail193.html, (last visited Jan. 13, 2026).

[5] Merajikhah A, Imani B, Khazaei S, Bouraghi H. Impact of Surgical Smoke on the Surgical Team and Operating Room Nurses and Its Reduction Strategies: A Systematic Review. Iran J Public Health. 2022 Jan;51(1):27-36. doi: 10.18502/ijph.v51i1.8289. PMID: 35223623; PMCID: PMC8837875. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8837875/, (last visited Jan. 13, 2026).

[6] United States Department of Labor, Occupational Safety and Health Administration, *Surgical Suite >> Smoke Plume*, available at https://www.osha.gov/etools/hospitals/surgical-suite/smoke-plume, (last visited Jan. 13, 2026).

- Using new tubing before each procedure and replace the smoke evacuator filter as recommended by the manufacturer.
- Inspecting smoke evacuator systems regularly to ensure proper functioning.[7]

Additionally, the Joint Commission, a major accrediting organization for hospitals and ambulatory surgical centers, addressed the issue of surgical smoke in its newsletter entitled "Quick Safety Issue 56: Alleviating the Dangers of Surgical Smoke."[8] In the newsletter the Joint Commission recommends that "health care organizations that conduct surgery and other procedures using lasers and other devices that produce surgical smoke should take the following actions to help protect patients and especially staff from the dangers of surgical smoke.

- Implement standard procedures for the removal of surgical smoke and plume through the use of engineering controls, such as smoke evacuators and high filtration masks.
- Use specific insufflators for patients undergoing laparoscopic procedures that lessen the accumulation of methemoglobin buildup in the intra-abdominal cavity. (Surgical smoke is cytotoxic if absorbed into the blood and can cause elevated methemoglobin.) For example, a lapro-shield smoke evacuation device — a filter that attaches to a trocar — helps clear the field inside the abdomen.
- During laser procedures, use standard precautions, such as those promulgated by the Blood-Borne Pathogen Standard (29 CFR 1910.1030) and the Center for Disease Control and Prevention's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, to prevent exposure to the aerosolized blood, blood by-products and pathogens contained in surgical smoke plumes.
- Establish and periodically review policies and procedures for surgical smoke safety and control. Make these policies and procedures available to staff in all areas where surgical smoke is generated.
- Provide surgical team members with initial and ongoing education and competency verification on surgical smoke safety, including the organization's policies and procedures.
- Conduct periodic training exercises to assess surgical smoke precautions and consistent evacuation for the surgical suite or procedural area."

III. Effect of Proposed Changes:

The bill creates s. 395.1013, F.S., to require that hospitals and ambulatory surgical centers (ASC) adopt and implement policies that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke. The bill defines:

- "Smoke evacuation system" to mean equipment that effectively captures, filters, and eliminates surgical smoke at the point of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room; and
- "Surgical smoke" to mean the gaseous byproduct produced by energy-generating devices such as lasers and electrosurgical devices. The term includes, but is not limited to, surgical plume, smoke plume, bioaerosols, laser-generated airborne contaminants, and lung-damaging dust.

[7] *Supra* n. 5.
[8] Quick Safety Issue 56: Alleviating the Dangers of Surgical Smoke., Joint Commission, December 2020, available at https://digitalassets.jointcommission.org/api/public/content/0aab00e86a2241c7afd0b117ce83610a?v=50bb955a, (last visited Jan. 13, 2026).

The bill requires hospitals and ASCs to adopt and implement the required policies by January 1, 2027.

The bill provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 162 may have an indeterminant negative fiscal impact on a hospital or an ASC if the hospital or ASC is required to purchase and maintain equipment in order to meet the requirements of the bill.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 395.1013 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Davis

5-00545-26 2026162__

A bill to be entitled

An act relating to protection from surgical smoke; creating s. 395.1013, F.S.; defining the terms "smoke evacuation system" and "surgical smoke"; requiring hospitals and ambulatory surgical centers, by a specified date, to adopt and implement policies requiring the use of smoke evacuation systems during certain surgical procedures; providing an effective date.

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

Section 1. Section 395.1013, Florida Statutes, is created to read:

395.1013 Smoke evacuation systems required.—

(1) As used in this section, the term:

(a) "Smoke evacuation system" means equipment that effectively captures, filters, and eliminates surgical smoke at the point of origin before the smoke makes contact with the eyes or respiratory tracts of occupants in the room.

(b) "Surgical smoke" means the gaseous byproduct produced by energy-generating devices, such as lasers and electrosurgical devices. The term includes, but is not limited to, surgical plume, smoke plume, bioaerosols, laser-generated airborne contaminants, and lung-damaging dust.

(2) By January 1, 2027, each licensed facility shall adopt and implement policies that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke.

Section 2. This act shall take effect July 1, 2026.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 340
INTRODUCER:	Senator Harrell
SUBJECT:	Human Trafficking Training for Nursing Students
DATE:	January 16, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 340 requires prelicensure professional and practical nursing education programs to include a two-hour course on human trafficking as part of the program's core curriculum. The course must meet the statutory content requirements applicable to the existing biennial licensure-renewal course for nurses licensed under ch. 464, F.S., be approved by the Board of Nursing (Board), and be completed by each student before graduation.

The bill also requires the Board, in coordination with the Department of Health (DOH), to oversee implementation and enforcement of the new requirement and to consult with specified stakeholders to ensure that the course content aligns with existing human trafficking education efforts.

The bill's new curriculum requirement applies to students who enroll in a nursing education program on or after July 1, 2027, and does not apply to students in accredited programs.

The bill takes effect upon becoming a law.

II. Present Situation:

Human Trafficking

Human trafficking is a form of modern-day slavery in which people are exploited through force, fraud, or coercion for sexual exploitation or forced labor.[1] The two primary types of trafficking are sex trafficking and labor trafficking.

[1] Section 787.06, F.S.

Sex trafficking is defined as a commercial sex act induced by force, fraud, or coercion, or any commercial sex act involving a child under 18, including prostitution or pornography, used to generate money for a trafficker.[2] Labor trafficking involves recruiting, harboring, transporting, providing, or obtaining a person for labor or services through force, fraud, or coercion, for purposes such as involuntary servitude, debt bondage, or slavery.[3] Florida criminalizes human trafficking for commercial sexual activity or for labor or services under s. 787.06, F.S.

Statewide efforts such as the Florida Statewide Council on Human Trafficking,[4] the direct-support organization Florida Alliance to End Human Trafficking,[5] and the annual Human Trafficking Summit[6] are designed to coordinate statewide prevention, victim identification, and response strategies among law enforcement, education, health care, and social-services stakeholders.

Reporting of Human Trafficking; Hotlines

Suspected human trafficking may be reported to several hotlines that serve different but complementary purposes.

- The National Human Trafficking Hotline (1-888-373-7888, or by texting "HELP" or "INFO" to 233733) is a confidential, toll-free, 24/7 resource operated by a nongovernmental organization with financial support from the Administration for Children and Families within the U.S. Department of Health and Human Services. [7] The hotline is a specialized, victim-centered resource that provides crisis assistance, confidential support, service referrals, and help in identifying potential trafficking situations. It is not an emergency first responder or a law enforcement agency, but it may refer cases to appropriate authorities when warranted. According to data from the National Human Trafficking Hotline, Florida ranks third in the nation in human trafficking cases reported.[8]
- Suspected trafficking in this state may be reported directly to law enforcement through the Florida Human Trafficking Hotline at 1-855-FLA-SAFE (1-855-352-7233), a statewide toll-free number operated by the Florida Department of Law Enforcement.[9]

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[2] Department of Children and Families, What is Human Trafficking?, available at https://www.myflfamilies.com/services/abuse/what-human-trafficking (last visited Jan. 14, 2026).
[3] *Id*.
[4] Section 16.617, F.S. Florida Office of the Attorney General, Statewide Council on Human Trafficking, available at https://www.myfloridalegal.com/human-trafficking/council (last visited Jan. 14, 2026).
[5] Section 16.618, F.S. Florida Alliance to End Human Trafficking, available at https://www.floridaallianceendht.com/ (last visited Jan. 14, 2026).
[6] Section 16.617(4)(d), F.S., Florida Alliance to End Human Trafficking, Human Trafficking Summit, available at https://www.humantraffickingsummit.com (last visited Jan. 14, 2026).
[7] National Human Trafficking Hotline, Human Trafficking Hotline, available at https://humantraffickinghotline.org/en (last visited Jan. 14, 2026).
[8] *Id*.
[9] According to the Attorney General's website, Attorney General Moody worked with FDLE to designate the statewide trafficking hotline after learning that the National Human Trafficking Hotline was not always sending tips directly to law enforcement. Information reported to the state hotline is directly sent to the law enforcement authority in the state best suited to provide assistance. Florida Office of the Attorney General, VIDEO: Florida Launches Statewide Human Trafficking Hotline After Radical CEO Demands National Hotline Stop Giving Timely Information to Police (May 16, 2024), available at https://www.myfloridalegal.com/newsrelease/video-florida-launches-statewide-human-trafficking-hotline-after-radical-ceo-demands (last visited Jan. 14, 2026).

- Additionally, the U.S. Department of Homeland Security, through Homeland Security Investigations, operates a separate 24/7 tip line (1-866-DHS-2-ICE) to receive reports of a wide range of federal crimes, including human trafficking. Although not specific to trafficking, this line is intended for reporting suspected criminal activity that may warrant federal investigation, particularly cases involving cross-border trafficking, immigration-related exploitation, or organized criminal networks.[10]

Biennial Human Trafficking Continuing Education for Licensed Nurses

Section 464.013, F.S., requires all nurses licensed under part I of ch. 464, F.S., to complete a two-hour continuing education course on human trafficking as a condition of license renewal every two years. This includes Licensed Practical Nurses (LPNs), Registered Nurses (RNs), and Advanced Practice Registered Nurses (APRNs).

The course must include:
- Data and information on the types of human trafficking, such as labor and sex, and the extent of human trafficking;
- Factors that place a person at greater risk of being a victim of human trafficking; public and private social services available for rescue, food, clothing, and shelter referrals;
- Hotlines for reporting human trafficking which are maintained by the National Human Trafficking Resource Center and the U.S. Department of Homeland Security;
- Validated assessment tools for identifying a human trafficking victim and general indicators that a person may be a victim of human trafficking;
- Procedures for sharing information related to human trafficking with a patient; and
- Referral options for legal and social services.[11]

There are approximately 55 of these courses available to licensees with prices ranging from $0.00 to $30.00.[12]

Signage Requirements for other Health Care Practitioners

Section 456.0341, F.S., establishes human trafficking training and workplace notice requirements for certain licensed health care practitioners. The section applies to each person licensed or certified under:
- Chapter 457, F.S. (acupuncture);
- Chapter 458, F.S. (allopathic medicine);
- Chapter 459, F.S.(osteopathic medicine);
- Chapter 460, F.S. (chiropractic medicine);
- Chapter 461, F.S. (podiatric medicine);
- Chapter 463, F.S. (optometry);
- Chapter 465, F.S. (pharmacy);

[10] U.S. Department of State, Domestic Trafficking Hotlines, available at https://www.state.gov/domestic-trafficking-hotlines (last visited Jan. 14, 2026).
[11] Section 464.013(3)(c), F.S.
[12] Department of Health, Senate Bill 340 Legislative Analysis (Nov. 10, 2025) (on file with the Senate Committee on Health Policy).

- Chapter 466, F.S. (dentistry);
- Part II, part III, part V, or part X of ch. 468, F.S. (including, among others, speech-language pathology and audiology, nursing home administration, dietetics and nutrition, and respiratory therapy);
- Chapter 480, F.S. (massage therapy);[13] and
- Chapter 486, F.S. (physical therapy).

Section 456.0341(1), F.S., requires that, by January 1, 2021, each licensee or certificate-holder must complete a one-hour continuing education course on human trafficking that is board-approved, or the DOH-approved if there is no board.[14] The course must address both sex trafficking and labor trafficking, how to identify individuals who may be victims, how to report suspected cases, and available victim resources. Any board that requires completion of the course must count this hour within the total continuing education hours otherwise required for that profession, rather than as an additional requirement.

Subsection (3)[15] requires that, by January 1, 2025, licensees or certificate-holders post in their place of work, in a conspicuous area accessible to employees, a sign at least 11 by 15 inches, printed in a clearly legible font of at least 32-point type, stating in English and Spanish[16] the specific human-trafficking notice language set out in the statute:

> *"If you or someone you know is being forced to engage in an activity and cannot leave, whether it is prostitution, housework, farm work, factory work, retail work, restaurant work, or any other activity, call the Florida Human Trafficking Hotline, 1-855-FLA-SAFE, to access help and services. Victims of slavery and human trafficking are protected under United States and Florida law."*

While this requirement does not apply to persons licensed under ch. 464, F.S., nurses commonly practice in health care settings such as hospitals, clinics, physician offices, and other facilities, with licensees who are subject to the notice requirement. As a result, nurses are likely to work in environments where the human trafficking notice required by s. 456.0341(3), F.S., is displayed.

III. Effect of Proposed Changes:

SB 340 adds a new paragraph (h) to s. 464.019(1), F.S.

Under the bill, the professional or practical nursing education program must:

- Require students to complete a two-hour course on human trafficking that meets the requirements of s. 464.013(3)(c), F.S.

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[13] Section 480.043, F.S., imposes additional requirements on massage establishments relating to human trafficking.
[14] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within DOH or, in some cases, within DOH's Division of Medical Quality Assurance (MQA).
[15] Chapter 2024-184, Laws of Fla.
[16] The DOH has also provided Mandarin translations of signs for use in offices where those languages are spoken. Florida Department of Health, *Human Trafficking*, FLHealthSource.gov, available at https://flhealthsource.gov/humantrafficking/ (last visited Jan. 14, 2026).

- Include this course as part of its core curriculum.
- Obtain Board of Nursing approval for the course.
- Require students to complete the course before graduating from the program.

By cross-referencing s. 464.013(3)(c), F.S., the bill incorporates into prelicensure education the same substantive content currently required for nurses' biennial human trafficking continuing education, including instruction on types of trafficking, risk factors, indicators, screening, communication, and referral options. While the human trafficking continuing education requirement for practicing nurses does not expressly require a "board-approved" course, SB 340 explicitly requires Board of Nursing approval for the prelicensure course.

SB 340 directs the Board, in coordination with the DOH, to:

- Oversee implementation and enforcement of the new curriculum requirement; and
- Consult with human trafficking advocacy organizations and local law enforcement agencies to ensure that the human trafficking course curriculum offered by nursing education programs:
  - Remains consistent with current laws and best practices, and
  - Aligns with existing human trafficking education efforts.

The bill provides that the new paragraph (h) applies to students who enroll in a nursing education program on or after July 1, 2027, giving the Board time to approve courses and programs time to incorporate the requirement into their curricula before it becomes a graduation requirement for new cohorts.

The bill provides that it will take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Nursing education programs will need to obtain a human trafficking course that meets the bill's requirements, integrate the course into their curriculum, and ensure documentation that all affected students complete the course before graduation. Associated costs are expected to be modest, given the existing body of human trafficking training materials available to health care providers.[17]

C. Government Sector Impact:

The bill requires the Board of Nursing and the DOH to review and approve the human trafficking course and to oversee the implementation and enforcement of the bill's requirements. While there may be some additional workload associated with course reviews and ongoing oversight, the fiscal impact on the Board and the DOH is expected to be minor and absorbable within current resources.

VI. Technical Deficiencies:

The DOH has noted that once the Board approves a program application, the program becomes an approved program and the Board may not impose any condition or requirement on an approved program except as expressly provided in that section, pursuant to s. 464.019(8), F.S.[18] There is no explicit directive in the bill for an existing approved program to seek revision of its program and include an approved human trafficking course as part of its curriculum or to require its students to take such a course. An amendment may be considered for clarification.

VII. Related Issues:

Because the new requirement is placed in s. 464.019(1), F.S., and accredited programs are exempt from subsections (1)-(3) under s. 464.019(9)(a), F.S., the bill excludes accredited programs from the human trafficking curriculum requirement. If it is intended for the course requirement to apply to all nursing education programs, then the bill should be amended.

VIII. Statutes Affected:

This bill substantially amends section 464.019 of the Florida Statutes.

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[17] CE Broker, course search results for "human trafficking" – Florida advanced practice registered nurse, available at https://courses.cebroker.com/search/fl/advanced-practice-registered-nurse?coursePageIndex=1&term=human%20trafficking (last visited Jan. 14, 2026).

[18] *Supra* note 12.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

. . . . . .

The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (e) is added to subsection (1) of section 464.008, Florida Statutes, to read:

464.008 Licensure by examination.—

(1) Any person desiring to be licensed as a registered nurse or licensed practical nurse shall apply to the department to take the licensure examination. The department shall examine

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each applicant who:

(e) Beginning July 1, 2027, has completed a 2-hour course on human trafficking. The course must include the content required for the human trafficking continuing education course required under s. 464.013(3)(c).

Section 2. This act shall take effect July 1, 2026.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to human trafficking education for nurse licensure; amending s. 464.008, F.S.; revising requirements for initial licensure as a registered nurse or licensed practical nurse, beginning on a specified date, to include completion of a certain course on human trafficking; providing an effective date.

By Senator Harrell

31-00332B-26 2026340__

A bill to be entitled

An act relating to human trafficking training for nursing students; amending s. 464.019, F.S.; requiring nursing education programs to include a course on human trafficking meeting specified criteria as part of their core curriculum; requiring that the course be approved by the Board of Nursing; requiring that students complete the course before graduating from such programs; requiring the board, in coordination with the Department of Health, to oversee implementation and enforcement of the new education requirements; requiring the board and the department to consult with certain entities to ensure the course curriculum remains consistent with certain criteria; providing applicability; providing an effective date.

WHEREAS, the Legislature finds that human trafficking is a critical public health crisis and safety issue affecting thousands of individuals across Florida, and

WHEREAS, nurses play a key role in identifying and assisting victims of human trafficking, as nurses are often among the first and the last health care providers to interact with individuals at risk, and

WHEREAS, the state has already taken steps to educate licensed nurses on human trafficking through chapter 2017-23, Laws of Florida, which requires continuing education on human trafficking biennially as a condition of licensure renewal for nurses, and

WHEREAS, to expand and strengthen these efforts, the

Legislature finds that requiring human trafficking training as a condition for initial licensure for nurses will ensure that all newly licensed nurses in Florida enter the workforce with the skills and knowledge to identify and respond to human trafficking cases, NOW, THEREFORE,

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

Section 1. Paragraph (h) is added to subsection (1) of section 464.019, Florida Statutes, to read:

464.019 Approval of nursing education programs.—

(1) PROGRAM APPLICATION.—An educational institution that wishes to conduct a program in this state for the prelicensure education of professional or practical nurses must submit to the department a program application and review fee of $1,000 for each prelicensure nursing education program to be offered at the institution's main campus, branch campus, or other instructional site. The program application must include the legal name of the educational institution, the legal name of the nursing education program, and, if such institution is accredited, the name of the accrediting agency. The application must also document that:

(h) The professional or practical nursing education program requires students to complete a 2-hour course on human trafficking which meets the requirements of s. 464.013(3)(c) as part of its core curriculum. The course must be approved by the board. The program must require students to complete the course before graduating from the program. The board, in coordination with the department, shall oversee implementation and enforcement of this paragraph and consult with human trafficking

advocacy organizations and local law enforcement agencies to ensure that the course curriculum offered by nursing education programs remains consistent with current laws and best practices and aligns with existing human trafficking education efforts. This paragraph applies to students who enroll in a nursing education program on or after July 1, 2027.

Section 2. This act shall take effect upon becoming a law.

Health Care Practitioner Regulation in Florida and Other States

Presentation to the Senate Committee on Health Policy

Wendy Scott, Staff Director for Health and Human Services

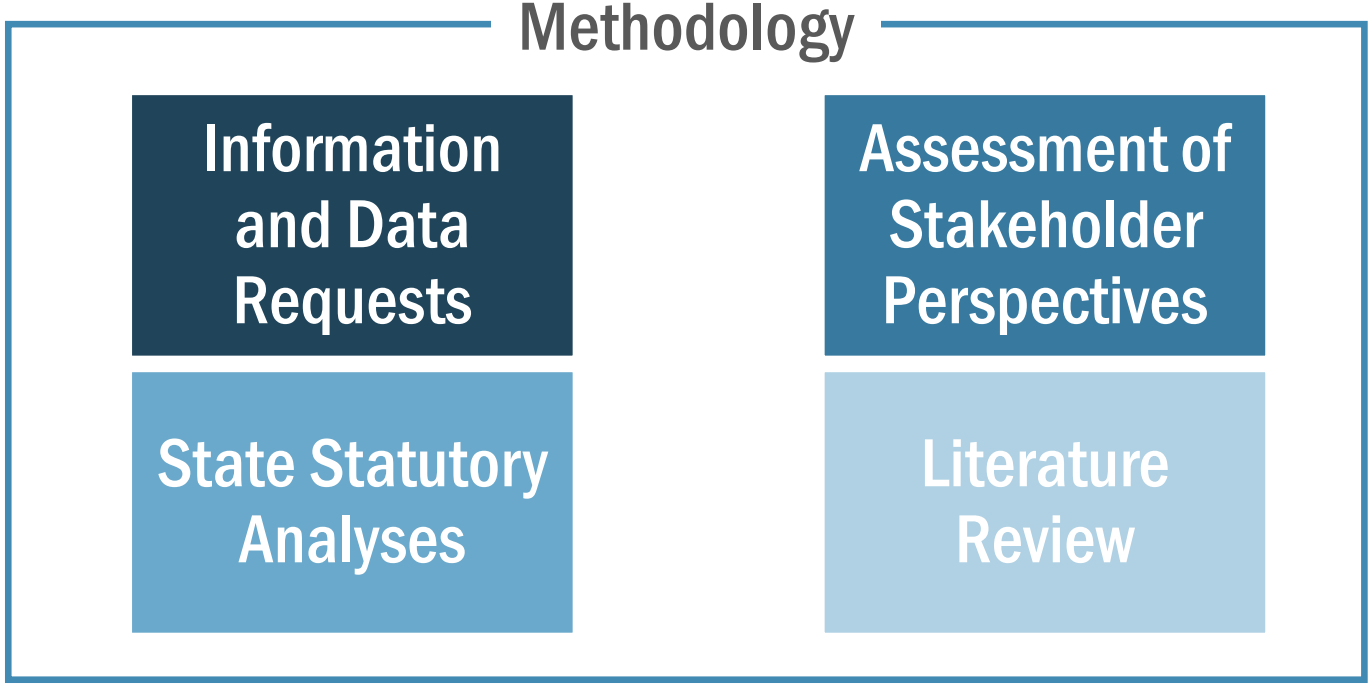
OPPAGA

Office of Program Policy Analysis and Government Accountability

JANUARY 20, 2026

Project Scope and Methodology

- As directed by the Legislature, OPPAGA examined
  - Health care practitioner regulation and licensure in Florida and other states
  - Best practices to address licensure barriers
  - Alternatives to Florida's approach to health care board oversight



Occupational Licensure

Occupational licensing has several benefits, but requirements may pose barriers to entering a profession

Benefits

- Safeguards the public
- Allows consumers to distinguish low-quality from high-quality practitioners
- Allows practitioners to achieve greater professionalization, legitimacy, and pay

Drawbacks

- Licensing requirements such as examination, continuing education, and licensure and renewal fees may pose barriers to entering a profession
- State-specific licensing requirements may reduce geographic mobility, which can disproportionally affect certain populations such as active-duty military service families

Regulating and Licensing Occupations

Multiple entities collaborate to regulate and license occupations

State legislatures establish occupational licensing laws and regulations

State agencies and boards establish rules about licensing requirements and perform licensing functions

Administration

- Setting and collecting examination, licensing, and other fees
- Managing boards' budgets

Licensure and Professional Practice

- Determining standards for licensing, relicensing, continuing education, and professional practice
- Administering licensure examinations
- Reviewing license applications and issuing licenses and renewals
- Investigating complaints and disciplining licensees

Occupational Licensing Best Practices

Research suggests best practices for reducing barriers and complying with anti-trust laws

Best practices for reducing barriers to entering a profession and allowing geographic mobility

- Promoting licensure reciprocity across states
- Aligning licensing requirements among states

Best practices for complying with federal anti-trust laws

- Appointing non-practitioners to boards
- Strengthening state supervision of boards

Supreme Court Case

- In 2010, the U.S. Federal Trade Commission brought an anti-trust complaint against the North Carolina Board of Dental Examiners for notifying non-dentists and their suppliers that only licensed dentists could whiten teeth.
- In 2015, the U.S. Supreme Court ruled that because a controlling number of the board's decision makers are active participants in the occupation that the board regulates, the board was treated as a private entity and its actions were anti-competitive and in violation of federal anti-trust laws.

Health Care Practitioners Are Subject to Occupational Licensure

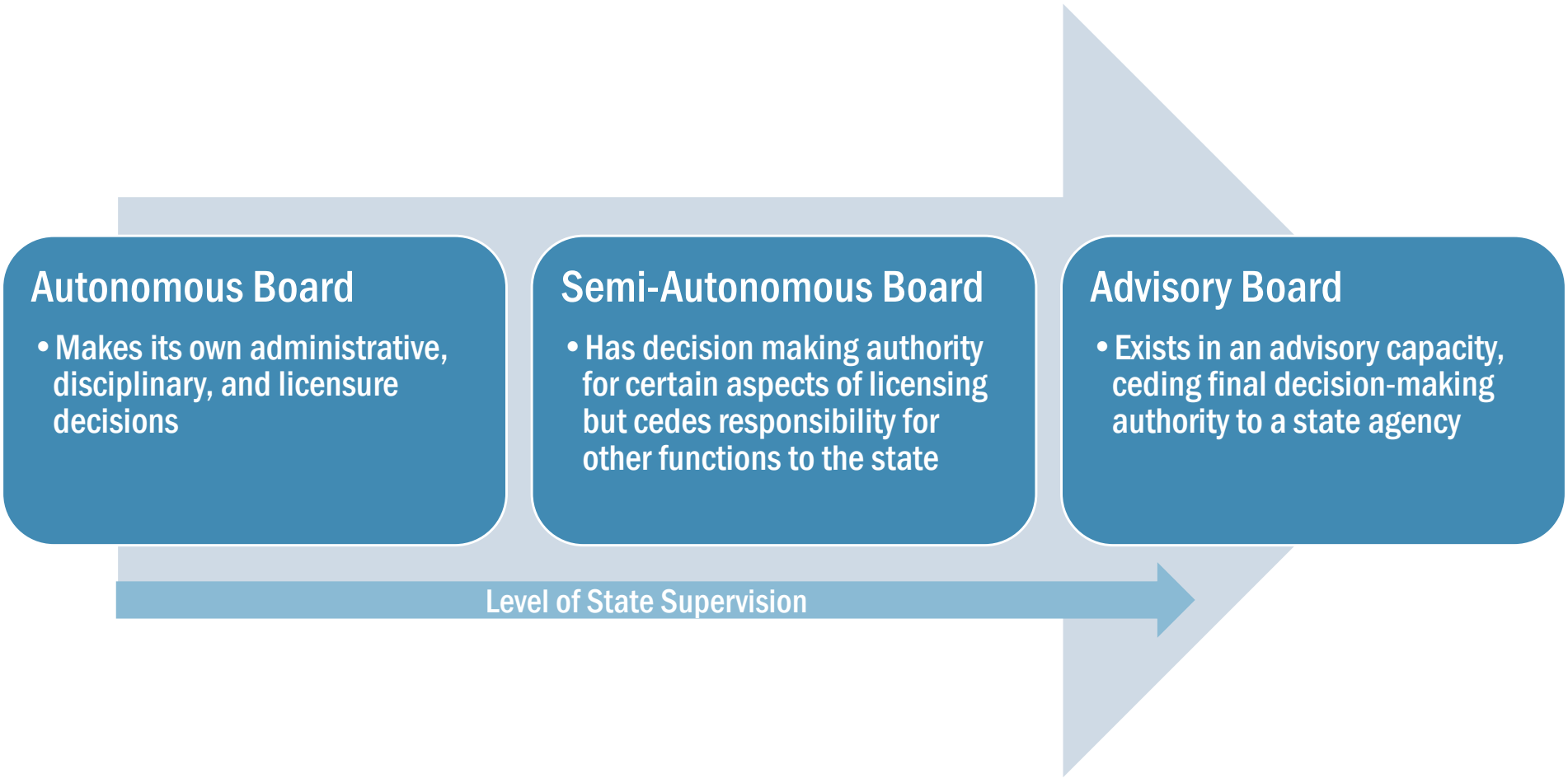
Health care boards are involved in the regulation and licensure of health care occupations

Health care boards are in all states and are charged with regulating and licensing health care professions, though functions vary by state. Boards are typically composed of volunteer members of the regulated profession and lay members.

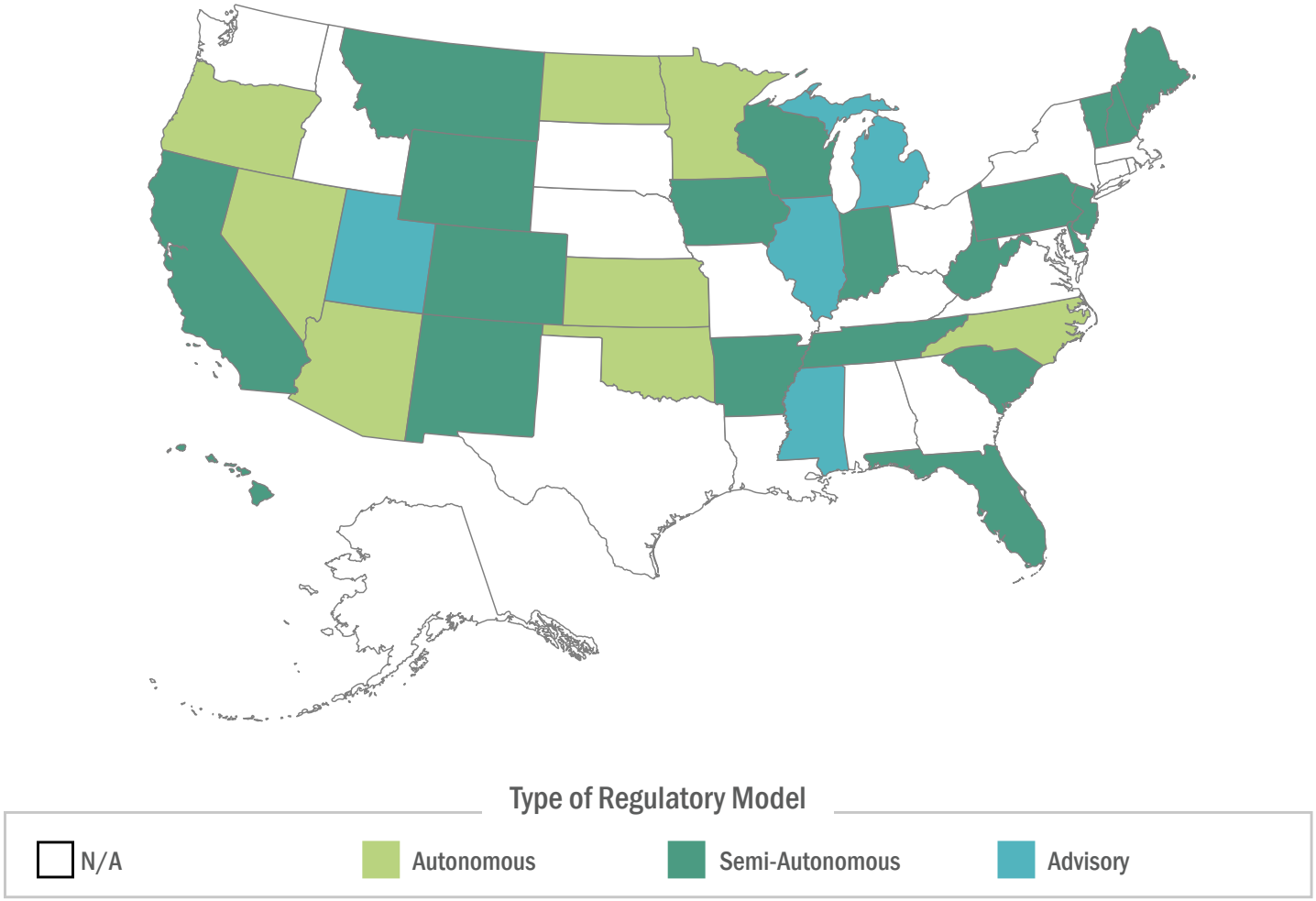
In Florida, the Department of Health (DOH) is responsible for licensing and regulating more than 40 health care professions and provides administrative support for 22 professional boards including the boards of

- Medicine
- Osteopathic Medicine
- Nursing

Health Care Board Regulatory Autonomy Varies by State; Florida Has Semi-Autonomous Boards



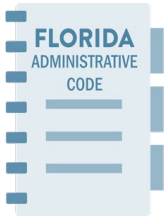
Among States That Use Only One Regulatory Model, the Most Commonly Reported Was Semi-Autonomous



Source: OPPAGA analysis of Council on Licensure, Enforcement, and Regulation self-reported survey data.

Florida Health Care Boards Share Licensing Responsibilities With DOH

Licensing Responsibilities



DOH and Boards both have rulemaking authority, depending on the implementing statute

DOH conducts administrative review of applications for licensure

Boards certify that licensees meet licensure requirements

DOH issues licenses

DOH investigates complaints

Boards discipline practitioners

Alternatives to Florida's Health Care Board Oversight: Other State Examples

Some States Supervise Boards Using the Advisory Regulatory Model

In Florida, boards are semi-autonomous and share responsibilities with the Department of Health.

Other States Use the Advisory Model

In advisory states, the legislature does not statutorily authorize health care boards to have independent decision-making authority. Instead, a state agency is typically authorized to create rules and conduct disciplinary hearings, though boards may advise state agencies in certain matters.

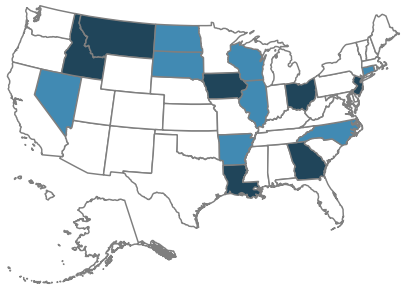
- The Illinois Medical Board advises the Department of Financial and Professional Regulation in several areas, including
  - changing rules related to practitioner regulation;
  - assisting the department in reviewing applications; and
  - conducting hearings related to disciplinary actions

- In Utah, boards advise the regulatory department and retain several other functions, including
  - approving and establishing a passing score for applicant examinations; and
  - screening applicants for licensure.

States May Provide Board Oversight via Legislative Review of Proposed or Existing Rules

In Florida, s. 120.545, *Florida Statutes*, authorizes the Joint Administrative Procedures Committee (JAPC) to examine proposed rules. However, the relevant state agency or board is not required to modify, amend, withdraw, or repeal the rule if JAPC objects.

Other States



15 states authorize legislative entities to reject or invalidate proposed or existing rules, using either a two-house veto or committee veto.

Two-House Veto

A rule can be rejected or modified by majority vote of the whole legislature.

Committee Veto

The committee itself can reject or modify a rule.

Other Methods of Board Oversight Include Processes for Halting Board Actions and Removing Board Members

Florida

Halting Board Actions

Florida law provides the State Surgeon General standing to challenge any health care board rule or proposed rule to the Division of Administrative Hearings.

Removing Board Members

The Governor can suspend from office any board member for malfeasance, neglect of duty, drunkenness, incompetence, permanent inability to perform official duties, or commission of a felony.

Other States

The Vermont Director of the Office of Professional Regulation monitors board actions and can halt board actions and implement alternative actions.

In Illinois, the secretary of the department that oversees health care practitioner licensing can remove any member of the board of nursing.

In Utah, the director of professional licensing may remove a board member.

Some States Require Legislative Appropriation of Board Funds, While Some Boards Have Direct Access to Funds

Typically, states' health care boards are funded through fees from practitioner licenses and fines.

Type of Board Funding	
Florida	
Legislative appropriation of fees and fines	• Legislative appropriation through the Medical Quality Assurance Trust fund, funded through board fees and fines.
Other States	
Direct access to fees and fines revenue	• Boards of health charge fees for licensing and can discipline practitioners through imposing fines. Boards deposit these revenues into banks outside state treasuries and access them directly. (Alabama and Nevada)
Legislative appropriation from state general funds	• Legislature allocates health care boards general revenue funds for expenditures in addition to trust funds comprised of practitioner-related fees. (Massachusetts)

State Statute Determines Board Composition, Which Varies by State

Practitioner Specialty

- Florida statute does not require some boards to have members with certain subfields or specialties.
- The Illinois Medical Board requires members with subspecialties.

Geographic Location

- Florida statute does not have requirements related to appointment of board members based on location.
- Alabama requires board membership to reflect the geographic and urban/rural composition of the state.
- Minnesota allots no more than one member per congressional district.

Inclusion of Lay Members

- In Florida, the Governor must appoint one or more non-practitioners to health care boards, but there are no requirements for lay members characteristics.
- South Carolina, Louisiana, and Nebraska impose lay member requirements.

Governors or State Entities Appoint Board Members; Practitioners or The Board Also Elect Board Members

In Florida, the Governor selects and appoints health care board members, who are then confirmed by the Senate.

Other States

State agency head appointment	Heads of agencies that oversee health care boards appoint board members (Illinois, New York—Board of Nursing, and Utah)
Governor appointment with recommendations from professional associations	Professional associations make recommendations. Statute may specify which professional associations submit lists of practitioners to the governor; in some cases, governor must select from list (Kansas, Minnesota, and New York—State Board of Professional Medical Conduct)
Executive and legislative appointment	Governor, lieutenant governor, and speaker of the house of representatives appoint board members (Alabama—Medical Licensure Commission)
Board election	Board conducts an election among licensed practitioners to nominate some or all board members (Alabama—Board of Medical Examiners and South Carolina)
Governor and board appointment	Governor appoints members to an oversight board and that board appoints members of all boards (Nebraska)

State Statutes May Dictate Term Limits for Board Members

In Florida, members of the boards of Medicine, Osteopathic Medicine, and Nursing serve four-year terms until the Governor appoints a successor; statute does not limit the number of terms members can serve.

Other States

Term number	Dictate the number of terms a board member may serve. (Illinois, Minnesota, Nebraska)
Term sequence	Specify whether terms can be consecutive. For example, members of the Illinois Medical Board, Kansas Board of Nursing, Nebraska Board of Health, and Utah Board of Medical Practice may only serve two consecutive terms.
Member vacancies	Clarify the number of additional terms a replacement board member can serve after filling a vacancy. For example, replacements may serve the remainder of an unexpired term (Kansas Board of Nursing, Nebraska State Board of Health, and Illinois Board of Medicine) or one additional term after the replacement term (Utah health care licensing boards).

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FLORIDA LEGISLATURE OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations.

OPPAGA
Office of Program Policy Analysis and Government Accountability

Research Memorandum

January 14, 2026

Health Care Practitioner Regulation in Florida and Other States

EXECUTIVE SUMMARY

Multiple entities collaborate to regulate and license occupations. Occupational licensing establishes minimum educational, training, and experience requirements to protect public safety. However, licensing may also create barriers to entering professions, and because each state may have different requirements, reduce geographic mobility in licensed professions. Research suggests that best practices to reduce barriers include promoting licensure reciprocity across states, aligning licensing requirements among states, and increasing licensing and regulatory oversight. Licensure reciprocity and aligning licensing requirements among states can be accomplished by joining health care interstate licensure compacts, which are legally enacted agreements between two or more states to mutually recognize each state's practitioner licenses.

REPORT SCOPE

As directed by the Legislature, OPPAGA examined how states license and regulate health care practitioners and whether Florida's framework could be strengthened by adopting best practices that would enhance public safety and reduce unnecessary barriers to becoming licensed to practice. Additionally, OPPAGA examined alternatives to Florida's approach to health care board oversight.

Regulatory frameworks determine how state agencies and licensing boards oversee health care practitioners, which may be the responsibility of state agencies, licensing boards, or a shared responsibility between these two entities. OPPAGA examined physician and nurse boards across seven states and found that boards, rather than state agencies, were most often responsible for functions related to licensing and discipline and were funded fully or in part through licensure fees. In addition, OPPAGA found variability in the person or entity responsible for reviewing, approving, or vetoing a board's rulemaking activities.

In addition, OPPAGA examined health care practitioner regulatory board (health care board) oversight mechanisms in other states to identify processes that differ from those in Florida. Other states may provide oversight of health care boards in several ways that vary from Florida, including through an advisory regulatory model, legislative and executive review of proposed or existing board rules, and halting board actions or removing board members. Further, while Florida's nurse and physician regulatory boards are funded by fees from practitioner licenses that the Legislature appropriates to

the Florida Department of Health, boards in other states OPPAGA reviewed have direct access to funds generated by fees or have a mixed model of funding from fees and legislative appropriation. Unlike Florida's general approach that does not require board members with particular specialties or from specific areas, other states require some boards to have members with certain specialties or geographical representation. In addition, in Florida, board members serve four-year terms until the Governor appoints the successor and there is no limit for the number of terms a board member can serve. In other states, statutes dictate how many terms a board member may serve.

BACKGROUND

Multiple entities collaborate to regulate and license occupations; licensing has benefits and drawbacks

Occupational licensure is a regulatory method that requires people to secure a license from the government to practice a certain trade or profession. Licensing laws and regulations are established independently by each state legislature.[1] State laws and regulations may specify the requirements for obtaining a license (e.g., education, training, and experience requirements; licensure examinations; and licensure fees). State legislatures establish occupational licensing laws and regulations to specify requirements that must be met to practice in a licensed profession. Some states authorize state agencies to establish occupational licensing requirements. In other states, boards may perform these duties. Board regulatory autonomy and responsibilities vary.

In general, there are benefits of occupational licensing, such as enhanced public safety due to the establishment of minimum educational, training, and experience requirements for licensure. However, occupational licensing may also create barriers to entering professions and reduce employment and geographic mobility in licensed professions. Research on occupational licensing suggests that best practices to reduce barriers to licensing include promoting licensure reciprocity across states, aligning licensing requirements among states, and increasing licensing and regulatory oversight.

States specify the regulatory requirements necessary for occupational licensing

States vary regarding what government entity is authorized to create occupational licensing requirements and perform licensing functions. State agencies and boards establish rules for licensing, relicensing, continuing education, and professional practice standards. Other licensure-related functions of state agencies and boards include reviewing license applications and issuing licenses and renewals; investigating complaints and disciplining licensees; and setting and collecting examination, licensing, and other fees. License requirements may include background checks, education, examination, and experience. State agencies involved in licensure may include state departments that oversee the particular profession (e.g., a department of health regulating health care practitioners) but can also be state departments of consumer affairs or similar agencies that regulate all professionals.

Functions of State Agencies and Boards That Regulate Occupations

Administration

- Setting and collecting examination, licensing, and other fees
- Managing board funding

Licensure and Professional Practice

- Determining standards for licensing, relicensing, continuing education, and professional practice
- Administering licensure examinations
- Reviewing license applications and issuing licenses and renewals
- Investigating complaints and disciplining licensees

Boards typically comprise volunteer members of the regulated profession and members of the public. In some states, board members are appointed by the state's governor and confirmed by the state's senate. States may rely on different regulatory bodies and processes for confirmation.

[1] The Tenth Amendment of the U.S. Constitution reserved for the states those powers not explicitly assigned to the federal government, including occupational licensing. It also authorized states to establish laws and regulations protecting the health, safety, and general welfare of citizens.

Board regulatory autonomy and responsibilities may vary by state. Boards may be autonomous, semi-autonomous, or advisory as it relates to performing occupational licensure-related functions.[2]

- An **autonomous board** can make its own administrative, disciplinary, and licensure decisions.
- A **semi-autonomous board** has decision-making authority for certain aspects of licensing but cedes responsibility for other functions to a state agency (e.g., administration, complaint investigations, discipline).
- An **advisory board** exists in an advisory capacity, ceding final decision-making authority to a state agency. Advisory boards may still be responsible for contributing to the development of some or all of the licensing and practice standards described above but the state is responsible for providing final approval.

Board frameworks have a variety of reported advantages. A 2019 survey asked U.S. professional and regulatory organizations about the advantages and disadvantages of state regulatory structures.[3] Survey researchers categorized open-ended responses across seven domains—efficiency; funding and budget; decision-making authority; streamlining and standardization; communication and collaboration; oversight; and political authority. Autonomous boards reported advantages related to efficiency, funding and budget, and decision-making authority. Semi-autonomous boards reported advantages related to funding and budget, decision-making authority, streamlining and standardization, communication and collaboration, oversight, and political authority. (See Exhibit 1.)

Exhibit 1
States Reported Advantages Associated With Autonomous and Semi-Autonomous Boards

Domain	Examples of Reported Advantages
	Autonomous Boards
Efficiency	Faster and more direct/personal customer assistance as well as ease and flexibility to make changes and be responsive to the needs of the industry and the public
Funding and Budget	Funded by fees at no cost to the jurisdiction, with the board controlling its budget and spending
Decision-Making Authority	Latitude to carry out mission, and profession-specific legislation allows for subject matter experts with a deeper knowledge of the profession
	Semi-Autonomous Boards
Funding and Budget	- Sharing staff and resources leads to cost savings - Having a budget for multiple boards under a central agency is helpful to less financially secure boards
Decision-Making Authority	- Allows boards some decision-making autonomy - Allows practitioners with expertise to make decisions
Streamlining and standardization	- Umbrella agency provides consistency and streamlining for complaints and applications to ensure similar service - Consistency in rulemaking and other functions - Standardization of state records, financial management, human resource functions
Communication and collaboration	Facilitates communication among boards and provides one credentialing system that allows access to all board data
Political authority	A large agency has more political authority
Oversight	The agency provides appropriate oversight so that boards do not run afoul of the North Carolina Dental Decision[1]

[1] The U.S. Supreme Court determined that state regulatory boards that include a controlling number of active market participants (i.e. dentists on the North Carolina Board of Dental Examiners) are not entitled to immunity from federal antitrust laws unless the boards can show active state supervision. See North Carolina State Board of Dental Examiners v. Federal Trade Commission, 574 U.S. 494 (2015).

Source: OPPAGA analysis of Council on Licensure, Enforcement and Regulation data and information from the Florida Office of the Attorney General.

[2] The Council on Licensure, Enforcement and Regulation uses a five-model classification system (models A – E) to categorize state regulatory models. In this report, OPPAGA adopted a three-model classification system informed by the National Governor's Association. OPPAGA categorized states that use model A as *autonomous*, those that use models B, C, or D as *semi-autonomous*, and those that use model E as *advisory*.

[3] In 2020, the Council on Licensure, Enforcement and Regulation published results of a survey on occupational and professional regulation. Of the organizations surveyed, 161 respondents represented 45 states and the District of Columbia. Respondents were asked about their state's regulatory structure (i.e., number and type of models employed), advantages and disadvantages of the current model(s), and whether states recently transitioned (or considered transitioning) from one model to another.

There are positive and negative aspects of occupational licensing

Research is mixed regarding the effects of occupational licensing. Some subject matter experts view minimum educational, training, and experience requirements for licensure as a means of quality control. For example, professionals' overall quality of services may be increased by having minimum educational and training requirements (e.g., completion of medical school, clinical supervision). Licensing allows consumers to distinguish between low-quality and high-quality providers and thus may reduce the number of low-quality providers in the market. Further, practitioners may seek to become licensed to achieve greater professionalization, legitimacy, social status, and pay. However, research also suggests that occupational licensing requirements can create barriers to entering professions and reduce employment and geographic mobility in licensed professions. Requirements such as examination, continuing education, and licensure and renewal fees can pose barriers to entering a licensed occupation and can reduce employment in that occupation. In addition, licensing rules can restrict geographic mobility; licensed workers may be less likely than unlicensed workers with similar education to move to a new state, in part because they may be required by the new state to complete different training and educational requirements than their previous state and would have to pay associated fees. Diminished mobility generates inefficiency in the labor market, with workers unable to migrate easily to locations where job demand is higher.

Restriction of geographic mobility can disproportionally affect certain populations, such as active-duty military service members and military spouses. For example, according to a 2017 survey of 1,273 spouses of retired or active-duty military service members, more than one in five military spouses reported that the inability to transfer their professional license to a new state was among the greatest employment challenges. Compared to civilians, military spouses are 10 times more likely to have moved across states, which may make it difficult and costly to obtain a new license in each new state.

Research identifies best practices to reduce barriers to licensure. According to occupational licensing research, best practices to reduce barriers to licensing include promoting licensure reciprocity across states, aligning licensing requirements among states, and reducing the potential for board member conflicts of interest. Some economic research indicates that restrictions on licensure reciprocity limit occupational migration and mobility for at least some professions by restricting the number of available practitioners in a geographic area.[4] Removing these restrictions or taking other measures—such as aligning the training and educational licensing requirements between states—can ease practitioners' ability to enter new markets. Aligning licensing requirements among states involves standardizing the requirements a licensee must complete for licensure (e.g., minimum number of clinical hours, years and type of training experience, examination requirements), such that the least restrictive standard is applied in each state.

In addition, appointing more non-practitioners to boards is a best practice to address a potential conflict of interest that could arise from majority practitioner boards developing licensing rules to regulate their own profession. Increasing licensure and regulatory oversight may also mitigate the potential conflict of interest of practitioners on boards who have a vested interest in writing rules that prevent other practitioners from encroaching on their scope of practice.[5] For example, in 2010, the U.S. Federal Trade Commission brought an anti-trust complaint against the North Carolina Board of Dental Examiners for sending a cease-and-desist letter to non-dentists and their suppliers warning them that

[4] License reciprocity agreements are arrangements between states in which at least one state recognizes the professional license of a person from the other state.

[5] Scope of practice refers to those activities that a licensed professional is permitted to perform, which is generally determined by statutes enacted by state legislatures and by rules adopted by the appropriate licensing entity.

only licensed dentists could whiten teeth. The U.S. Supreme Court ruled that because a controlling number of the board's decision makers are active participants in the occupation that the board regulates, the board was treated as a private entity and its actions were anti-competitive and in violation of federal anti-trust laws.[6]

QUESTIONS AND ANSWERS

What regulatory frameworks do Florida and other states use to oversee health care professionals, and what are related advantages and disadvantages?

Regulatory frameworks determine how state agencies and licensing boards oversee health care practitioners. Practitioner oversight functions may be the responsibility of state agencies or licensing boards or a shared responsibility between these two entities. Regulatory models are a way to categorize the degree of autonomy that boards have within a regulatory framework, which may vary within states. The three types of regulatory models used are autonomous, semi-autonomous, and advisory. Florida uses a semi-autonomous regulatory model for all health care practitioner boards. Health care practitioner regulatory boards (health care boards) reported a variety of advantages of the regulatory model the boards use, including that board rulemaking authority allows those with clinical experience and expertise to make the rules.

State regulatory models are characterized by shared responsibility between state agencies and health care boards

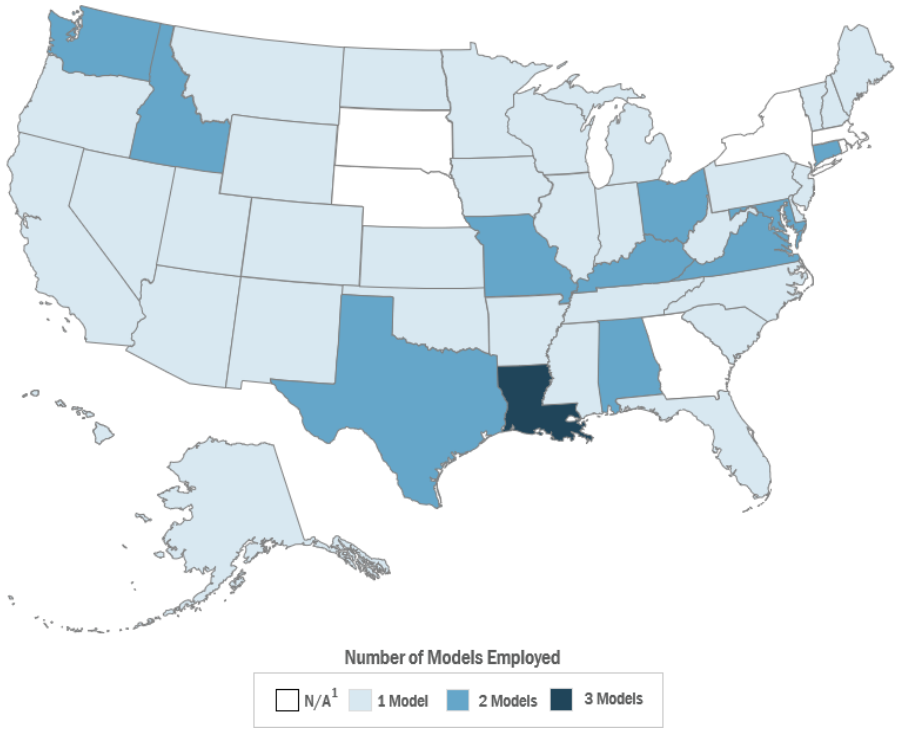
All states have health care practitioner licensing boards, but the number and type of regulatory models that a state employs varies. Some states have a single regulatory model (e.g., autonomous), while others employ multiple models. For example, a state may use an autonomous model for certain health care boards and a semi-autonomous model for others. A 2019 survey of U.S. professional and regulatory organizations found that for a subset of health care professional boards that responded to the survey, 33 of the 44 responding states employed one regulatory model for all health care practitioners, while 10 states used two models.[7,8,9] One state (Louisiana) used all three models. In the same survey, among health care professions the most commonly used model for states reporting one regulatory model was semi-autonomous. (See Exhibit 2.) According to the Florida Department of Health (DOH), all Florida health care boards are categorized as semi-autonomous.[10]

[6] North Carolina State Board of Dental Examiners v. Federal Trade Commission, 574 U.S. 494 (2015).
[7] Council on Licensure, Enforcement and Regulation. *Professional and Occupational Regulation: U.S. State Regulatory Structures.* 2020. https://compacts.csg.org/wp-content/uploads/2022/06/CLEAR-Professional-and-Occupational-Regulatory-Structures-2020.pdf.
[8] OPPAGA adapted the National Governor's Association three-model classification system, categorizing states that would be classified by the Council on Licensure, Enforcement and Regulation as model A as *autonomous*, models B, C, or D as *semi-autonomous*, and model E as *advisory*.
[9] These totals include states that reported a model that could be categorized as autonomous, semi-autonomous, advisory, or another model.
[10] DOH licenses and regulates more than 40 health care professions and provides administrative support for 22 professional boards.

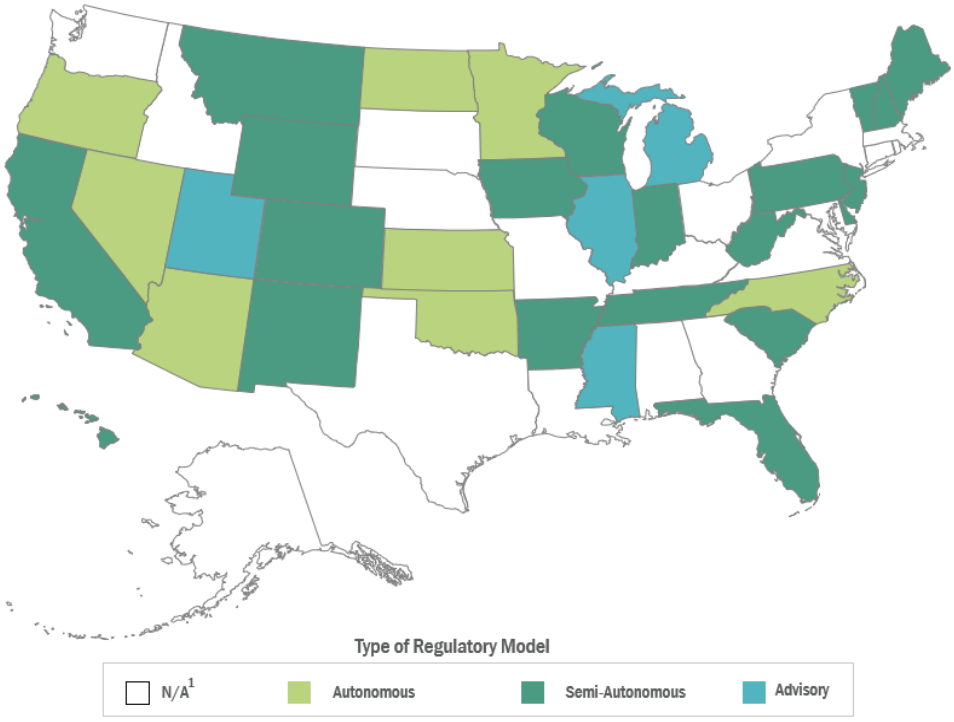
Exhibit 2

States Most Often Used a Single Regulatory Model for Health Care Professions; a Semi-Autonomous Model Was Most Often Employed in These States

Number of Models Used as of 2020



Types of Models Used in States That Used a Single Model as of 2020



[1] N/A means not applicable. For the first map, the states did not provide responses to the survey; for the second map, the states either did not provide responses or employed more than one model. Additionally, Alaska reported that it uses a model that did not meet any of these descriptions.

Source: OPPAGA analysis of Council on Licensure, Enforcement and Regulation data.

OPPAGA examined seven states' laws to identify board functions for medicine, nursing, and osteopathic medicine and found that functions vary by state. These states are California, Florida, Georgia, Illinois, New York, Oklahoma, and Texas.[11] Responsibility for determining standards for licensing and practice in rule, reviewing license applications and issuing licenses and renewals, setting and collecting licensure fees, investigating complaints, and disciplining licensees varies across the states. (See Exhibit 3.)

In four states (California, Georgia, Oklahoma, Texas), health care boards have rulemaking authority to determine standards for licensing and practice. In the remaining three states, the rule-making authority to determine standards is either made by the state (Illinois) or is shared by the state and health care boards (Florida, New York). In Georgia, Oklahoma, and Texas, health care boards review licensure applications and issue licenses and renewals and set and collect examination, licensing, and other fees. In New York, the Department of Education's Office of Professions is responsible for these tasks, although fees are set by statute. In Illinois, the Department of Financial and Professional Regulation fulfills each of these responsibilities, again with the exception of setting fees; for the Board of Medicine, statute sets fees but the Department of Financial and Professional Regulation collects the fees, while the department sets and collects fees for the Board of Nursing. In Florida, DOH and the individual health care boards share responsibility for reviewing license applications and issuing licenses and renewals and setting and collecting licensing fees. Across the seven states that OPPAGA reviewed, boards are most often responsible for functions related to licensing and discipline.

Exhibit 3
Across the Seven States That OPPAGA Reviewed, Health Care Boards Were Most Often Responsible for Functions Related to Licensing and Discipline

	Board	Rulemaking Authority to Determine Standards for Licensing and Practice[1]	Reviewing License Applications and Issuing Licenses and Renewals	Setting and Collecting Licensure Fees[2]	Investigating Complaints and Disciplining Licensees
 California	Medicine	Board	Board	Statute sets fees; Board collects fees	Board
	Nursing			Shared	
	Osteopathic Medicine				
 Florida	Medicine	Shared—Florida Department of Health and Board	Shared	Shared	Shared—Florida Department of Health investigates; Board disciplines
	Nursing				
	Osteopathic Medicine				
 Georgia	Medicine	Board	Board	Board	Board
	Nursing				
 Illinois	Medicine	Department of Financial and Professional Regulation[3]	Department of Financial and Professional Regulation	Statute sets fees; Department of Financial and Professional Regulation collects fees	Department of Financial and Professional Regulation
	Nursing			Department of Financial and Professional Regulation	

[11] While some states have one board of medicine that includes both medical doctors and osteopathic physicians, California, Florida, New York, and Oklahoma have one board for each physician type.

	Board	Rulemaking Authority to Determine Standards for Licensing and Practice[1]	Reviewing License Applications and Issuing Licenses and Renewals	Setting and Collecting Licensure Fees[2]	Investigating Complaints and Disciplining Licensees
 New York	Medicine	Shared—Department of Education, Office of Professions, and Board	Department of Education, Office of Professions	Statute sets fees; Department of Education, Office of Professions collects fees	State Board for Professional Medical Conduct
	Nursing				Shared—Department of Education, Office of Professions, investigates; Board disciplines
 Oklahoma	Medicine	Board	Board	Board	Board
	Nursing				
	Osteopathic Medicine				
 Texas	Medicine	Board	Board	Board	Board
	Nursing				

[1] In most cases, legislatures determine standards for licensing and practice in statute. Though responsibility to enforce the provisions of law varies, some states may give such authority to departments responsible for occupational licensing or to health care boards.
[2] Shared as it relates to setting and collecting licensure fees indicates that any legislature, department, or board collaborates in setting fees. In some cases, the legislature may set fees in statute, while in other cases the legislature directs the board to set fees.
[3] While the Illinois Department of Financial and Professional Regulation has rule-making authority to determine standards for licensing and practice, department rules relating to physician licensure and regulation must first be reviewed by the Illinois State Medical Board.

Source: OPPAGA analysis of state statute and information received from state health care boards.

Among the seven states examined, oversight of board rules and selection and confirmation of board members also varies. Health care boards in all seven states that OPPAGA reviewed are funded fully or in part through licensing fees. However, across the states, there is variability in the person or entity responsible for reviewing, approving, or vetoing a board's rulemaking activities, which can include rules to determine standards for licensing, relicensing, continuing education, and professional practice. (See Exhibit 4.)

In Georgia, the governor has the authority and duty to actively supervise all professional licensure boards. For example, the governor must approve or veto any rules made by a state board, in writing, before the rule is filed with the secretary of state or becomes effective. In Texas, such oversight is provided through legislative review and by the Regulatory Compliance Division within the Office of the Governor; health care boards are statutorily required to periodically review established board rules. In Florida, the surgeon general may challenge any rule or proposed rule made by a health care board. Upon such a challenge, the rule is subject to review by an administrative law judge. Proposed rules are also reviewed by the Office of Fiscal Accountability and Regulatory Reform (OFARR) within the Executive Office of the Governor.[12] OFARR may suspend or halt rules that it determines impede entry to the profession or industry; impose additional or unnecessary fees on professionals or industries currently in the profession or seeking entry into the profession; or are not the most efficient and cost-effective method of imposing a regulation.

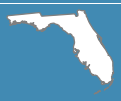
Although most state health care boards that OPPAGA examined have an entity responsible for reviewing and approving board rules, boards reported that this oversight does not typically result in rules being overturned or vetoed. OPPAGA asked health care board officials in Georgia, Oklahoma, and Texas if the entity that oversees health care board rules has ever disapproved or vetoed board rules. Officials from Georgia's Composite Medical Board reported that to their knowledge, the last three

[12] Office of the Governor Executive Order Number 11-01 created the OFARR in 2011.

governors have not vetoed any rules. Similarly, Texas Board of Nursing representatives reported that to their knowledge, the Governor's Regulatory Compliance Division has never disapproved rules. In Oklahoma, a board of medicine representative reported that only once, in 2023, did the legislature and governor disapprove board rules related to physician assistants and controlled substances with a high potential for abuse. In Florida, DOH officials reported that since 2020, the Surgeon General has not declared health care practitioner board rules invalid, and they are not aware of OFARR suspending or halting any health care board rules.

The selection and confirmation of board members is frequently performed by the governor and subject to state senate confirmation. In six of the seven states OPPAGA examined, the governor selects board members. In five states, board appointments are then confirmed by the state senate. In New York, the board of regents appoints a state board for each licensed profession on the recommendation of the commissioner of education.[13]

Exhibit 4
Across the Seven States Reviewed, Health Care Boards Have Various Funding, Practice Rules Oversight, and Board Member Selection and Confirmation Processes

	Board	Board Funding	Approval and Review of Practice Rules	Selection and Confirmation of Board Members
 California	Medicine	License fees and fines	Administrative Procedure Act	Appointed by governor, confirmed by Senate; Senate and Assembly each appoint one member
	Nursing			Appointed by governor; Senate and Assembly each appoint one member
	Osteopathic Medicine	License fees, fines, and bail forfeitures from prosecution of the Medical Malpractice Act		Appointed by governor, confirmed by Senate; Senate and Assembly each appoint one member
 Florida	Medicine	License fees and fines	Surgeon General and the Governor's Office of Fiscal Accountability and Regulatory Reform	Appointed by Governor, confirmed by Senate
	Nursing			
	Osteopathic Medicine			
 Georgia	Medicine	License fees	Governor	Appointed by governor, confirmed by Senate
	Nursing			
 Illinois	Medicine	License fees and fines	Board reviews Department of Financial and Professional Regulation rules	Appointed by governor, consent of Senate
	Nursing	License fees, fines, and penalties	Board consults on Department of Financial and Professional Regulation rules	Appointed by Secretary of the Department of Financial and Professional Regulation
 New York	Medicine	License fees	Administrative Regulations Review Commission	Appointed by Board of Regents on recommendation of Commissioner of Department of Education
	Nursing			

[13] In New York, the board of regents is a 17-member committee elected by the legislature and responsible for the general supervision of all educational activities in the state, including licensing professions.

	Board	Board Funding	Approval and Review of Practice Rules	Selection and Confirmation of Board Members
 Oklahoma	Medicine	License fees	Governor, Legislature	Appointed by governor from nominees submitted by Oklahoma State Medical Association
	Nursing			Appointed by governor from list submitted by nursing organizations
	Osteopathic Medicine			Appointed by governor from list submitted by Oklahoma Osteopathic Association
 Texas	Medicine	License fees	Legislative review and Governor; Boards are statutorily required to periodically review established board rules	Appointed by governor, advice and consent of Senate
	Nursing			

Source: OPPAGA analysis of state statute and information received from state health care boards.

Health care board structures have a variety of reported advantages; several states modified board structures to avoid conflicts of interest associated with practitioners regulating their own professions

For the seven states that it examined, OPPAGA asked nursing and medical boards about advantages and disadvantages of the current regulatory model.[14] Boards with rulemaking authority highlighted the advantage of decisions and rules being made by those with subject matter expertise and direct clinical experience. Two boards reported that authorizing boards to determine standards for licensing, continuing education, and professional practice has the advantage of consistency and uniformity as well as protecting the public, facilitating accountability, and providing expert oversight. In addition, two boards that shared licensure responsibilities with state agencies noted that the arrangement helped ease administrative burdens. For example, a stakeholder reported that state agencies have staff trained and equipped to handle financial and collections processing, freeing up board staff to focus on practice policies and disciplinary adjudication.

To avoid potential board member conflicts of interest, several states have tried to strengthen health care board oversight mechanisms. For example, in 2017, Mississippi proposed and passed legislation that authorized the governor, secretary of state, and attorney general to approve any new regulation passed by a state licensing board prior to it taking effect. Mississippi law was amended again in 2020 to include within this regulatory authority the power to review existing occupational regulations promulgated by an occupational licensing board. In 2018 and 2019, Kentucky proposed but did not pass legislation to reorganize all of the state's professional licensing boards within the Department of Professional Licensing to provide centralized legal and administrative services and active state supervision, which 39 of the state's 43 occupational licensing boards do not have.[15,16] In 2022, the California State Assembly proposed legislation that would increase the number of public board members on the Medical Board of California to a majority, shifting the board's powers to the public; the legislature did not approve the legislation.[17]

[14] OPPAGA received responses from the Medical Board of California, Florida Department of Health, Georgia Composite Medical Board, Oklahoma Board of Medical Licensure and Supervision, Oklahoma State Board of Osteopathic Examiners, and Texas Board of Nursing.
[15] Another reason for the proposed legislation was to protect board members from personal liability in anti-trust lawsuits after the 2015 Supreme Court ruling that boards must show active state supervision to comply with federal anti-trust law.
[16] Kentucky's 2018 and 2019 legislation was unsuccessful, in part, because stakeholders were concerned that active state supervision would not prioritize a profession's best interests.
[17] The California Orthopaedic Association opposed having a board public member majority because the association asserted that physicians are uniquely qualified to establish and maintain appropriate standards for their profession.

What are alternatives to Florida's approach to health care board oversight?

OPPAGA examined health care board oversight mechanisms in other states to identify processes that differ from those in Florida and may offer alternatives to the state's current approach. OPPAGA found that other states may oversee boards in several ways that vary from Florida's approach, including through an advisory regulatory model, legislative and executive review of board rules, and halting board actions or removing board members. Further, while Florida's nurse and physician regulatory boards are funded by fees from practitioner licenses that the Legislature appropriates to the Florida Department of Health, boards in other states have direct access to funds generated by fees or have a mixed model of funding from fees and legislative appropriation. Unlike Florida's general approach that does not require board members with particular specialties or from specific areas, other states require some boards to have members with certain specialties or geographical representation and to have lay members with certain characteristics. Finally, in Florida, board members serve four-year terms until the Governor appoints the successor and there is no limit for the number of terms a board member can serve. In other states, statutes dictate how many terms a board member may serve.

States supervise health care boards via the advisory regulatory model, through legislative and executive review of board rules, and by halting board actions or removing board members

States' supervision of health care boards has been influenced by anti-trust litigation. The U.S. Supreme Court's 2015 ruling on the Federal Trade Commission's anti-trust complaint against the North Carolina Board of Dental Examiners held that boards dominated by active-market participants require "active state supervision" to prevent violation of anti-trust laws.[18,19] To determine how other states' supervision of boards differs from Florida, OPPAGA reviewed some states' statutes and found that, unlike Florida, some states deem boards to only be advisory, provide legislative review of proposed and existing rules, and create processes for halting board actions and removing board members.

Health care board authority varies across states, from full autonomy to semi-autonomous to advisory; advisory boards are one mechanism to increase state supervision. Unlike health care boards that are fully autonomous and can make independent administrative, disciplinary, and licensure decisions, Florida's boards are semi-autonomous, having decision-making authority for certain aspects of licensing but ceding responsibility for other functions to a state agency. For example, DOH performs the administrative function of issuing licenses and license renewals, but boards certify that applicants meet licensure requirements. Similarly, for licensee discipline, DOH investigates complaints against licensees, but boards discipline licensees by imposing penalties (e.g., continuing education, reprimands, fines, restriction of practice, and suspension or revocation of a license).

In contrast, in advisory states, the legislature does not statutorily authorize health care boards to have independent decision-making authority. Instead, a state agency is typically authorized to conduct disciplinary actions and create rules, though boards may advise state agencies in certain matters. For example, the Illinois Medical Board advises the Department of Financial and Professional Regulation

[18] North Carolina State Board of Dental Examiners v. Federal Trade Commission, 574 U.S. 494 (2015).
[19] An active market participant is a member of a state regulatory board in the occupation the board regulates if they are licensed by the board or provide any service that is subject to the regulatory authority of the board.

in several areas, including conducting hearings related to disciplinary actions; assisting the department in reviewing applications in certain instances, such as when determining if an applicant is physically, mentally, and professionally fit for practicing medicine; and changing rules related to practitioner regulation. While the board provides recommendations to the department's secretary for consideration, the secretary may act contrary to the recommendations. In addition to advising the primary regulatory department, in Utah, boards retain a variety of other functions, including acting as presiding officer in hearings associated with judicial review of agency health care practitioner rules; approving and establishing a passing score for applicant examinations; and screening applicants.

States may provide board oversight via legislative review of proposed or existing rules. States oversee rule development by creating mechanisms to review, and in some cases reject, agency and board rules. In particular, state administrative procedure acts govern processes for state agencies to propose and issue regulations and are applicable to all agencies and boards when such entities have rulemaking authority. In Florida, s. 120.545, *Florida Statutes*, authorizes the Joint Administrative Procedures Committee (JAPC) to examine proposed rules.[20] However, if JAPC objects to a proposed rule, the relevant state agency or board is not required to modify, amend, withdraw, or repeal the rule. In such cases, JAPC provides public notice of the committee's objection, the objection is noted when the rule appears in the *Florida Administrative Code*, and JAPC may submit to the President of the Senate and the Speaker of the House of Representatives a recommendation that legislation be introduced to address the committee's objection.

Some states may authorize more direct legislative oversight of agency and board rulemaking.[21] For example, 15 states authorize legislative entities to reject or invalidate proposed or existing rules.[22] Some of these states use a two-house veto that requires agreement of both legislative chambers to veto a rule, while others use a committee veto that allows a joint legislative committee to veto a rule.[23] In states that use a committee veto, both the reviewing responsibility and the veto power rest with a single committee. Typically, the review begins with either a joint legislative committee or with each chamber's standing committee that has subject-matter expertise relevant to the rule under review; such committees can provide feedback on the rule and, if dissatisfied, can formally recommend rejection or modification. In states that use a two-house veto, the rule can be rejected or modified by majority vote of the whole legislature. In states that use a committee veto, the committee itself can reject or modify the rule. In some states, legislative objection requires the executive branch to make a final decision about the proposed rule. For example, in 10 states, an objection by a legislative review committee sends a rule to the governor or lieutenant governor for a final decision as to whether to approve or disapprove a rule.[24]

States may provide board oversight via executive review of proposed or existing rules. Governors may also oversee proposed or existing rules separate from legislative review. For example, Florida's Office of Fiscal Accountability and Regulatory Reform may suspend or halt any agency or board rule for various reasons, including determination that the rule impedes entry to a profession or imposes additional or unnecessary fees on professionals. Several states employ different models of

[20] JAPC's review determines whether the rule is an invalid exercise of delegated legislative authority and, among other things, whether the rule is consistent with legislative intent.
[21] Clinger, Derek, and Miriam Seifter. *Unpacking State Legislative Vetoes*. State Democracy Research Initiative, University of Wisconsin Law School. November 2023.
[22] The 15 states are Arkansas, Connecticut, Georgia, Idaho, Illinois, Iowa, Louisiana, Montana, Nevada, New Jersey, North Carolina, North Dakota, Ohio, South Dakota, and Wisconsin.
[23] Seven states authorize two-house vetoes: Georgia, Idaho, Iowa, Louisiana, Montana, New Jersey, and Ohio. Eight states authorize a legislative committee to veto proposed or existing rules: Arkansas, Connecticut, Illinois, Nevada, North Carolina, North Dakota, South Dakota, and Wisconsin.
[24] The 10 states are Alabama, Kentucky, Louisiana, Maryland, Missouri, Oklahoma, South Carolina, Virginia, Washington, and Wyoming.

executive oversight.[25] In Arizona, rules are submitted to and approved by the governor's Regulatory Review Council, which consists of seven members representing interests of the public, business community, and small business owners; the council includes one member suggested by the state's senate president and one member suggested by the speaker of the house. Similarly, in Vermont, all rules are reviewed by the Interagency Committee on Administrative Rules, members of which are appointed by the governor; the committee reviews existing and proposed rules for style, consistency with the law and legislative intent, and to ensure that policies are aligned with the governor's priorities. In California, the Office of Administrative Law—an executive branch office—reviews and can disapprove proposed rules; however, the governor may overrule office decisions.

Other methods of health care board oversight include processes for halting board actions and removing board members. OPPAGA identified examples of other states' processes for halting health care board actions, such as licensure determinations and disciplinary decisions. Florida law allows the State Surgeon General to have standing to challenge any rule or proposed rule of a health practitioner board through a process established pursuant to s. 120.56, *Florida Statutes*.[26] The Surgeon General files a rule challenge with the Division of Administrative Hearings, and the challenge is then assigned to an administrative law judge who, within 30 days, conducts a hearing to determine if the rule is an invalid exercise of delegated legislative authority. Within 30 days after the hearing, the judge must render a decision about the invalidity of the rule.[27] However, other states have provisions that allow state agency heads to immediately intervene in board proceedings beyond rulemaking. For example, in Vermont, the Director of the Office of Professional Regulation is required to actively monitor board actions and ensure that board actions are lawful, consistent with state policy, calculated to protect the public, and not an undue restraint of trade. If the director finds that an exercise of board authority does not meet these standards, they may, except in the case of disciplinary actions, provide written notice to the board explaining the perceived inconsistency, which has the effect of halting the action and implementing any alternative action prescribed by the director.[28]

In addition, some states have provisions that facilitate board member removal under certain circumstances, though the entity authorized to remove members may vary. In Florida, only the Governor has the authority to remove a board member. The Governor can investigate complaints or reports received by the Executive Office of the Governor, DOH, or a board about actions of an entire board or individual members and suspend any board member for malfeasance, neglect of duty, drunkenness, incompetence, permanent inability to perform official duties, or commission of a felony.[29,30]

In other states, agency heads have this responsibility. For example, in Illinois, the Secretary of Financial and Professional Regulation—the department that oversees health care practitioner licensing—can remove any member of the Board of Nursing for misconduct, incapacity, or neglect of duty. Similarly, in New York, any member of the Board of Professional Medical Conduct may be removed at the

[25] Baugus, Brian, Feler Bose, and James Broughel. *A 50-State Review of Regulatory Procedures: Supplementary State Administrative Procedure Reports.* Mercatus Center at George Mason University. April 2022.
[26] Section 456.012, *F.S.*
[27] DOH officials reported that since 2020, health care practitioner board rules have not been declared invalid pursuant to s. 456.012, *F.S.*
[28] After providing written notice to the board, the director then must schedule a meeting with the board to resolve questions about the action and explore alternatives. Within 60 days of the meeting, the director must issue a written directive finding that the exercise of board authority is consistent with state policy and the initial board action can be reinstated; the exercise of board authority is inconsistent with state policy but may be modified to achieve consistency; or that the exercise of board authority is inconsistent with state policy and any alternative prescribed by the director shall stand as the regulatory policy of the state.
[29] Section 456.008, *F.S.*
[30] While the Governor can suspend board members under certain circumstances, a board member's seat on a board may also be void when a member has three consecutive unexcused absences or absences constituting 50% or more of the board's meetings within any 12-month period.

pleasure of the Commissioner of the Department of Health. In Utah, the director of professional licensing may, with approval of the Executive Director of the Department of Commerce, remove a board member for failing to fulfill responsibilities such as attending board meetings, engaging in unlawful or unprofessional conduct, or failing to maintain an active license if appointed to the board as a licensed member of the board.[31]

See Exhibit 5 for examples of different ways that states supervise boards including health care boards, such as via the advisory regulatory model, through legislative and executive review of board rules, and by halting board actions or removing board members.

Exhibit 5
There Are Several Ways That States Can Supervise Health Care Boards

Type of Supervision	Examples
	Florida
Legislative review of and recommendations about board rules	Joint Administrative Procedures Committee can recommend that legislation be introduced to address committee objections to published rules.
Executive review of board rules	Office of Fiscal Accountability and Regulatory Reform may suspend or halt rules that it determines impede entry to the profession; impose additional or unnecessary fees on professionals or industries; or are not the most efficient and cost-effective method of imposing a regulation.
Governor removal of board members	Governor may investigate complaints and suspend board members from office for malfeasance, neglect of duty, drunkenness, incompetence, permanent inability to perform official duties, or commission of a felony.
	Other States
Advisory boards	State agency maintains final approval and authority over boards. (Illinois and Utah)
Legislative review of and veto of board rules	• Joint legislative committee is authorized to recommend a rule be vetoed by a majority vote of the legislature. (Georgia, Idaho, Iowa, Louisiana, Montana, New Jersey, and Ohio) • Joint legislative committee is authorized to directly veto or modify a proposed or existing rule. (Arkansas, Connecticut, Illinois, Nevada, North Carolina, North Dakota, South Dakota, and Wisconsin)
Halting board actions	State agency head actively monitors health care boards and ensures that all board actions are lawful, consistent with policy, and protective of the public. If the agency head finds board authority does not meet these standards, they may halt the board action and implement an alternative. (Vermont)
Agency head removal of board members	• Secretary of regulatory agency can remove board members for misconduct, incapacity, or neglect of duty. (Illinois) • State regulatory agency can remove board members for failing to fulfill responsibilities such as attending board meeting, engaging in unlawful or unprofessional conduct, or failing to maintain an active license. (Utah)

Source: OPPAGA analysis of state statutes; Clinger and Seifter, *Unpacking State Legislative Vetoes*; and Baugus, Bose, and Broughel, *A 50-State Review of Regulatory Procedures: Supplementary State Administrative Procedure Reports.*

Some states require legislative appropriation of board funds, while some have direct access to funds

While physician and nurse boards are typically funded through fees from practitioner licenses, authority over the release of such funds may vary by state. Physician and nurse boards are typically self-sustaining through practitioner licensing and registration fees. According to a 2024 survey of 58 jurisdictions with boards of nursing, 62% of the 49 responding jurisdictions were financially self-sustaining.[32] However, some self-sustaining boards do not have direct access to funds consisting of licensure-related fees and may instead rely on the legislature to appropriate such funds for board use. Other boards have direct access to funding from fees and fines, and one board included in OPPAGA's review has a mixed model wherein the boards received funding from fees as well as state appropriations.

[31] In Utah, the Division of Professional Licensing within the Department of Commerce administers and enforces licensing laws for occupations and professions.
[32] National Council of State Boards of Nursing. *2024 Board Structure Survey*. https://www.ncsbn.org/public-files/board_structure_survey_2024.pdf.

In some states, legislatures appropriate funds to state regulatory agencies that then disburse funds to health care boards. Florida's health care boards are funded by the Medical Quality Assurance Trust Fund, which contains health care professional fees and fines. The Legislature appropriates trust funds to DOH to provide administrative support for regulating health care professionals and other purposes the Legislature deems appropriate, including funding health care practitioner boards for expenses such as board member per diem and travel to attend board meetings. Similarly, in Utah, the fees collected by the Division of Professional Licensing and Department of Commerce are added to a general fund that is used to fund health care boards.[33] All of the department's expenditures from the fund, including per diem and travel expenses for board members, must have legislative approval, allowing for transparency of board expenses.

Health care boards in some states may have direct access to funds. For example, in Nevada, the Board of Medical Examiners and the Board of Osteopathic Medicine deposit fine and fee revenues into banks outside the state treasuries and can directly access funds. The boards use these revenues to fund board operations for board members while engaged in board business. The boards set rates for board member salaries of not more than $150 a day, a per diem allowance, and travel expenses. In Alabama, the Board of Medical Examiners and the Medical Licensure Commission operate outside of the state's treasury and have authority over funds raised through license and registration fees, fines, and penalties.

Massachusetts has a mixed model of funding from fees as well as general fund appropriations. According to legislative mandate, the Massachusetts Board of Nursing is funded by both licensure-related fees and state appropriations.[34] Board funds are generated from the Quality in Health Professions Trust Fund and state appropriations from the general fund in the appropriations act. The trust fund consists of 50% of the fee revenue collected by health care boards, in addition to fees collected from renewing a license, certificate, permit, or authority. The state health department can spend trust fund monies for board operations and administration, including licensing and enforcement activities.

See Exhibit 6 for examples of different ways that state health care boards receive funding, including through legislative appropriation of fees and fines, direct access to fees and fines, and legislative appropriation from state general funds.

Exhibit 6
Health Care Boards Can Receive Funding From Fees and Fines or General Revenue; Access to Funds May Be Direct or Through Legislative Appropriation

Type of Board Funding	Examples
	Florida
Legislative appropriation of fees and fines	Legislative appropriation from the Medical Quality Assurance Trust fund, funded through board fees and fines.
	Other States
Direct access to fees and fines revenue	Boards of health charge fees for licensing and can discipline practitioners through imposing fines. Boards deposit these revenues into banks outside the state treasuries and access them directly. (Alabama and Nevada)
Legislative appropriation from state general funds	Legislature allots health care boards general revenue funds for expenditures in addition to trust funds comprised of practitioner-related fees. (Massachusetts)

Source: OPPAGA analysis of statutes and documents from Florida and other states.

[33] In Utah, the Commerce Service Account is within the general fund and is composed of licensure fees collected by the Department of Commerce, which includes the Division of Professional Licensing.

[34] Other health care boards in Massachusetts that are similarly funded include pharmacy, physician assistants, perfusionists, nursing home administrators, dentistry, genetic counselors, certification of community health workers, naturopathy, and respiratory therapists.

For some states, health care board composition and member characteristics are specified in law; while governors typically appoint board members, their level of involvement varies

Some states differ from Florida in board composition and member appointment practices. State legislatures may control the composition or characteristics of board members, including potential members' specialty, practice experience, and geographic location. States also have varied requirements for appointing lay or public board members. While in most states that OPPAGA reviewed, including Florida, the governor appoints board members, in other states the governor has less involvement or may appoint members from lists submitted by trade associations.

State statute determines the composition of health care boards, with board composition varying by state. States can ensure that boards reflect diverse perspectives by establishing member criteria in statute. These criteria can include practitioner specialty, years of practice, geographic location, and inclusion of lay members.

- *Practitioner specialty.* Florida statutes specify that 12 Board of Medicine members must be licensed physicians, and 5 Board of Osteopathic Medicine members must be licensed osteopathic physicians, but state law does not indicate a subfield or specialty. [35] In contrast, the Illinois Medical Board requires members with subspecialties and other specific members, including two osteopathic physicians, two physicians who collaborate with physician assistants, two chiropractic physicians, and two physician assistants.
- *Years of practice.* Florida requires health care board members to have at least four years of practice in their profession prior to appointment while other states, including Illinois, Kansas, and New York, require five.
- *Geographic location.* While Florida does not have requirements related to apportionment based on location, Alabama requires that board membership be inclusive and reflect the geographic and urban/rural diversity of the state.[36] Minnesota allots no more than one member per congressional district.
- *Inclusion of lay members.* Health care boards, including in Florida, are typically required to appoint one or more non-practitioners (i.e., lay members, public members, or consumer members), often residents of the state who are not licensed health care practitioners.[37] States vary regarding the number of lay members appointed and lay member qualities. For example, Florida's Board of Medicine and Board of Nursing require three lay members and the Board of Osteopathic Medicine requires two. While Florida does not impose any additional

[35] Although the statutes for Florida's Board of Medicine and Board of Osteopathic Medicine do not follow the model of requiring specialties, Florida's Board of Nursing statute does. Specifically, s. 464.004, *F.S.*, requires that the seven registered nurse who are board members should represent the diverse areas of practice within the nursing profession.

[36] Per Alabama law, the membership of the board shall be inclusive and reflect the racial, gender, geographic, urban/rural, and economic diversity of the state (Alabama Code §34-21-2 (2024)).

[37] Appointing non-practitioners to boards is a best practice to address a potential conflict of interest that could arise from majority practitioner boards developing licensing rules to regulate their own profession. However, quorum rules may weaken the role of lay board members. For example, state statutes typically use a simple majority to constitute a quorum, meaning lay members may not need to be present to conduct board business. New York's State Board for Professional Medical Conduct also requires a simple majority to constitute a quorum but specifies that any committee on professional conduct shall consist of a lay member and two physicians. This ensures that a lay member perspective is present in the state's disciplinary proceedings.

requirements for lay members, other states do.[38] For example, South Carolina appoints three lay members who must have a baccalaureate degree or higher and no history of conviction for a felony or crime of moral turpitude. Louisiana requires that for at least every other term, lay member appointees be a minority. For its State Board of Health, Nebraska appoints two lay members who are at least age 21 and interested in the health of the people in the state; for other Nebraska professional health care boards, lay members must have lived in the state for at least one year and be at least age 19.

Health care board members may be appointed by governors or state entities or elected by practitioners or the board. Typically, health care board members are appointed by the governor and for the 16 boards that OPPAGA reviewed, vacancies are typically filled in the same manner as they were appointed.[39] In Florida, the Governor selects and appoints health care board members who are then confirmed by the Senate. In contrast, in some states another state position has this responsibility. For example, in Illinois, New York, and Utah, the Secretary of Financial and Professional Regulation (Illinois), Commissioner of Health (New York), Board of Regents (New York), and Executive Director of the Department of Commerce (Utah) appoint health care board members. In Alabama and Nebraska, the governor has joint involvement with other entities in appointing health care boards or appoints members for only one oversight board. In Alabama, the governor, lieutenant governor, and the speaker of the house of representatives each appoint physician members to the Medical Licensure Commission.[40] In Nebraska, the governor appoints the State Board of Health members and acts as an ex officio member, but the State Board of Health has the authority to appoint members to all other health care boards.[41]

While some states require the solicitation of recommendations from professional associations as part of the board member appointment process, Florida does not. In Kansas, Minnesota, and New York, statutes specify which professional associations are required to submit board member recommendations to the governor or other relevant state entity. In Kansas, the governor must appoint Board of Nursing members from lists provided by both the Kansas State Nurses Association and the Kansas Federation of Licensed Practical Nurses. In Minnesota, the governor may appoint members to the Board of Medical Practice from lists provided by the State Medical Association, the Mental Health Association of Minnesota, and the Minnesota Osteopathic Medical Society. New York uses a percentage-based quota for appointments to the State Board of Professional Medical Conduct, with statute dictating that no less than 85% of physician members must be appointed based on nominations submitted from six recommending associations.

In Alabama and South Carolina, the board conducts an election among licensed providers to nominate some or all board members. In Alabama, members of the Medical Association of the State of Alabama elect the Board of Medical Examiners from among its members. In South Carolina, the board is partially appointed by the governor, president of the senate, speaker of the house, and via election. A physician

[38] One researcher recommends that states could appoint lay board members who are economists or experienced consumer advocates, as they would be in a better position to understand the costs to consumers, in terms of price and health care availability, that may be associated with board rules that seek to improve quality. Allensworth, Rebecca Haw. "Foxes at the Henhouse: Occupational Licensing Boards Up Close." California Law Review 105, no. 6 (December 2017): 1567–1610. https://scholarship.law.vanderbilt.edu/faculty-publications/11/.

[39] Statute may also specify term limits for appointments and/or vacancies filled before the end of a term.

[40] In Alabama, two entities regulate the practice of medicine: the Medical Licensure Commission has the exclusive power and authority to issue, revoke, and reinstate all licenses and the Board of Medical Examiners certifies that applicants meet requirements for licensure, works jointly with the Board of Nursing and Board of Pharmacy, and has other duties like certifying individuals who manufacture, distribute, or dispense controlled substances.

[41] An ex officio member is one who is on the board by virtue of their position.

and an osteopath from the state at large are elected by the board and seven physicians representing each of the state's congressional districts are elected among physicians in each district.

See Exhibit 7 for examples of different ways that states appoint health care board members, including through governor appointment and senate confirmation; governor or state agency appointment with recommendations from professional associations; state agency head appointment; executive and legislative appointment; governor and board appointment; and board election.

Exhibit 7
States May Appoint Health Care Board Members in Several Ways

Type of board appointment	Examples
	Florida
Governor appointment; Senate confirmation	Governor appoints health care board members and Senate confirms appointments.
	Other States
Governor or state agency appointment with recommendation from professional associations	Professional associations make recommendations. Statute may specify which professional associations must submit lists of practitioners to the governor; in some states, governor must select from list, in other states, governor does not. (Kansas, Minnesota, and New York)
State agency head appointment	Heads of agencies that oversee health care boards appoint board members. (Illinois, New York, and Utah)
Executive and legislative appointment	Governor, lieutenant governor, and speaker of the house of representatives appoint board members. (Alabama—Medical Licensure Commission).[1]
Governor and board appointment	Governor appoints members to an oversight board and that board appoints members of all other boards. (Nebraska)
Board election	Board conducts an election among licensed providers to nominate some or all board members. (Alabama—Board of Medical Examiners and South Carolina)

[1] Alabama's Board of Medical Examiners and Medical Licensure Commission have different appointment processes, hence their repetition in the exhibit.

Source: OPPAGA analysis of state statutes and the Constitution of the Medical Association of the State of Alabama.

State statutes may dictate term limits for health care board members. Research on over 80 licensing board meeting minutes found that it was common for boards to have one or more vacancies.[42] In Florida, members of the Board of Medicine, Board of Osteopathic Medicine, and Board of Nursing serve four-year terms until the Governor appoints the successor, and statute does not include a limitation on the number of terms these health care board members can serve. In other states, like Illinois, Minnesota, and Nebraska, statutes dictate how many terms a board member may serve. In addition, some states specify whether terms can be consecutive. For instance, Illinois Medical Board members, Kansas Board of Nursing members, Nebraska Board of Health members, and Utah Board of Medical Practice members may only serve two consecutive terms. In Utah, if a Board of Medical Practice member ceases to serve, they must wait for two years from the cessation of service to serve on the board again. Another state, Minnesota, prohibits Board of Medical Practice members from serving more than eight years consecutively. Unlike Florida, some states clarify the number of additional terms a replacement board member can serve after filling a vacancy in an unexpired term. For example, replacements may serve the remainder of the term (Kansas Board of Nursing, Nebraska State Board of Health, and Illinois Board of Medicine) or one additional term after the replacement term (Utah health care licensing boards).

[42] Allensworth, Rebecca Haw. "Foxes at the Henhouse: Occupational Licensing Boards Up Close." California Law Review 105, no. 6 (December 2017): 1567–1610. https://scholarship.law.vanderbilt.edu/faculty-publications/11/.

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