By Senator Osgood

32-00791-26 2026740__

A bill to be entitled

An act relating to comprehensive health care for residents; creating part IV of ch. 641, F.S., entitled the "Healthy Florida Act"; creating s. 641.71, F.S.; providing a short title; creating s. 641.72, F.S.; providing the purpose of the Florida Health Plan; creating s. 641.73, F.S.; defining terms; creating s. 641.74, F.S.; providing for eligibility for and coverage of the plan; authorizing the Florida Health Board to establish certain financial arrangements with other states and foreign countries under certain circumstances; providing reimbursement rates; prohibiting healthcare providers from billing the patient for covered services under certain circumstances; providing duties of the board relating to plan enrollment; providing enrollment requirements; providing that certain data collected through plan applications and enrollment is private data; authorizing such data to be released to certain persons for specified purposes; creating s. 641.755, F.S.; authorizing plan enrollees to choose to receive services from certain health care providers; providing covered health care benefits; authorizing the board to expand health care benefits under certain circumstances; specifying health care services that are not covered by the plan; requiring enrollees to have primary care providers and access to care coordination; authorizing enrollees to see health care specialists without referral; authorizing the board to

establish a computerized registry; authorizing the plan employees to assist enrollees in choosing primary care providers; prohibiting cost-sharing requirements from being imposed on enrollees; creating s. 641.77, F.S.; requiring the board to secure repeals and waivers of certain provisions of federal law; requiring the Department of Health and the Agency for Health Care Administration to provide assistance to the board; requiring the board to adopt rules under certain circumstances; providing that the plan's responsibility for providing health care is secondary to existing Federal Government programs under certain circumstances; creating s. 641.78, F.S.; defining the term "collateral source"; requiring the plan to collect health care costs from collateral sources under certain circumstances; requiring the board to negotiate waivers, seek federal legislation, and make arrangements to incorporate collateral sources into the plan; requiring plan enrollees to notify health care providers of collateral sources and health care providers to forward such information to the board; authorizing the board to take appropriate actions to recover reimbursement from collateral sources; requiring collateral sources to pay for health care services under certain circumstances; providing specified authority and rights to the board relating to collateral sources; creating s. 641.791, F.S.; providing that defaults, underpayments, and late payments of certain obligations result in certain

remedies and penalties; prohibiting eligibility for health care benefits from being impaired by such defaults, underpayments, and late payments; creating s. 641.792, F.S.; providing for eligible health care providers to participate in the plan; requiring participating providers to comply with certain federal laws and regulations; providing that patient care may not be affected by fee schedules and financial incentives; providing requirements for the payment system for noninstitutional providers; providing requirements for the annual budgets for institutional providers; requiring the board to develop a capital investment plan; prohibiting noninstitutional and institutional providers that accept payments from the plan from billing patients; providing requirements for capital expenditures by institutional and noninstitutional providers which exceed a specified amount; requiring the board to establish payment criteria and payment methods for care coordination; creating s. 641.793, F.S.; establishing the Florida Health Board by a specified date; providing the purpose of the board; providing for board membership, terms, and compensation; providing duties of the board; providing reporting requirements; creating s. 641.794, F.S.; requiring the Secretary of Health Care Administration to designate health planning regions by a specified date; providing considerations for such designations; requiring health planning regions to be administered by a regional health planning board;

providing requirements for regional planning boards; providing board membership, terms, compensation, and first meetings of regional planning boards with the Florida Health Board; providing duties of the regional planning boards; creating s. 641.795, F.S.; creating the Office of Health Quality and Planning; providing the purpose and duties of the office; authorizing the Florida Health Board to convene advisory panels for certain purposes; creating s. 641.796, F.S.; providing applicability of the Code of Ethics for Public Officers and Employees; providing for disciplinary actions for failure to comply with the code of ethics; prohibiting certain persons from engaging in specified acts or from being employed by specified entities; creating the Conflict-of-Interest Committee; providing the duties of the committee; creating s. 641.797, F.S.; creating the Ombudsman Office for Patient Advocacy; providing the purpose of the office; providing for appointment and qualifications of the ombudsman; providing the duties and authority of the ombudsman; providing that data collected on plan enrollees in their complaints to the ombudsman is private data; authorizing such data to be released to certain persons and to the board for specified purposes; providing requirements for the office budget; requiring the ombudsman to establish specified offices; creating s. 641.798, F.S.; creating the position of auditor for the plan; providing the purpose, appointment, and duties of the auditor;

creating s. 641.799, F.S.; providing that the plan policies and procedures are exempt from the Administrative Procedure Act; providing procedures and requirements for adoption of certain rules on plan policies and procedures; requiring specified persons to regularly update the Legislature on certain information; providing a timeline for the operation of the plan; prohibiting certain health insurance policies and contracts from being sold in this state on and after a specified date; requiring an analysis of specified capital expenditure needs; providing reporting requirements; providing an effective date.

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

Section 1. Part IV of chapter 641, Florida Statutes, consisting of ss. 641.71-641.799, Florida Statutes, is created and entitled the "Healthy Florida Act."

Section 2. Section 641.71, Florida Statutes, is created to read:

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

Section 3. Section 641.72, Florida Statutes, is created to read:

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

(1) Ensuring that all residents of this state, regardless of immigration status, have access to health care.

(2) Covering all necessary care, including dental; vision; hearing; mental health; reproductive care, including abortion services and prenatal and postpartum care; gender-affirming health care, including medication and treatment; substance use disorder treatment; prescription drugs; durable medical equipment and supplies; and long-term care and home care, including long-term services and supports in home- and community-based settings.

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

(4) Reducing costs by negotiating fair prices and cutting administrative bureaucracy, through measures such as a global budget approach to institutional providers, rather than by restricting or denying care.

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

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

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

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

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

(10) Using a simple funding and payment system.

(11) Providing a just transition for a displaced workforce affected by changes.

Section 4. Section 641.73, Florida Statutes, is created to read:

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

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

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

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

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

(5) "Plan" means the Florida Health Plan.

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

Section 5. Section 641.74, Florida Statutes, is created to read:

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

(1) ELIGIBILITY.—

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

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

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

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

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

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

(g) The board may establish financial arrangements with

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

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

a. Is a minor;

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

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

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

(2) ENROLLMENT.—

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

(b) Data collected from a person through application for

and enrollment in the plan is private data; however, the data may be released to:

1. A health care provider for purposes of confirming enrollment and processing payments for benefits; and

2. The ombudsman of the Ombudsman Office for Patient Advocacy and the auditor for the Florida Health Plan for purposes of performing their duties under ss. 641.797 and 641.798, respectively.

Section 6. Section 641.755, Florida Statutes, is created to read:

641.755 Benefits.—

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

(2) Except for the exclusions provided in subsection (4), covered health care benefits under the plan include all prescribed medically necessary care, including, but not limited to:

(a) Inpatient and outpatient health care facility services.

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

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

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

(e) Inpatient and outpatient rehabilitative care.

(f) Emergency care services.

(g) Necessary transportation for health care services:

1. As covered under Medicaid or Medicare; or

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

(h) Child and adult immunizations and preventive care.

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

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

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

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

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

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

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

(p) Vision care.

(q) Hearing care.

(r) Prescription drugs.

(s) Podiatric care.

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

(u) Blood and blood products.

(v) Dialysis.

(w) Licensed qualified adult day care.

(x) Rehabilitative and habilitative services.

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

(z) Case management and care coordination.

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

(bb) Services provided by qualified community health workers.

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

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

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

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

(a) Treatments and procedures primarily for cosmetic

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

(b) Services of a health care provider or facility that is not licensed, certified, or accredited by this state. The licensure, certification, or accreditation requirements do not apply to health care providers or facilities that provide services to residents of this state who require medical attention while traveling out of state.

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

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

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

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

Section 7. Section 641.77, Florida Statutes, is created to read:

641.77 Federal preemption.—

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

board to secure any repeal or waiver.

(2)(a) The board shall, under the section 1332 waivers of the Patient Protection and Affordable Care Act, request to repeal or waive any of the following provisions to the extent necessary to implement this part:

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

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

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

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

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

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

Section 8. Section 641.78, Florida Statutes, is created to read:

641.78 Subrogation.—

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

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

2. The medical components of worker's compensation.

3. A pension plan and retiree health care benefits.

4. An employer plan.

5. An employee benefit contract.

6. A government benefit program.

7. A judgment for damages for personal injury.

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

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

(b) The term does not include:

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

2. Any governmental unit, agency, or service to the extent that subrogation is prohibited by law. An entity described in paragraph (a) is not excluded from the obligations imposed by this section by virtue of a contract or relationship with a governmental unit, agency, or service.

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

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

(4) If a person who receives health care services under the plan is entitled to coverage, reimbursement, indemnity, or other

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

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

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

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

(5) To the extent permitted by federal law, the board has the same right of subrogation over contractual retiree health care benefits provided by employers as other contracts, allowing the plan to recover the cost of health care services provided to a person covered by the retiree health care benefits, unless arrangements are made to transfer the revenues of the health

care benefits directly to the plan.

Section 9. Section 641.791, Florida Statutes, is created to read:

641.791 Defaults, underpayments, and late payments.—

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

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

Section 10. Section 641.792, Florida Statutes, is created to read:

641.792 Provider payments.—

(1) All health care providers licensed to practice in this state may participate in the plan. The board may determine the eligibility of any other health care providers to participate in the plan.

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

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

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

(a) The board shall pay noninstitutional providers based on rates negotiated with noninstitutional providers. The rates must

take into account the need to address the shortage of noninstitutional providers.

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

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

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

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

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

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

(b) Institutional and noninstitutional providers that propose to make capital purchases in excess of $500,000 must

obtain board approval. The board may alter the threshold expenditure level that triggers the requirement to submit information on capital expenditures. Institutional providers must propose these expenditures and submit the required information as part of the annual budget they submit to the board. Noninstitutional providers must apply to the board for approval of these expenditures. The board must respond to capital expenditure applications in a timely manner.

(5) The board shall establish payment criteria and payment methods for care coordination for patients, especially those with chronic illness and complex medical needs.

Section 11. Section 641.793, Florida Statutes, is created to read:

641.793 Florida Health Board.—

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

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

1. One patient member and one employer member.

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

3. Five health care provider members, including one physician, one registered nurse, one mental health provider, one dentist, and one health care facility director.

(b) Each member shall take the oath of office to uphold the Constitution of the United States and the Constitution of the State of Florida and to operate the plan in the public interest by upholding the underlying principles of this part.

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

(d) Board members shall set the board's compensation, not to exceed the compensation of the Florida Public Service Commission members. The board shall select the chair from among its membership.

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

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

(3) The board shall:

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

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

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

(d) Provide technical assistance to the regional planning

boards established in s. 641.794.

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

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

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

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

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

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

(k) Require that all electronic health records used by health care providers be fully interoperable with the open source electronic health records system used by the United States Department of Veterans Affairs.

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

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

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

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

(4) Before submitting a waiver application under section 1332 of the Patient Protection and Affordable Care Act, the board must do all of the following, as required by federal law:

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

(b) Conduct or contract for any necessary economic analyses needed to support the board's estimates that the waiver will comply with the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements in federal law. These analyses must include:

1. A detailed 10-year budget plan.

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

(c) Establish a detailed draft implementation timeline for

the waiver plan.

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

(5) The board has the following financial duties:

(a) To approve statewide and regional budgets.

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

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

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

(e) To seek federal approval to bill another state for health care coverage provided to a patient from out of state who comes to this state for long-term care or other costly treatment when the patient's home state fails to provide such coverage, unless a reciprocal agreement with the patient's home state to provide similar coverage to residents of this state relocating to that state can be negotiated.

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

(g) To ensure appropriate cost control by:

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

2. Making changes in the delivery of health care services

and administration that improve efficiency and care quality.

3. Minimizing administrative costs.

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

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

(6) The board has the following management duties:

(a) To develop and implement enrollment procedures for the plan.

(b) To implement and review eligibility standards for the plan.

(c) To arrange for health care services to be provided at convenient locations to serve communities in need in the same manner as federally qualified health centers, including ensuring the availability of school nurses so that all students have access to health care, immunizations, and preventive care at public schools, and encouraging health care providers to provide services at easily accessible locations.

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

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

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

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

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

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

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

(a) To develop and implement cost control and quality assurance procedures.

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

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

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

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

(9) By July 1 of each year, the board shall report to the President of the Senate, the Speaker of the House of Representatives, and ranking members of the committees having

cognizance over health care issues on:

(a) The performance of the plan.

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

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

(d) Any recommendations for statutory changes.

(e) Receipts of revenues from all sources.

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

(g) Future goals and priorities.

(h) Major new technology and prescription drugs.

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

Section 12. Section 641.794, Florida Statutes, is created to read:

641.794 Health planning regions.—

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

(a) Patterns of use of health care services.

(b) Health care resources, including workforce resources.

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

(d) Geography.

(e) Population and demographic characteristics.

(f) Other considerations the board deems appropriate.

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

be created by October 1, 2026.

(a) Each regional planning board shall consist of:

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

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

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

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

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

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

(3) A regional planning board has the following duties:

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

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

(c) To collaborate with local public health care agencies to:

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

2. Implement public health and wellness initiatives.

(d) To hire a regional health planning director.

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

Section 13. Section 641.795, Florida Statutes, is created to read:

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

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

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

(b) Access to health care.

(c) Quality improvement.

(d) Efficiency of administration.

(e) Adequacy of the budget and funding.

(f) Appropriateness of payments to health care providers.

(g) Capital expenditure needs.

(h) Long-term health care.

(i) Mental health and substance abuse services.

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

(k) Identification of the number and mix of health care

facilities and providers necessary to meet the needs of the plan.

(l) Care for chronically ill patients.

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

(n) Research needs.

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

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

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

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

(5) Assess and evaluate health care benefits by:

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

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

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

the proposals.

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

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

Section 14. Section 641.796, Florida Statutes, is created to read:

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

(1) The Code of Ethics for Public Officers and Employees under part III of chapter 112 applies to the employees and the chief executive officer of the Florida Health Plan, the employees and members of the Florida Health Board, the employees and members of the regional planning boards and the regional health planning directors, the employees and the director of the Office of Health Quality and Planning, the employees and the ombudsman of the Ombudsman Office for Patient Advocacy, and the auditor for the Florida Health Plan. Failure to comply with the code of ethics under part III of chapter 112 is grounds for disciplinary action, which may include termination of employment or removal from the board.

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

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

(b) Publicly endorse a political candidate.

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

(d) Attempt to avoid compliance with this subsection by

making a contribution through a spouse or other family member.

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

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

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

(b) The committee shall review all proposed transactions and arrangements that involve the plan. In considering a proposed transaction or arrangement, if the committee determines a conflict of interest exists, the committee must investigate alternatives to the proposed transaction or arrangement. After exercising due diligence, the committee shall determine whether the plan can obtain with reasonable efforts a more advantageous transaction or arrangement with a person or entity which would not give rise to a conflict of interest. If the committee determines that a more advantageous transaction or arrangement

is not reasonably possible under the circumstances, the committee shall make a recommendation to the board on whether the transaction or arrangement is in the best interest of the plan, and whether the transaction is fair and reasonable. The committee shall provide to the board all material information used to make the recommendation. After reviewing all relevant information, the board shall decide whether to approve the transaction or arrangement.

Section 15. Section 641.797, Florida Statutes, is created to read:

641.797 Ombudsman Office for Patient Advocacy.—

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

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

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

(b) The ombudsman shall:

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

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

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

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

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

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

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

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

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

(b) A health care provider or an employee of a health care provider may join with, or otherwise assist, a complainant in submitting a complaint to the ombudsman. A health care provider

or an employee of a health care provider who, in good faith, joins with or assists a complainant in submitting a complaint is subject to protections and remedies under this part or under general law.

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

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

a. The complainant;

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

c. The board,

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

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

(4) Data collected on a plan enrollee in the enrollee's complaint to the ombudsman is private data; however, the data may be released to a health care provider that is the subject of the complaint or to the board for purposes of this section.

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

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

Section 16. Section 641.798, Florida Statutes, is created to read:

641.798 Auditor for the Florida Health Plan.—

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

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

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

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

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

(d) Investigate fraud and abuse.

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

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

Section 17. Section 641.799, Florida Statutes, is created to read:

641.799 Florida Health Plan policies and procedures;

rulemaking.—

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

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

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

(c) Within 60 days after the expiration of the period provided for the submission of written data or comments, or within 60 days after the completion of any hearing, the board shall issue a rule adopting, modifying, or revoking a policy or procedure, or make a determination that a rule should not be adopted. The rule may contain a provision delaying its effective date for such period as the board determines necessary.

Section 18. (1) The Director of the Office of Financial Regulation of the Department of Financial Services and the chief executive officer of the Florida Health Plan shall regularly update the Legislature on the status of the planning,

implementation, and financing of this act.

(2) The Florida Health Plan must be operational within 2 years after July 1, 2026.

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

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

(5) By July 1, 2027, the Department of Commerce shall provide to the Florida Health Board, the Governor, and the chairs and ranking members of the legislative committees with jurisdiction over health, human services, and commerce a report determining the appropriations and legislation necessary to assist all affected individuals and communities through the transition to the Florida Health Plan.

Section 19. This act shall take effect July 1, 2026.