By Senator Smith

17-00435A-25 20251670__

A bill to be entitled

An act relating to statewide health care coverage; defining terms; establishing the Task Force on Universal Health Care for Florida for a specified purpose; requiring the Office of Program Policy Analysis and Government Accountability (OPPAGA) to provide staff support to the task force; directing all agencies of state government to assist the task force, including furnishing information and advice deemed necessary by the task force; providing for the membership, meetings, and funding of the task force; requiring the task force to establish an advisory committee for a specified purpose; providing for the membership of the advisory committee; authorizing the task force to establish additional advisory and technical committees; specifying duties of the task force; requiring the task force to consider specified values and principles in developing certain recommendations; requiring the task force to make findings and recommendations for the design of the Health Care for All Florida Plan and for the Health Care for All Florida Board to administer the plan; specifying requirements for the design of the plan; specifying requirements for the plan and factors the task force must include in its recommendations; requiring the task force to engage in a public process to solicit public input on certain elements of the plan; specifying requirements for such process; specifying requirements for the report of the task

force's findings and recommendations; requiring that task force members be appointed by a specified date; requiring OPPAGA to begin preparing a work plan for the task force by a specified date; requiring the task force to submit a report of its findings and recommendations to the Governor and the Legislature by a specified date; requiring the Agency for Health Care Administration to develop a plan for a Medicaid buy-in program or a public health care option for certain residents of this state; specifying requirements for the plan; requiring the agency to report its plan to the Governor and the Legislature by a specified date; providing for the future repeal of specified provisions; providing an appropriation; providing an effective date.

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

Section 1. Task Force on Universal Health Care for Florida.—

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

(a) "Group practice" means a single legal entity composed of individual providers organized as a partnership, professional corporation, limited liability company, foundation, nonprofit corporation, or faculty practice plan or a similar association in which:

1. Each individual provider uses office space, facilities, equipment, and personnel shared with other individual providers to deliver medical care, consultation, diagnosis, treatment, or

other services that the provider routinely delivers in the provider's practice;

2. Substantially all of the services delivered by the individual providers are delivered on behalf of the group practice and billed as services provided by the group practice;

3. Substantially all of the payments to the group practice are to reimburse the cost of services provided by the individual providers in the group practice;

4. The overhead expenses of, and the income from, the group practice are shared among the individual providers in the group practice in accordance with methods agreed to by the individual providers who are members of the group practice; and

5. There is a unified business model with consolidated billing, accounting, and financial reporting and a centralized decisionmaking body that represents the individual providers who are members of the group practice.

(b) "Individual provider" means a health care practitioner who is licensed, certified, or registered in this state or who is licensed, certified, or registered to provide care in another state or country.

(c) "Institutional provider" means a single legal entity that is:

1. A health care facility, such as a hospital;

2. A comprehensive outpatient rehabilitation facility;

3. A home health agency; or

4. A hospice program.

(d) "Provider" means an individual provider, an institutional provider, or a group practice.

(e) "Single-payor health care financing system" means a

universal system used by the state for paying the cost of health care services or goods in which:

1. Institutional providers are paid directly for health care services or goods by the state or are paid by an administrator that does not bear risk in its contracts with the state;

2. Group practices are paid directly for health care services or goods by the state or are paid by an administrator that does not bear risk in its contracts with the state, by the employer of the group practice, or by an institutional provider; and

3. Individual providers are paid directly for health care services or goods by the state, by their employers, by an administrator that does not bear risk in its contracts with the state, by an institutional provider, or by a group practice.

(2) ESTABLISHMENT OF THE TASK FORCE ON UNIVERSAL HEALTH CARE; PURPOSE; AGENCY COOPERATION.—The Task Force on Universal Health Care is established to recommend the design of the Health Care for All Florida Plan, a universal health care system administered by the Health Care for All Florida Board which is equitable, affordable, and comprehensive; provides high-quality health care; and is publicly funded and available to every individual residing in this state. The Office of Program Policy Analysis and Government Accountability (OPPAGA) shall provide staff support to the task force. All agencies of state government are directed to assist the task force in the performance of its duties and, to the extent permitted by laws relating to confidentiality, to furnish information and advice deemed necessary by the task force to perform its duties.

(3) MEMBERSHIP; MEETINGS; FUNDING; ADVISORY COMMITTEES.—

(a) The task force shall be composed of the following 20 members:

1. Two members of the Senate, one from the majority party and one from the minority party, appointed by the President of the Senate.

2. Two members of the House of Representatives, one from the majority party and one from the minority party, appointed by the Speaker of the House of Representatives.

3. Thirteen members appointed by the Governor, each of whom must reside in this state and:

a. Represent to the greatest extent practicable:

(I) Diverse social identities, including, but not limited to, individuals who identify by geography, race, ethnicity, sex, gender nonconformance, sexual orientation, economic status, disability, or health status; and

(II) Diverse areas of expertise, based on knowledge and experience, including, but not limited to, patient advocacy, receipt of medical assistance, management of a business that offers health insurance to its employees, public health, organized labor, provision of health care, or owning a small business;

b. Represent, at a minimum, the following areas of expertise acquired by education, vocation, or personal experience:

(I) Rural health;

(II) Quality assurance and health care accountability;

(III) Fiscal management and change management;

(IV) Social services;

(V) Public health services;

(VI) Medical and surgical services;

(VII) Alternative therapy services;

(VIII) Services for persons with disabilities; and

(IX) Nursing services;

c. Include at least eight members who are representatives of labor unions representing employees who work in the health care field in this state;

d. Include at least one member who is a representative of a Florida legal aid organization helping health care patients;

e. Include at least one member who has produced at least three economic analyses of the economic benefits of single-payor programs on the state level. This member need not be a resident of this state in order to serve on the task force; and

f. Include at least one member who has an active license to practice social work in this state.

4. The State Surgeon General or his or her designee, who is a nonvoting member.

5. The Secretary of Business and Professional Regulation or his or her designee, who is a nonvoting member.

6. A member of the Florida Association of Counties, selected by the association, who is a nonvoting member.

(b) In making the appointments under subparagraph (a)3., the Governor shall ensure that there is no disproportionate influence by any individual, organization, government, industry, business, or profession in any decisionmaking by the task force and no actual or potential conflicts of interest.

(c) The task force shall elect one of its members to serve as chair and one to serve as vice chair.

(d) If there is a vacancy for any cause, the appointing authority must make an appointment to fill the vacancy, which appointment becomes effective immediately.

(e) Members of the Legislature appointed to the task force are nonvoting members of the task force and may act in an advisory capacity only.

(f) A majority of the voting members of the task force constitutes a quorum for the transaction of business.

(g) Official action by the task force requires the approval of a majority of the voting members of the task force.

(h) The task force shall meet at times and places specified by the call of the chair or by a majority of the voting members of the task force.

(i) Members of the task force are not entitled to compensation but are entitled to receive per diem and travel expenses as provided in s. 112.061, Florida Statutes.

(j) The task force may apply for public or private grants from nonprofit organizations for the costs of research.

(k)1. The task force shall establish an advisory committee to provide input from a consumer perspective and, to the greatest extent practicable, from the diverse social identities described in sub-sub-subparagraph (a)3.a.(I).

2. Members of the advisory committee must have the following qualifications, such that at least one member:

a. Has experience in seeking or receiving health care in this state to address one or more serious medical conditions or disabilities.

b. Is enrolled in health insurance offered by the state group insurance program or represents public employees.

c. Is enrolled in employer-sponsored health insurance, group health insurance, or a self-insured health plan offered by an employer.

d. Is enrolled in commercial insurance purchased without any employer contribution.

e. Receives medical assistance.

f. Is enrolled in Medicare.

g. Is a parent or guardian of a child enrolled in the Children's Health Insurance Program.

h. Is enrolled in the Federal Employees Health Benefits Program.

i. Is enrolled in TRICARE.

j. Receives care from the United States Department of Veterans Affairs Veterans Health Administration.

k. Receives care from the Indian Health Service.

(l) The task force may establish additional advisory or technical committees that the task force considers necessary. The committees may be continuing or temporary. The task force shall determine the representation, membership, terms, and organization of the committees and shall appoint the members of the committees.

(m) Members of advisory or technical committees are not entitled to compensation but may, in the discretion of the task force, be reimbursed for per diem and travel expenses as provided in s. 112.061, Florida Statutes.

(4) DUTIES; VALUES; PRINCIPLES.—

(a) The task force shall produce findings and recommendations for a well-functioning, single-payor health care financing system that is responsive to the needs and

expectations of the residents of this state by:

1. Improving the health status of individuals, families, and communities;

2. Defending against threats to the health of the residents of this state;

3. Protecting individuals from the financial consequences of ill health;

4. Providing equitable access to person-centered care;

5. Removing cost as a barrier to accessing health care;

6. Removing any financial incentive for a health care practitioner to provide care to one patient over another;

7. Making it possible for individuals to participate in decisions affecting their health and the health care system;

8. Establishing measurable health care goals and guidelines that align with other state and federal health standards; and

9. Promoting continuous quality improvement and fostering interorganizational collaboration.

(b) The task force, in developing its recommendations for the Health Care for All Florida Plan, shall consider, at a minimum, all of the following values:

1. Health care, as a fundamental element of a just society, is to be secured for all individuals on an equitable basis by public means, similar to public education, public safety, and other public infrastructure.

2. Access to a distribution of health care resources and services should be available according to each individual's needs and location within this state. Race, color, national origin, age, disability, wealth, income, citizenship status, primary language use, genetic conditions, previous or existing

medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions, such as termination of pregnancy, may not create any barriers to health care or disparities in health outcomes due to access to care.

3. The components of the system must be accountable and fully transparent to the public with regard to information, decisionmaking, and management through meaningful public participation in decisions affecting people's health care.

4. Funding for the Health Care for All Florida Plan is a public trust, and any savings or excess revenue is to be returned to that public trust.

(c) The task force, in developing its recommendations for the Health Care for All Florida Plan, shall consider, at a minimum, all of the following principles:

1. A participant in the plan may choose any individual provider who is licensed, certified, or registered in this state or any group practice.

2. The plan may not discriminate against any individual provider who is licensed, certified, or registered in this state to provide services covered by the plan and who is acting within the provider's scope of practice.

3. A participant and the participant's provider shall, within the scope of services covered within each category of care and within the plan's parameters for standards of care and requirements for prior authorization, determine whether a treatment is medically necessary or medically appropriate for that participant.

4. The plan must cover services from birth to death, based

on evidence-based decisions as determined by the Health Care for All Florida Board.

(5) SCOPE OF DESIGN FOR THE HEALTH CARE FOR ALL FLORIDA PLAN.—

(a) The task force shall make findings and recommendations for the design of the Health Care for All Florida Plan and the Health Care for All Florida Board, which shall administer the plan. The task force shall submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives as specified in subsection (6). The task force's recommendations must be succinct statements and include actions and timelines, the degree of consensus among the task force members, and the priority of each recommendation, based on urgency and importance. The task force may defer any recommendations to be determined by the board.

(b) The design of the Health Care for All Florida Plan recommended by the task force must:

1. Adhere to the values and principles described in paragraphs (4)(b) and (c);

2. Be a single-payor health care financing system;

3. Ensure that individuals who receive services from the United States Department of Veterans Affairs Veterans Health Administration or the Indian Health Services may be enrolled in the plan while continuing to receive those services;

4. Obtain a waiver of federal requirements that pose barriers to, or adopt other approaches, enabling equitable and uniform inclusion of all residents such that a resident of this state who has other coverage that is not subject to state

regulation may enroll in the plan without jeopardizing eligibility for the other coverage if the person moves out of this state; and

5. Preserve the coverage of the health services currently required by Medicare, Medicaid, the Children's Health Insurance Program, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, Florida's medical assistance program for the needy, and any other state or federal program.

(c) The plan must allow participation by any individual who:

1. Resides in this state;

2. Is a nonresident who works full time in this state and contributes to the plan; or

3. Is a nonresident who is a dependent of an individual described in subparagraph 1. or subparagraph 2.

The task force's recommendations must address issues related to the provision of services to nonresidents who receive services in this state and to plan participants who receive services outside of this state.

(d) Providers shall be paid under the plan as follows or through an alternative method that is similarly equitable and cost-effective:

1. Individual providers licensed in this state shall be paid:

a. On a fee-for-services basis;

b. As employees of institutional providers or members of

group practices that are reimbursed with global budgets; or

c. As individual providers in group practices that receive capitation payments for providing outpatient services as permitted by subparagraph 4.

2. Institutional providers shall be paid with global budgets that include separate capital budgets, determined through regional planning, and operational budgets.

3. Budgets must be determined for individual hospitals and not for entities that own multiple hospitals, clinics, or other providers of health care services or goods.

4. A group practice may be reimbursed with capitation payments if the group practice:

a. Primarily uses individual providers in the group practice to deliver care in the group practice's facilities;

b. Does not use capitation payments to reimburse the cost of hospital services; and

c. Does not offer financial incentives to individual providers in the group practice based on the use of services.

(e) In designing the plan, the task force shall:

1. Develop cost estimates for the plan, including, but not limited to, cost estimates for:

a. The approach recommended for achieving the result described in subparagraph (b)4.; and

b. The payment method designed by the task force under paragraph (d) in designing the plan;

2. Consider how the plan will impact the structure of existing state and local boards and commissions, counties, cities, and special districts, as well as the Federal Government, other states, and Indian tribes;

3. Investigate other states' attempts at providing universal coverage and using single-payor health care financing systems, including the outcomes of those attempts; and

4. Consider the work by existing health care professional boards and commissions and incorporate important aspects of such work into recommendations for the plan.

(f) In developing recommendations for long-term care services and supports for the plan under subparagraph (i)16., the task force shall convene an advisory committee that includes:

1. Persons with disabilities who receive long-term services and supports;

2. Older adults who receive long-term services and supports;

3. Individuals representing persons with disabilities and older adults;

4. Members of groups that represent the diversity, including by gender, race, and economic status, of individuals who have disabilities;

5. Providers of long-term services and supports, including in-home care providers who are represented by organized labor, and family attendants and caregivers who provide long-term services and supports; and

6. Academics and researchers in relevant fields of study.

Notwithstanding subparagraph (i)16., the task force may explore the effects of excluding long-term care services from the plan, including, but not limited to, the social, financial, and administrative costs.

(g) The task force's recommendations for the duties of the board and the details of the plan must ensure that, by considering the following factors, patients are empowered to protect their health, their rights, and their privacy:

1. The patient's access to patient advocates who are responsible to the patient and maintain patient confidentiality and whose responsibilities include, but are not limited to, addressing concerns about providers and helping patients navigate the process of obtaining medical care;

2. The patient's access to culturally and linguistically appropriate care and service;

3. The patient's ability to obtain needed care when a treating provider is unable or unwilling to provide the care;

4. Paying providers to complete forms or perform other administrative functions to assist patients in qualifying for disability benefits, family medical leave, or other income supports; and

5. The patient's access to and control of medical records, including:

a. Empowering patients to control access to their medical records and obtain independent second opinions, unless there are clear medical reasons not to do so;

b. Requiring that a patient or the patient's designee be provided a complete copy of the patient's health records promptly after every interaction or visit with a provider;

c. Ensuring that the copy of the health records provided to a patient includes all data used in the care of that patient; and

d. Requiring that the patient or the patient's designee

provide approval before any forwarding of the patient's data to, or access of the patient's data by, family members, caregivers, or other providers or researchers.

(h) In developing recommendations for the plan, the task force shall engage in a public process to solicit public input on the elements of the plan described in paragraphs (b), (i), (j), and (k). The public process must:

1. Ensure input from individuals in rural and underserved communities and from individuals in communities that experience health care disparities;

2. Solicit public comments statewide while providing to the public evidence-based information developed by the task force about the health care costs of a single-payor health care financing system, including the cost estimates developed under paragraph (e), as compared to the current system; and

3. Solicit the perspectives of:

a. Individuals throughout the range of communities that experience health care disparities;

b. A range of businesses, based on industry and employer size;

c. Individuals whose insurance coverage represents a range of current insurance types and individuals who are uninsured or underinsured; and

d. Individuals with a range of health care needs, including individuals needing disability services and long-term care services who have experienced the financial and social effects of policies requiring them to exhaust a large portion of their resources before qualifying for long-term care services paid for by the medical assistance program for the needy.

(i) With respect to administration of the plan, the report must include, but need not be limited to, all of the following:

1. The governance and leadership of the board, specifically:

a. The composition and representation of the membership of the board, appointed or otherwise selected using an open and equitable selection process;

b. The statutory authority the board will need to establish policies, guidelines, mandates, incentives, and enforcement needed to develop a highly effective and responsive single-payor health care financing system;

c. The ethical standards and their enforcement for members of the board such that there are the most rigorous protections and prohibitions from actual or perceived economic conflicts of interest; and

d. The steps for ensuring that there is no disproportionate influence by any individual, organization, government, industry, business, or profession in any decisionmaking by the board;

2. A list of federal and state laws and rules, state contracts or agreements, and court actions or decisions that may facilitate, constrain, or prevent implementation of the plan and an explanation of how they may facilitate or constrain or prevent implementation;

3. The plan's economic sustainability, operational efficiency, and cost control measures that include, but are not limited to, the following:

a. A financial governance system supported by relevant legislation, financial audit, and public expenditure reviews and clear operational rules to ensure efficient use of public funds;

and

b. Cost control features, such as multistate purchasing;

4. Features of the plan that are necessary to continue to receive federal funding that is currently available to the state and estimates of the amount of the federal funding that will be available;

5. Fiduciary requirements for the revenue generated to fund the plan, including, but not limited to, the following:

a. A dedicated fund, separate and distinct from the General Revenue Fund, which is held in trust for the residents of this state;

b. Restrictions to be authorized by the board on the use of the trust fund;

c. A process for creating a reserve fund by retaining moneys in the trust fund if, over the course of a year, revenue exceeds costs; and

d. Required accounting methods that eliminate the potential for misuse of public funds, detect inaccuracies in provider reimbursement, and use the most rigorous, generally accepted accounting principles, including annual external audits and audits at the time of each transition in the board's executive management;

6. Requirements for the purchase of reinsurance;

7. Bonding authority that may be necessary;

8. The board's role in workforce recruitment, retention, and development;

9. A process for the board to develop statewide goals, objectives, and ongoing review;

10. The appropriate relationship between the board and

regional or local authorities regarding oversight of health activities, health care systems, and providers to promote community health reinvestment, equity, and accountability;

11. Criteria to guide the board in determining which health care services are necessary for the maintenance of health, the prevention of health problems, the treatment or rehabilitation of health conditions, and the provision of long-term and respite care. Criteria may include, but are not limited to, the following:

a. Whether the services are cost-effective and based on evidence from multiple sources;

b. Whether the services are currently covered by the health benefit plans offered by the state group insurance program;

c. Whether the services are designated as effective by the United States Preventive Services Task Force, the United States Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, the federal Health Resources and Services Administration's Bright Futures Program, or the National Academies Institute of Medicine's Committee on Preventive Services for Women; and

d. Whether the evidence on the effectiveness of services comes from peer-reviewed medical literature, existing assessments and recommendations from state and federal boards and commissions, and other peer-reviewed sources;

12. A process to track and resolve complaints, grievances, and appeals, including establishing an Office of the Patient Advocate;

13. Options for transition planning, including an impact analysis on existing health care systems, providers, and patient

relationships;

14. Options for incorporating cost containment measures, such as prior approval and prior authorization requirements, and the effect of such measures on equitable access to quality diagnosis and care;

15. The methods for reimbursing providers for the cost of care as described in paragraph (d) and recommendations regarding the appropriate reimbursement for the cost of services provided to plan participants when they are traveling outside this state; and

16. Recommendations for long-term care services and supports that are tailored to each individual's needs based on an assessment. The services and supports may include, but need not be limited to:

a. Long-term nursing services provided by an institutional provider or in a community-based setting;

b. A broad spectrum of long-term services and supports, including home and community-based settings or other noninstitutional settings;

c. Services that meet the physical, mental, and social needs of individuals while allowing them maximum possible autonomy and maximum civic, social, and economic participation;

d. Long-term services and supports that are not based on the individual's type of disability, level of disability, service needs, or age;

e. Services provided in the least restrictive setting appropriate to the individual's needs;

f. Services provided in a manner that allows persons with disabilities to maintain their independence, self-determination,

and dignity;

g. Services and supports that are of equal quality and accessibility in every geographic region of this state; and

h. Services and supports that give the individual the opportunity to direct the services.

(j) The task force's report must include:

1. The waivers of federal laws or other federal approval that will be necessary to enable a person who is a resident of this state and who has other coverage that is not subject to state regulation to enroll in the plan without jeopardizing eligibility for the other coverage if the person moves out of this state;

2. Estimates of the savings and expenditure increases under the plan, relative to the current health care system, including, but not limited to:

a. Savings from eliminating waste in the current system and from administrative simplification, fraud reduction, monopsony power, simplification of electronic documentation, and other factors that the task force identifies;

b. Savings from eliminating the cost of insurance that currently provides medical benefits that would be provided through the plan; and

c. Increased costs due to providing better health care to more individuals than under the current health care system;

3. Estimates of the expected health care expenditures under the plan, compared to the current health care system, reported in categories similar to the National Health Expenditure Accounts compiled by the Centers for Medicare and Medicaid Services, including, but not limited to:

a. Personal health care expenditures;

b. Health consumption expenditures; and

c. State health expenditures;

4. Estimates of how much of the expenditures on the plan will be made from moneys currently spent on health care in this state from both state and federal sources and redirected or used, in an equitable and comprehensive manner, to the plan;

5. Estimates of the amount, if any, of additional state revenue that will be required;

6. Results of the task force's evaluation of the impact on individuals, communities, and the state if the current level of health care spending continues without implementing the plan, using existing reports and analysis where available; and

7. A description of how the Health Care for All Florida Board or another entity may enhance:

a. Access to comprehensive, high-quality, patient-centered, patient-empowered, equitable, and publicly funded health care for all individuals;

b. Financially sustainable and cost-effective health care for the benefit of businesses, families, individuals, and state and local governments;

c. Regional and community-based systems integrated with community programs to contribute to the health of individuals and communities;

d. Regional planning for cost-effective, reasonable capital expenditures that promote regional equity;

e. Funding for the modernization of public health, as an integral component of cost efficiency in an integrated health care system; and

f. An ongoing and deepening collaboration with Indian tribes and other organizations providing health care which will not be under the authority of the board.

(k)1. The task force's findings and recommendations regarding revenue for the plan, including redirecting existing health care moneys under subparagraph (j)4., must be ranked according to explicit criteria, including the degree to which an individual, class of individuals, or organization would experience an increase or decrease in the direct or indirect financial burden or whether they would experience no change. Revenue options may include, but are not limited to, the following:

a. The redirection of current public agency expenditures;

b. An employer payroll tax based on progressive principles that protect small businesses and that tend to preserve or enhance federal tax benefits for Florida employers that pay the costs of their employees' health care; and

c. A dedicated revenue stream based on progressive taxes that do not impose a burden on individuals who would otherwise qualify for medical assistance.

2. The task force may explore the effect of means-tested copayments or deductibles, including, but not limited to, the effect of increased administrative complexity and the resulting costs that cause patients to delay getting necessary care, resulting in more severe consequences for their health.

(l) The task force's recommendations must ensure:

1. Public access to state, regional, and local reports and forecasts of revenue expenditures;

2. That the reports and forecasts are accurate, timely, of

sufficient detail, and presented in a way that is understandable to the public to inform policymaking and the allocation or reallocation of public resources; and

3. That the information can be used to evaluate programs and policies, while protecting patient confidentiality.

(6) TASK FORCE TIMELINE.—

(a) Members of the task force must be appointed by May 31, 2026.

(b) By September 30, 2026, OPPAGA shall begin preparing a work plan for the task force.

(c) The task force shall submit a report containing its findings and recommendations for the design of the Health Care for All Florida Plan and the Health Care for All Florida Board to the Governor, the President of the Senate, and the Speaker of the House of Representatives by the first day of the 2027 regular session of the Legislature.

(7) PLAN FOR A MEDICAID BUY-IN PROGRAM OR A PUBLIC OPTION.—

(a) The Agency for Health Care Administration shall develop a plan for a Medicaid buy-in program or a public option to provide an affordable health care option to all Florida residents, with the primary focus being Florida residents who do not have access to health care. To the extent feasible, the plan must:

1. Have no net cost to the state;

2. Provide a comprehensive package of benefits that are, at a minimum, equivalent to the benefits offered by qualified plans offered through the federal health insurance exchange;

3. Impose no more than minimal cost sharing, deductibles, or copayments;

4. Take into account the impact on the distribution of risk in the health insurance market;

5. Encourage the use of premium tax credits available under s. 36B of the Internal Revenue Code and other subsidies available under federal law;

6. Maximize the receipt of federal funds to support the costs of the program or option;

7. Use the coordinated care organization health care delivery model; and

8. Use the coordinated care organization provider networks to the extent possible without destabilizing the networks.

(b) By May 1, 2026, the agency shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives the plan developed in accordance with paragraph (a), including:

1. A discussion of potential eligibility requirements for the Medicaid buy-in program or public option, as well as the implications of limiting or not limiting eligibility in various ways;

2. Options for Medicaid buy-in programs or public options targeted to specific populations, including, but not limited to:

a. Residents with household incomes above 400 percent and below 600 percent of the federal poverty guidelines who are unable to afford health insurance offered by their employers;

b. Residents who regularly cycle through enrolling and disenrolling in medical assistance and employer-sponsored health insurance; or

c. Other groups that face significant barriers to accessing affordable, quality health care;

3. Recommendations for legislative changes necessary to implement the plan; and

4. Any federal approval that will be required to implement the plan, such as demonstration projects under s. 1115 of the Social Security Act, a state plan amendment, or a waiver for state innovation under 42 U.S.C. s. 18052.

(8) REPEAL.—This section is repealed on January 2, 2028.

Section 2. For the 2025-2026 fiscal year, the nonrecurring sum of $1,174,816 is appropriated from the General Revenue Fund to the Agency for Health Care Administration for the purpose of implementing this act.

Section 3. This act shall take effect upon becoming a law.