By Senator Arrington

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1 A bill to be entitled
2 An act relating to comprehensive health care for
3 residents; creating part IV of ch. 641, F.S., entitled
4 the "Healthy Florida Act"; creating s. 641.71, F.S.;
5 providing a short title; creating s. 641.72, F.S.;
6 providing purpose of the Florida Health Plan; creating
7 s. 641.73, F.S.; providing definitions; creating s.
8 641.74, F.S.; providing eligibility for and coverage
9 of the plan; authorizing the Florida Health Board to
10 establish financial arrangements with other states and
11 foreign countries under certain circumstances;
12 providing duties of the board relating to plan
13 enrollment; providing enrollment requirements;
14 providing that certain data collected through plan
15 applications and enrollment is private data;
16 authorizing such data to be released to certain
17 persons for specified purposes; creating s. 641.755,
18 F.S.; authorizing plan enrollees to choose certain
19 health care providers; providing covered health care
20 benefits; authorizing the board to expand health care
21 benefits under certain circumstances; providing health
22 care services that are excluded from the plan;
23 requiring enrollees to have primary care providers and
24 access to care coordination; authorizing enrollees to
25 see health care specialists without referral;
26 authorizing the board to establish a computerized
27 registry; authorizing the plan to assist enrollees in
28 choosing primary care providers; prohibiting cost-
29 sharing requirements from being imposed on enrollees;

30 creating s. 641.77, F.S.; requiring the board to
31 secure repeals and waivers of certain provisions of
32 federal law; requiring the Department of Health and
33 the Agency for Health Care Administration to provide
34 assistance to the board; requiring the board to adopt
35 rules under certain circumstances; providing that the
36 plan’s responsibility for providing health care is
37 secondary to existing Federal Government programs
38 under certain circumstances; creating s. 641.78, F.S.;
39 defining the term “collateral source”; requiring the
40 plan to collect health care costs from collateral
41 sources under certain circumstances; requiring the
42 board to negotiate waivers, seek federal legislation,
43 and make arrangements to incorporate collateral
44 sources into the plan; requiring plan enrollees to
45 notify health care providers of collateral sources and
46 health care providers to forward such information to
47 the board; authorizing the board to take appropriate
48 actions to recover reimbursement from collateral
49 sources; requiring collateral sources to pay for
50 health care services under certain circumstances;
51 providing specified authority and rights to the board
52 relating to collateral sources; creating s. 641.791,
53 F.S.; providing that defaults, underpayments, and late
54 payments of certain obligations shall result in
55 remedies and penalties; prohibiting eligibility for
56 health care benefits from being impaired by such
57 defaults, underpayments, and late payments; creating
58 s. 641.792, F.S.; providing eligibility of health care

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59 providers for the plan; prohibiting patient care from
60 being affected by fee schedules and financial
61 incentives; providing requirements for the payment
62 system for noninstitutional providers; providing
63 requirements for the annual budgets for institutional
64 providers; prohibiting noninstitutional and
65 institutional providers that accept payments from the
66 plan from billing patients; providing requirements for
67 capital expenditures by noninstitutional and
68 institutional providers which exceed a specified
69 amount; requiring the board to establish payment
70 criteria and payment methods for care coordination;
71 creating s. 641.793, F.S.; creating the Florida Health
72 Board by a specified date; providing purpose of the
73 board; providing board membership, terms, and
74 compensation; providing duties of the board; providing
75 reporting requirements; creating s. 641.794, F.S.;
76 requiring the Secretary of Health Care Administration
77 to designate health planning regions; providing
78 considerations for such designations; providing
79 requirements for regional planning boards; providing
80 board membership, terms, and first meetings with the
81 Florida Health Board; providing duties of the board;
82 creating s. 641.795, F.S.; creating the Office of
83 Health Quality and Planning; providing purpose and
84 duties of the office; authorizing the Florida Health
85 Board to convene advisory panels under certain
86 circumstances; creating s. 641.796, F.S.; providing
87 applicability of the Code of Ethics for Public

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88 Officers and Employees; providing disciplinary actions
89 for failure to comply with the code of ethics;
90 prohibiting certain persons from engaging in specified
91 acts or from being employed by specified entities;
92 creating the Conflict-of-Interest Committee; providing
93 duties of the committee; creating s. 641.797, F.S.;
94 creating the Ombudsman Office for Patient Advocacy;
95 providing purpose of the office; providing appointment
96 and qualifications of the ombudsman; providing duties
97 and authority of the ombudsman; providing that data
98 collected on plan enrollees in their complaints to the
99 ombudsman is private data; authorizing such data to be
100 released to certain persons and to the board for
101 specified purposes; providing requirements for the
102 office budget; creating s. 641.798, F.S.; creating the
103 position of auditor for the plan; providing purpose,
104 appointment, and duties of the auditor; creating s.
105 641.799, F.S.; providing that the plan policies and
106 procedures are exempt from the Administrative
107 Procedure Act; providing procedures and requirements
108 for adoption of certain rules on plan policies and
109 procedures; requiring specified persons to regularly
110 update the Legislature on certain information;
111 providing a timeline for the operation of the plan;
112 prohibiting certain health insurance policies and
113 contracts from being sold in this state on and after a
114 specified date; requiring an analysis of specified
115 capital expenditure needs; providing reporting
116 requirements; providing a contingent effective date.

117

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

119

120 Section 1. Part IV of chapter 641, Florida Statutes,
121 consisting of ss. 641.71-641.799, Florida Statutes, is created
122 and entitled the "Healthy Florida Act."
123 Section 2. Section 641.71, Florida Statutes, is created to
124 read:
125 641.71 Short title.—This part may be cited as the "Florida
126 Health Plan."
127 Section 3. Section 641.72, Florida Statutes, is created to
128 read:
129 641.72 Purpose.—The purpose of the Florida Health Plan is
130 to keep residents of this state healthy and to provide the best
131 quality of health care by:
132 (1) Ensuring that all residents of this state, regardless
133 of immigration status, are covered.
134 (2) Covering all necessary care, including dental; vision;
135 hearing; mental health; reproductive care, including abortion
136 services and prenatal and postpartum care; gender-affirming
137 health care, including medication and treatment; substance use
138 disorder treatment; prescription drugs; durable medical
139 equipment and supplies; and long-term care and home care,
140 including long-term services and supports in home- and
141 community-based settings.
142 (3) Allowing patients to choose their health care
143 providers.
144 (4) Reducing costs by negotiating fair prices and cutting
145 administrative bureaucracy, through measures such as a global

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146 budget approach to institutional providers, and not by
147 restricting or denying care.
148 (5) Being affordable to all patients through financing
149 based on a patient's ability to pay and the elimination of
150 premiums, copayments, deductibles, and out-of-pocket expenses at
151 the point of service.
152 (6) Focusing on preventive care and early intervention to
153 improve health.
154 (7) Ensuring that there are enough health care providers to
155 guarantee timely access to care.
156 (8) Continuing this state's leadership in medical
157 education, research, and technology.
158 (9) Providing adequate and timely payments to health care
159 providers.
160 (10) Using a simple funding and payment system.
161 (11) Providing a just transition for a displaced workforce
162 affected by changes.
163 Section 4. Section 641.73, Florida Statutes, is created to
164 read:
165 641.73 Definitions.—As used in this part, the term:
166 (1) "Board" means the Florida Health Board established in
167 s. 641.793.
168 (2) "Institutional provider" means an inpatient hospital,
169 nursing facility, rehabilitation facility, or any other health
170 care facility that provides overnight care.
171 (3) "Medically necessary" means comprehensive services or
172 supplies needed to promote health and to prevent, diagnose, or
173 treat a particular patient's medical condition. The
174 comprehensive services and supplies must meet accepted standards

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175 of medical practice within a health care provider’s professional
176 peer group.
177 (4) “Noninstitutional provider” means an individual
178 provider, group practice, clinic, outpatient surgical center,
179 imaging center, or any other health care facility that does not
180 provide overnight care.
181 (5) “Plan” means the Florida Health Plan established in s.
182 641.72.
183 (6) “Resident of this state” means an individual who has
184 had a principal place of domicile in this state for more than 6
185 consecutive months, who has registered to vote in this state,
186 who has made a statement of domicile pursuant to s. 222.17, or
187 who has filed for homestead tax exemption on property in this
188 state.
189 Section 5. Section 641.74, Florida Statutes, is created to
190 read:
191 641.74 Eligibility for and enrollment in the Florida Health
192 Plan.—
193 (1) ELIGIBILITY.—
194 (a) All residents of this state, regardless of immigration
195 status, are eligible for the Florida Health Plan.
196 (b) Coverage for emergency care for a resident of this
197 state which is obtained out of state must be at prevailing local
198 rates where the care is provided. Coverage for nonemergency care
199 obtained out of state must be according to rates and conditions
200 established by the Florida Health Board. The board may require
201 that a resident of this state be transported back to this state
202 when prolonged treatment of an emergency condition is necessary
203 and when that transport will not adversely affect the patient’s

204 care or condition.
205 (c) A nonresident visiting this state shall be billed by
206 the board for all services received under the plan. The board
207 may enter into intergovernmental arrangements or contracts with
208 other states and foreign countries to provide reciprocal
209 coverage for temporary visitors.
210 (d) The board shall extend eligibility to nonresidents
211 employed in this state under a premium schedule set by the
212 board.
213 (e) For a business outside of this state which employs
214 residents of this state, the board shall apply for a federal
215 waiver to collect the employer contribution mandated by federal
216 law.
217 (f) A retiree who is covered under the plan and who elects
218 to reside outside of this state is eligible for benefits under
219 the terms and conditions of the retiree's employer-employee
220 contract.
221 (g) The board may establish financial arrangements with
222 other states and foreign countries in order to facilitate
223 meeting the terms of the contracts described in paragraph (f).
224 Payments for care provided by non-Florida health care providers
225 to retirees who are covered under the plan shall be reimbursed
226 at rates established by the board. Health care providers who
227 accept any payment from the plan for a covered service may not
228 bill the patient for the covered service.
229 (h)1. A person is presumed eligible for coverage under the
230 plan, and a health care provider shall provide health care
231 services as if the person is eligible for coverage under the
232 plan, if the person:

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233 a. Is a minor;
234 b. Arrives at a health care facility unconscious, comatose,
235 or otherwise unable to document eligibility or to act on the
236 person's own behalf because of the person's physical or mental
237 condition; or
238 c. Is involuntarily committed to an acute psychiatric
239 facility or to a hospital with psychiatric beds which provides
240 for involuntary commitment.
241 2. All health care facilities subject to state and federal
242 provisions governing emergency medical treatment must comply
243 with subparagraph 1.
244 (2) ENROLLMENT.—
245 (a) The board shall establish a procedure to enroll
246 residents of this state and provide each with identification
247 that may be used by health care providers to confirm eligibility
248 for services. The application for enrollment may not be more
249 than two pages.
250 (b) Data collected from a person through application for
251 and enrollment in the plan is private data; however, the data
252 may be released to:
253 1. A health care provider for purposes of confirming
254 enrollment and processing payments for benefits.
255 2. The ombudsman of the Ombudsman Office for Patient
256 Advocacy and the auditor for the Florida Health Plan for
257 purposes of performing their duties under ss. 641.797 and
258 641.798, respectively.
259 Section 6. Section 641.755, Florida Statutes, is created to
260 read:
261 641.755 Benefits.—

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262 (1) A person covered under the Florida Health Plan may
263 choose to receive services from any qualified, licensed health
264 care provider that participates in the plan.
265 (2) Except for the exclusions provided in subsection (4),
266 covered health care benefits under the plan include all
267 prescribed medically necessary care, which includes:
268 (a) Inpatient and outpatient health care facility services.
269 (b) Inpatient and outpatient licensed health care provider
270 services.
271 (c) Diagnostic imaging, laboratory services, and other
272 diagnostic and evaluative services.
273 (d) Durable medical equipment, appliances, and assistive
274 technology, including, but not limited to, prescribed
275 prosthetics, eye care, and hearing aids and their repair,
276 technical support, and customization required for individual
277 use.
278 (e) Inpatient and outpatient rehabilitative care.
279 (f) Emergency care services.
280 (g) Necessary transportation for health care services:
281 1. As covered under Medicaid or Medicare; or
282 2. For persons with disabilities, older persons with
283 functional limitations, and low-income persons.
284 (h) Child and adult immunizations and preventive care.
285 (i) Health and wellness education for chronic or
286 preventative care as provided by licensed health care providers.
287 (j) Reproductive health care, including abortion services,
288 contraceptives, and prenatal and postpartum care.
289 (k) Childbirth and maternity care, including doula services
290 and care in freestanding childbirth centers.

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291 (l) Gender-affirming health care, including medication and
292 treatment.
293 (m) Holistic licensed health care services such as
294 chiropractic, acupressure, acupuncture, massage, and nutritional
295 services.
296 (n) Mental health services, including substance use
297 disorder treatment, services in substance use disorder treatment
298 facilities, and mental health care provided by licensed or
299 certified mental health providers such as licensed
300 psychologists, licensed mental health counselors, licensed
301 professional counselors, licensed clinical social workers,
302 certified master social workers, rehabilitation support service
303 providers, and any providers that the board deems eligible.
304 (o) Dental care, including diagnostics and restoration and
305 durable equipment such as braces and mouthguards.
306 (p) Vision care.
307 (q) Hearing care.
308 (r) Prescription drugs.
309 (s) Podiatric care.
310 (t) Therapies that are shown by the National Institutes of
311 Health National Center for Complementary and Integrative Health
312 to be safe and effective.
313 (u) Blood and blood products.
314 (v) Dialysis.
315 (w) Licensed qualified adult day care.
316 (x) Rehabilitative and habilitative services.
317 (y) Ancillary health care or social services previously
318 covered by this state’s qualified public health programs.
319 (z) Case management and care coordination.

320 (aa) Language interpretation and translation for health
321 care services, including sign language and Braille or other
322 services needed for persons with communication barriers.
323 (bb) Services provided by qualified community health
324 workers.
325 (cc) Health care and long-term supportive services,
326 including in a home or community-based setting, assisted living
327 facility, and nursing home, with home health care providers,
328 home health aides, and palliative and hospice care.
329 (dd) Any item or service described in this subsection which
330 is furnished using telehealth, to the extent practicable.
331 (3) The Florida Health Board may expand health care
332 benefits beyond the minimum benefits described in subsection (2)
333 if the expansion meets the intent of this part and when there
334 are sufficient funds to cover the expansion.
335 (4) The following health care services are excluded from
336 coverage by the plan:
337 (a) Treatments and procedures primarily for cosmetic
338 purposes, unless required to correct a congenital defect or to
339 restore or correct a part of the body that has been altered as a
340 result of an injury, a disease, or a surgery or unless
341 determined to be medically necessary by a qualified, licensed
342 health care provider in the plan.
343 (b) Services of a health care provider or facility that is
344 not licensed, certified, or accredited by this state. The
345 licensure, certification, or accreditation requirements do not
346 apply to health care providers or facilities that provide
347 services to residents of this state who require medical
348 attention while traveling out of state.

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349 (5)(a) All plan enrollees must have a primary care provider
350 and must have access to care coordination.
351 (b) A plan enrollee does not need a referral to see a
352 health care specialist.
353 (c) The board may establish a computerized registry to
354 assist patients in identifying appropriate providers, and the
355 plan may assist an enrollee with choosing a primary care
356 provider if the enrollee so chooses.
357 (6) The plan may not impose a deductible, copayment,
358 coinsurance, or any other cost-sharing requirement on an
359 enrollee with respect to a covered benefit.
360 Section 7. Section 641.77, Florida Statutes, is created to
361 read:
362 641.77 Federal preemption.—
363 (1) The Florida Health Board shall secure a repeal or a
364 waiver of any provision of federal law that preempts any
365 provision of this part. The Department of Health and the Agency
366 for Health Care Administration shall provide all necessary
367 assistance to the board to secure any repeal or waiver.
368 (2)(a) The board shall, under the section 1332 waivers of
369 the Patient Protection and Affordable Care Act, request to
370 repeal or waive any of the following provisions to the extent
371 necessary to implement this part:
372 1. Title 42 of the United States Code, ss. 18021-18024.
373 2. Title 42 of the United States Code, ss. 18031-18033.
374 3. Title 42 of the United States Code, s. 18071.
375 4. Section 5000A of the Internal Revenue Code of 1986, as
376 amended.
377 (b) If a repeal or a waiver of a federal law or regulation

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378 cannot be secured, the board shall adopt rules, or seek
379 conforming state legislation, consistent with federal law, in an
380 effort to best fulfill the purposes of this part.
381 (c) The Florida Health Plan's responsibility for providing
382 health care is secondary to existing Federal Government programs
383 for health care services to the extent that funding for these
384 programs is not transferred or that the transfer is delayed
385 beyond the date on which initial benefits are provided under the
386 plan.
387 Section 8. Section 641.78, Florida Statutes, is created to
388 read:
389 641.78 Subrogation.—
390 (1)(a) As used in this section, the term "collateral
391 source" includes:
392 1. A health insurance policy, health maintenance contract,
393 continuing care contract, and prepaid health clinic contract,
394 and the medical components of motor vehicle insurance,
395 homeowner's insurance, and other forms of insurance.
396 2. The medical components of worker's compensation.
397 3. A pension plan and retiree health care benefits.
398 4. An employer plan.
399 5. An employee benefit contract.
400 6. A government benefit program.
401 7. A judgment for damages for personal injury.
402 8. The state of last domicile for individuals moving to
403 Florida for medical care who have extraordinary medical needs.
404 9. Any third party who is or may be liable to an individual
405 for health care services or costs.
406 (b) The term does not include:

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407 1. A contract or plan that is subject to federal
408 preemption.
409 2. Any governmental unit, agency, or service to the extent
410 that subrogation is prohibited by law. An entity described in
411 paragraph (a) is not excluded from the obligations imposed by
412 this section by virtue of a contract or relationship with a
413 governmental unit, agency, or service.
414 (2) When other payers for health care have been terminated,
415 the plan shall collect health care costs from a collateral
416 source if health care services provided to a patient are, or may
417 be, covered services under the collateral source available to
418 the patient, or if the patient has a right of action for
419 compensation permitted under law.
420 (3) The board shall negotiate waivers, seek federal
421 legislation, or make other arrangements to incorporate
422 collateral sources into the plan.
423 (4) If a person who receives health care services under the
424 plan is entitled to coverage, reimbursement, indemnity, or other
425 compensation from a collateral source, the person must notify
426 the health care provider and provide information identifying the
427 collateral source, the nature and extent of coverage or
428 entitlement, and other relevant information. The health care
429 provider shall forward this information to the board. The person
430 entitled to coverage, reimbursement, indemnity, or other
431 compensation from a collateral source must provide additional
432 information as requested by the board.
433 (a) The plan shall seek reimbursement from the collateral
434 source for services provided to the person and may take
435 appropriate action, including legal proceedings, to recover the

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436 reimbursement. Upon demand, the collateral source shall pay the
437 sum that it would have paid or spent on behalf of the person for
438 the health care services provided by the plan.
439 (b) In addition to any other right to recovery provided in
440 this section, the board has the same right to recover the
441 reasonable value of health care benefits from the collateral
442 source.
443 (c) If the collateral source is exempt from subrogation or
444 the obligation to reimburse the plan, the board may require that
445 the person who is entitled to health care services from the
446 collateral source first seek those services from the collateral
447 source before seeking the services from the plan.
448 (5) To the extent permitted by federal law, the board has
449 the same right of subrogation over contractual retiree health
450 care benefits provided by employers as other contracts allowing
451 the plan to recover the cost of health care services provided to
452 a person covered by the retiree health care benefits, unless
453 arrangements are made to transfer the revenues of the health
454 care benefits directly to the plan.
455 Section 9. Section 641.791, Florida Statutes, is created to
456 read:
457 641.791 Defaults, underpayments, and late payments.—
458 (1) Defaults, underpayments, or late payments of any
459 premium or other obligation imposed by this part shall result in
460 the remedies and penalties provided by law, except as provided
461 in this part.
462 (2) Eligibility for health care benefits may not be
463 impaired by any default, underpayment, or late payment of any
464 premium or other obligation imposed by this part.

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465 Section 10. Section 641.792, Florida Statutes, is created
466 to read:
467 641.792 Provider payments.—
468 (1) All health care providers licensed to practice in this
469 state may participate in the Florida Health Plan. The Florida
470 Health Board may determine the eligibility of any other health
471 care providers to participate in the plan.
472 (a) A participating health care provider shall comply with
473 all federal laws and regulations governing referral fees and fee
474 splitting, including, but not limited to, 42 U.S.C. ss. 1320a-7b
475 and 1395nn, whether reimbursed by federal funds or not.
476 (b) A fee schedule or financial incentive may not adversely
477 affect the care a patient receives or the care a health provider
478 recommends.
479 (2) The board shall establish and oversee a fair and
480 efficient payment system for noninstitutional providers.
481 (a) The board shall pay noninstitutional providers based on
482 rates negotiated with noninstitutional providers. The rates must
483 take into account the need to address the shortage of
484 noninstitutional providers.
485 (b) Noninstitutional providers that accept any payment from
486 the plan for a covered health care service may not bill the
487 patient for the covered health care service.
488 (c) Noninstitutional providers shall be paid within 30
489 business days for claims filed following procedures established
490 by the board.
491 (3) The board shall set an annual budget for each
492 institutional provider, which consists of an operating and a
493 capital budget, to cover the institutional provider's

494 anticipated health care services for the following year based on
495 past performance and projected changes in prices and health care
496 service levels.
497 (a) The annual budget for each individual institutional
498 provider must be set separately. The board may not set a joint
499 budget for a group of more than one institutional provider nor
500 for a parent corporation that owns or operates one or more
501 institutional providers.
502 (b) Institutional providers that accept any payment from
503 the plan for a covered health care service may not bill the
504 patient for the covered health care service.
505 (4)(a) The board shall periodically develop a capital
506 investment plan that will serve as a guide in determining the
507 annual budgets of institutional providers and in deciding
508 whether to approve applications for approval of capital
509 expenditures by noninstitutional providers.
510 (b) Institutional and noninstitutional providers that
511 propose to make capital purchases in excess of $500,000 must
512 obtain board approval. The board may alter the threshold
513 expenditure level that triggers the requirement to submit
514 information on capital expenditures. Institutional providers
515 must propose these expenditures and submit the required
516 information as part of the annual budget they submit to the
517 board. Noninstitutional providers must apply to the board for
518 approval of these expenditures. The board must respond to
519 capital expenditure applications in a timely manner.
520 (5) The board shall establish payment criteria and payment
521 methods for care coordination for patients, especially those
522 with chronic illness and complex medical needs.

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523 Section 11. Section 641.793, Florida Statutes, is created
524 to read:
525 641.793 Florida Health Board.—
526 (1) By December 1, 2025, the Florida Health Board shall be
527 established to promote the delivery of high-quality, coordinated
528 health care services that enhance health; prevent illness,
529 disease, and disability; slow the progression of chronic
530 diseases; and improve personal health management. The board
531 shall administer the Florida Health Plan. The board shall
532 oversee the Office of Health Quality and Planning established in
533 s. 641.795.
534 (2)(a) The board shall consist of at least 15 members,
535 including the representatives selected by the regional planning
536 boards established in s. 641.794. These representatives shall
537 appoint the following additional members to serve on the board:
538 1. One patient member and one employer member.
539 2. Seven representatives of labor organizations who
540 represent health care workers or social workers.
541 3. Five health care provider members that include one
542 physician, one registered nurse, one mental health provider, one
543 dentist, and one health care facility director.
544 (b) Each member shall take the oath of office to uphold the
545 Constitution of the United States and the Constitution of the
546 State of Florida and to operate the plan in the public interest
547 by upholding the underlying principles of this part.
548 (c) Board members shall serve 4 years; however, for the
549 purpose of providing staggered terms, of the initial
550 appointments, those members appointed by the representatives of
551 regional planning boards shall serve 2-year terms.

552 (d) Board members shall set the board’s compensation, not
553 to exceed the compensation of the Florida Public Service
554 Commission members. The board shall select the chair from among
555 its membership.
556 (e)1. A board member may be removed by a two-thirds vote of
557 the members voting on removal. After receiving notice and
558 hearing, a member may be removed for malfeasance or nonfeasance
559 in performance of the member’s duties.
560 2. Conviction of any criminal behavior, regardless of how
561 much time has lapsed, is grounds for immediate removal.
562 (3) The board shall:
563 (a) Ensure that all of the requirements of the plan are
564 met.
565 (b) Hire a chief executive officer for the plan, who must
566 take the oath described in paragraph (2)(b).
567 (c) Hire a director for the Office of Health Quality and
568 Planning, who must take the oath described in paragraph (2)(b).
569 (d) Provide technical assistance to the regional planning
570 boards established in s. 641.794.
571 (e) Conduct investigations and inquiries and require the
572 submission of information, documents, and records that the board
573 considers necessary to carry out the purposes of this part.
574 (f) Establish a process for the board to receive concerns,
575 opinions, ideas, and recommendations of the public regarding all
576 aspects of the plan and the means of addressing those concerns.
577 (g) Conduct activities the board considers necessary to
578 carry out the purposes of this part.
579 (h) Collaborate with the Department of Health and with the
580 Agency for Health Care Administration, which licenses health

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581 care facilities, to ensure that facility performance is
582 monitored and deficient practices are recognized and corrected
583 in a timely manner.
584 (i) Establish conflict-of-interest standards that prohibit
585 health care providers from receiving financial benefit from
586 their medical decisions outside of board reimbursement,
587 including any financial benefit for referring a patient for a
588 service, product, or health care provider or for prescribing,
589 ordering, or recommending a drug, product, or service.
590 (j) Establish conflict-of-interest standards related to
591 pharmaceuticals and medical equipment, supplies, and devices,
592 and their marketing to a health care provider, so that the
593 health care provider does not receive any incentive to
594 prescribe, administer, or use a product or service.
595 (k) Require all electronic health records used by health
596 care providers to be fully interoperable with the open source
597 electronic health records system used by the United States
598 Department of Veterans Affairs.
599 (l) Provide financial help and assistance in retraining and
600 job placement to workers in this state who may be displaced
601 because of the administrative efficiencies of the plan.
602 (m) Ensure that assistance is provided to all workers and
603 communities that may be affected by provisions in this part.
604 (n) Work with the Department of Commerce to ensure that
605 funding and program services are promptly and efficiently
606 provided to all affected workers. The Department of Commerce
607 shall monitor and report on a regular basis on the status of
608 displaced workers.
609 (o) Adopt rules, policies, and procedures as necessary to

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610 carry out the duties assigned under this part.
611 (4) Before submitting a waiver application under section
612 1332 of the Patient Protection and Affordable Care Act, the
613 board must do all of the following, as required by federal law:
614 (a) Conduct, or contract for, any actuarial analyses and
615 actuarial certifications necessary to support the board's
616 estimates that the waiver will comply with the comprehensive
617 coverage, affordability, and scope of coverage requirements in
618 federal law.
619 (b) Conduct or contract for any necessary economic analyses
620 needed to support the board's estimates that the waiver will
621 comply with the comprehensive coverage, affordability, scope of
622 coverage, and federal deficit requirements in federal law. These
623 analyses must include:
624 1. A detailed 10-year budget plan.
625 2. A detailed analysis regarding the estimated impact of
626 the waiver on health insurance coverage in this state.
627 (c) Establish a detailed draft implementation timeline for
628 the waiver plan.
629 (d) Establish quarterly, annual, and cumulative targets for
630 the comprehensive coverage, affordability, scope of coverage,
631 and federal deficit requirements in federal law.
632 (5) The board has the following financial duties:
633 (a) Approve statewide and regional budgets.
634 (b) Negotiate and establish payment rates for health care
635 providers through their professional associations.
636 (c) Monitor compliance with all budgets and payment rates
637 and take action to achieve compliance to the extent authorized
638 by law.

639 (d) Pay claims for medical products or services as
640 negotiated and, if deemed necessary, issue requests for
641 proposals from nonprofit business corporations in this state for
642 a contract to process claims.
643 (e) Seek federal approval to bill another state for health
644 care coverage provided to a patient from out of state who comes
645 to this state for long-term care or other costly treatment when
646 the patient’s home state fails to provide such coverage, unless
647 a reciprocal agreement with the patient’s home state to provide
648 similar coverage to residents of this state relocating to that
649 state can be negotiated.
650 (f) Implement fraud prevention measures necessary to
651 protect the operation of the plan.
652 (g) Work to ensure appropriate cost control by:
653 1. Instituting aggressive public health measures, early
654 intervention and preventive care, health and wellness education,
655 and promotion of personal health improvement.
656 2. Making changes in the delivery of health care services
657 and administration that improve efficiency and care quality.
658 3. Minimizing administrative costs.
659 4. Ensuring that the delivery system does not contain
660 excess capacity.
661 5. Negotiating the lowest possible prices for prescription
662 drugs, medical equipment, and health care services.
663 (6) The board has the following management duties:
664 (a) Develop and implement enrollment procedures for the
665 plan.
666 (b) Implement and review eligibility standards for the
667 plan.

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668 (c) Arrange for health care services to be provided at
669 convenient locations to serve communities in need in the same
670 manner as federally qualified health centers, including ensuring
671 the availability of school nurses so that all students have
672 access to health care, immunizations, and preventive care at
673 public schools and encouraging health care providers to provide
674 services at easily accessible locations.
675 (d) Make recommendations, when needed, to the Legislature
676 about changes in the geographic boundaries of the health
677 planning regions.
678 (e) Establish an electronic claim and payment system for
679 the plan.
680 (f) Monitor the operation of the plan through consumer
681 surveys and regular data collection and evaluation activities,
682 including evaluations of the adequacy and quality of services
683 provided under the plan, the need for changes in the benefit
684 package, the cost of each type of service, and the effectiveness
685 of cost control measures under the plan.
686 (g) Disseminate information and establish a health care
687 website to provide information to the public about the plan,
688 including health care providers and facilities, and state and
689 regional planning board meetings and activities.
690 (h) Collaborate with public health agencies, schools, and
691 community clinics.
692 (i) Ensure that plan policies and health care providers,
693 including public health care providers, support all residents of
694 this state in achieving and maintaining maximum physical and
695 mental health.
696 (7) The board, in conjunction with the office and

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697 administrative staff of the plan’s chief executive officer, has
698 the following policy duties:
699 (a) Develop and implement cost control and quality
700 assurance procedures.
701 (b) Ensure strong public health services, including
702 education and community prevention and clinical services.
703 (c) Ensure a continuum of coordinated high-quality primary
704 to tertiary care to all residents of this state.
705 (d) Implement policies to ensure that all residents of this
706 state receive culturally and linguistically competent care.
707 (8) The board shall determine the feasibility of self-
708 insuring health care providers for malpractice and shall
709 establish a self-insurance system and create a special fund for
710 payment of losses incurred if the board determines self-insuring
711 health care providers would reduce costs.
712 (9) By July 1 of each year, the board shall report to the
713 President of the Senate, the Speaker of the House of
714 Representatives, and ranking members of the committees having
715 cognizance over health care issues on:
716 (a) The performance of the plan.
717 (b) The fiscal condition and need for payment adjustment.
718 (c) Any needed changes in geographic boundaries of the
719 health planning regions.
720 (d) Any recommendations for statutory changes.
721 (e) Receipts of revenues from all sources.
722 (f) Whether current year goals and priorities are met.
723 (g) Future goals and priorities.
724 (h) Major new technology and prescription drugs.
725 (i) Other circumstances that may affect the cost or quality

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726 of health care.

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

729 641.794 Health planning regions.—

730 (1) By August 1, 2025, the Secretary of Health Care
731 Administration shall designate health planning regions within
732 this state which are composed of geographically contiguous areas
733 grouped on the basis of the following considerations:

734 (a) Patterns of use of health care services.

735 (b) Health care resources, including workforce resources.

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

738 (d) Geography.

739 (e) Population and demographic characteristics.

740 (f) Other considerations the board deems appropriate.

741 (2) Each health planning region is administered by a
742 regional planning board. A minimum of eight regional planning
743 boards shall be created, and all regional planning boards shall
744 be created by October 1, 2025.

745 (a) Each regional planning board shall consist of:

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

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

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

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755 (c) Each regional planning board shall select the chair
756 from among its membership.
757 (d) Regional planning board members shall serve for 4-year
758 terms; however, for the purpose of providing staggered terms, of
759 the initial appointments, at least half of the board members
760 shall be appointed to 2-year terms. Board members may receive
761 per diem for meetings.
762 (e) The Secretary of Health Care Administration, or his or
763 her designee, shall convene the first meeting of each regional
764 planning board with the Florida Health Board within 30 days
765 after the regional planning board is established.
766 (3) A regional planning board's duties shall consist of:
767 (a) Recommending health standards, goals, priorities, and
768 guidelines for the health planning region.
769 (b) Preparing an operating and capital budget for the
770 health planning region to recommend to the Florida Health Board.
771 (c) Collaborating with local public health care agencies
772 to:
773 1. Educate consumers and health care providers on public
774 health programs, goals, and the means of reaching those goals.
775 2. Implement public health and wellness initiatives.
776 (d) Hiring a regional health planning director.
777 (e) Ensuring that all parts of the health planning region
778 have access to a 24-hour nurse hotline and to 24-hour urgent
779 care clinics.
780 Section 13. Section 641.795, Florida Statutes, is created
781 to read:
782 641.795 Office of Health Quality and Planning.—The Florida
783 Health Board shall establish the Office of Health Quality and

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784 Planning to assess the quality, access, and funding adequacy of
785 the Florida Health Plan. The Office of Health Quality and
786 Planning shall:
787 (1) Make annual recommendations to the board on the overall
788 direction of the plan on the following subjects:
789 (a) Overall effectiveness of the plan in addressing public
790 health and wellness.
791 (b) Access to health care.
792 (c) Quality improvement.
793 (d) Efficiency of administration.
794 (e) Adequacy of the budget and funding.
795 (f) Appropriateness of payments to health care providers.
796 (g) Capital expenditure needs.
797 (h) Long-term health care.
798 (i) Mental health and substance abuse services.
799 (j) Staffing levels and working conditions in health care
800 facilities.
801 (k) Identification of the number and mix of health care
802 facilities and providers necessary to meet the needs of the
803 plan.
804 (l) Care for chronically ill patients.
805 (m) Health care provider training on promoting the use of
806 advance directives with patients to enable patients to obtain
807 the health care of their choice.
808 (n) Research needs.
809 (o) Integration of disease management programs into health
810 care delivery.
811 (2) Analyze shortages in the health care workforce that is
812 required to meet the needs of the population and develop plans

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813 to meet those needs in collaboration with regional planners and
814 educational institutions.
815 (3) Analyze methods of paying health care providers and
816 make recommendations to improve the quality of health care
817 services and to control costs.
818 (4) Assist in coordination of the plan and public health
819 programs.
820 (5) Assess and evaluate health care benefits by:
821 (a) Considering health care benefit additions to the plan
822 and evaluating the additions based on evidence of clinical
823 efficacy.
824 (b) Establishing a process and criteria by which health
825 care providers may request authorization to provide health care
826 services and treatments that are not included in the plan
827 benefit set, such as experimental health care treatments.
828 (c) Evaluating proposals to increase the efficiency and
829 effectiveness of the health delivery system, and making
830 recommendations to the board based on the cost-effectiveness of
831 the proposals.
832 (d) Identifying complementary and alternative health care
833 modalities that have been shown to be safe and effective.
834 (6) The board may convene advisory panels as needed to
835 assess the quality, access, and funding adequacy of the plan.
836 Section 14. Section 641.796, Florida Statutes, is created
837 to read:
838 641.796 Ethics and conflicts of interest; Conflict of
839 Interest Committee.—
840 (1) The Code of Ethics for Public Officers and Employees
841 under part III of chapter 112 applies to the employees and the

842 chief executive officer of the Florida Health Plan, the
843 employees and members of the Florida Health Board, the employees
844 and members of the regional planning boards and the regional
845 health planning directors, the employees and the director of the
846 Office of Health Quality and Planning, the employees and the
847 ombudsman of the Ombudsman Office for Patient Advocacy, and the
848 auditor for the Florida Health Plan. Failure to comply with the
849 code of ethics under part III of chapter 112 is grounds for
850 disciplinary action, which may include termination of employment
851 or removal from the board.
852 (2) In order to avoid the appearance of political bias or
853 impropriety, the chief executive officer of the plan may not:
854 (a) Engage in leadership of, or employment by, a political
855 party or political organization.
856 (b) Publicly endorse a political candidate.
857 (c) Contribute to a political candidate, political party,
858 or political organization.
859 (d) Attempt to avoid compliance with this subsection by
860 making a contribution through a spouse or other family member.
861 (3) In order to avoid a conflict of interest, a person
862 specified in subsection (1) may not be employed by a health care
863 provider or a pharmaceutical, health insurance, or medical
864 supply company while holding the position specified in
865 subsection (1), except for the five health care provider members
866 appointed to the Florida Health Board by the representatives of
867 regional planning boards under s. 641.793(2)(a)2. These five
868 members may be employed by a health care provider, but not by a
869 pharmaceutical, health insurance, or medical supply company
870 while serving on the board.

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871 (4) The board shall establish a Conflict-of-Interest
872 Committee to develop standards of practice for persons or
873 entities doing business with the plan, including, but not
874 limited to, board members, health care providers, and medical
875 suppliers.
876 (a) The committee shall establish guidelines on the duty to
877 disclose to the committee the existence of any financial
878 interest and all material facts related to a financial interest.
879 (b) The committee shall review all proposed transactions
880 and arrangements that involve the plan. In considering a
881 proposed transaction or arrangement, if the committee determines
882 a conflict of interest exists, the committee must investigate
883 alternatives to the proposed transaction or arrangement. After
884 exercising due diligence, the committee shall determine whether
885 the plan can obtain with reasonable efforts a more advantageous
886 transaction or arrangement with a person or entity which would
887 not give rise to a conflict of interest. If the committee
888 determines that a more advantageous transaction or arrangement
889 is not reasonably possible under the circumstances, the
890 committee shall make a recommendation to the board on whether
891 the transaction or arrangement is in the best interest of the
892 plan, and whether the transaction is fair and reasonable. The
893 committee shall provide to the board all material information
894 used to make the recommendation. After reviewing all relevant
895 information, the board shall decide whether to approve the
896 transaction or arrangement.
897 Section 15. Section 641.797, Florida Statutes, is created
898 to read:
899 641.797 Ombudsman Office for Patient Advocacy.—

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900 (1) The Ombudsman Office for Patient Advocacy is created to
901 represent the interests of consumers of health care and to help
902 residents of this state secure the health care services and
903 health care benefits to which they are entitled under this part.
904 The Ombudsman Office for Patient Advocacy shall also advocate on
905 behalf of enrollees of the Florida Health Plan.
906 (2) The Ombudsman Office for Patient Advocacy shall be
907 headed by the ombudsman, who shall be appointed by the Secretary
908 of Health Care Administration. The ombudsman shall serve in the
909 unclassified service and may be removed only for just cause. The
910 ombudsman must be selected without regard to political
911 affiliation and must be knowledgeable about and have experience
912 in health care services and administration. A person may not
913 serve as ombudsman while holding another public office.
914 (a) The ombudsman may gather information about decisions
915 and acts of the Florida Health Board and about any matters
916 related to the board, health care providers, and health care
917 programs.
918 (b) The ombudsman shall:
919 1. Ensure that patient advocacy services are available to
920 all residents of this state.
921 2. Establish and maintain the grievance system according to
922 subsection (3).
923 3. Receive, evaluate, and respond to consumer complaints
924 about the plan.
925 4. Establish a process to receive recommendations from the
926 public about ways to improve the plan.
927 5. Develop educational and informational guides that
928 describe consumer rights and responsibilities.

929 6. Ensure that the guides described in subparagraph 5. are
930 widely available to consumers and available in health care
931 provider offices and facilities.
932 7. Prepare an annual report about the consumer's
933 perspective on the performance of the plan, including
934 recommendations for needed improvements.
935 (3) The ombudsman shall establish a grievance system for
936 complaints. The system must provide a process that ensures
937 adequate consideration of plan enrollee grievances and
938 appropriate remedies.
939 (a) The ombudsman may refer any complaint that does not
940 pertain to compliance with this part to the federal Centers for
941 Medicare and Medicaid Services or any other appropriate local,
942 state, and federal government entity for investigation and
943 resolution.
944 (b) A health care provider or an employee of a health care
945 provider may join with, or otherwise assist, a complainant in
946 submitting a complaint to the ombudsman. A health care provider
947 or an employee of a health care provider who, in good faith,
948 joins with or assists a complainant in submitting a complaint is
949 subject to protections and remedies under this part or under
950 general law.
951 (c) In reviewing a complaint, the ombudsman may require a
952 health care provider or the board to submit any information the
953 ombudsman deems necessary.
954 (d)1. The ombudsman shall send a written notice of the
955 final disposition of the complaint and the reasons for the
956 decision to:
957 a. The complainant;

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958 b. Any health care provider or employee of a health care
959 provider who joins with or assists the complainant in submitting
960 the complaint; and
961 c. The board,
962
963 within 30 calendar days after receipt of the complaint, unless
964 the ombudsman determines that additional time is reasonably
965 necessary to fully and fairly evaluate the relevant grievance.
966 2. The ombudsman's order of corrective action is binding on
967 the plan. A decision of the ombudsman is subject to de novo
968 review by the district court.
969 (4) Data collected on a plan enrollee in the enrollee's
970 complaint to the ombudsman is private data; however, the data
971 may be released to a health care provider that is the subject of
972 the complaint or to the board for purposes of this section.
973 (5) The budget for the Ombudsman Office for Patient
974 Advocacy shall be determined by the Legislature and shall be
975 independent from the board.
976 (6) The ombudsman shall establish offices to provide
977 convenient access to residents of this state.
978 Section 16. Section 641.798, Florida Statutes, is created
979 to read:
980 641.798 Auditor for the Florida Health Plan.—
981 (1) There is created in the Office of the Auditor General
982 the position of auditor for the Florida Health Plan to prevent
983 health care fraud and abuse of the plan. The auditor for the
984 Florida Health Plan shall be appointed by the legislative
985 auditor.
986 (2) The auditor for the Florida Health Plan shall:

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987 (a) Investigate, audit, and review the financial and
988 business records of the plan.
989 (b) Investigate, audit, and review the financial and
990 business records of individuals, public and private agencies and
991 institutions, and private corporations that provide services or
992 products to the plan which are reimbursed by the plan.
993 (c) Investigate allegations of misconduct on the part of an
994 employee or appointee of the Florida Health Board and on the
995 part of any health care provider that is reimbursed by the plan,
996 and report any findings of misconduct to the Attorney General.
997 (d) Investigate fraud and abuse.
998 (e) Arrange for the collection and analysis of data needed
999 to investigate inappropriate use of a product or service that is
1000 reimbursed by the plan.
1001 (f) Annually report recommendations for improvements to the
1002 plan to the board.
1003 Section 17. Section 641.799, Florida Statutes, is created
1004 to read:
1005 641.799 Florida Health Plan policies and procedures;
1006 rulemaking.—
1007 (1) The Florida Health Plan policies and procedures are
1008 exempt from the Administrative Procedure Act.
1009 (2)(a) If the board determines that a rule should be
1010 adopted under this part to establish, modify, or revoke a policy
1011 or procedure, the board must publish in the state register the
1012 proposed rule and must afford interested persons a period of 30
1013 days after publication to submit written data or comments.
1014 (b) On or before the last day of the 30-day period provided
1015 for the submission of written data or comments under paragraph

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1016 (a), any interested person may file with the board written
1017 objections to the proposed rule, stating the grounds for
1018 objection and requesting a public hearing on those objections.
1019 Within 30 days after the last day for submitting written data or
1020 comments, the board shall publish in the state register a notice
1021 specifying the rule to which objections have been filed and a
1022 hearing requested and specifying a time and place for the
1023 hearing.
1024 (c) Within 60 days after the expiration of the period
1025 provided for the submission of written data or comments, or
1026 within 60 days after the completion of any hearing, the board
1027 shall issue a rule adopting, modifying, or revoking a policy or
1028 procedure, or make a determination that a rule should not be
1029 adopted. The rule may contain a provision delaying its effective
1030 date for such period as the board determines is necessary.
1031 Section 18. (1) The Director of the Office of Financial
1032 Regulation of the Department of Financial Services and the chief
1033 executive officer of the Florida Health Plan shall regularly
1034 update the Legislature on the status of the planning,
1035 implementation, and financing of this act.
1036 (2) The Florida Health Plan must be operational within 2
1037 years after July 1, 2025.
1038 (3) On and after the day the Florida Health Plan becomes
1039 operational, a health insurance policy, a health maintenance
1040 contract, a continuing care contract, a prepaid health clinic
1041 contract, or any policy or contract that offers coverage for
1042 services covered by the Florida Health Plan may not be sold in
1043 this state.
1044 (4) The Office of the Inspector General of the Agency for

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1045 Health Care Administration shall prepare an analysis of this
1046 state's capital expenditure needs for the purpose of assisting
1047 the Florida Health Board in adopting the statewide capital
1048 budget for the year following implementation. The Office of the
1049 Inspector General shall submit this analysis to the board.
1050 (5) By July 1, 2026, the Department of Commerce shall
1051 provide to the Florida Health Board, the Governor, and the
1052 chairs and ranking members of the legislative committees with
1053 jurisdiction over health, human services, and commerce a report
1054 determining the appropriations and legislation necessary to
1055 assist all affected individuals and communities through the
1056 transition to the Florida Health Plan.
1057 Section 19. This act shall take effect July 1, 2025, but
1058 only if SB ____ or similar legislation is adopted in the same
1059 legislative session or an extension thereof and becomes a law.