The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 1110
INTRODUCER:	Banking and Insurance Committee and Senators Truenow and Smith
SUBJECT:	Coverage for Orthotics and Prosthetics Services
DATE:	February 12, 2026 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Knudson	BI	**Fav/CS**
2.			AHS	
3.			AP	

I. Summary:

CS/SB 1110 modifies the optional Medicaid coverage for durable medical equipment to include orthotics and prosthetics. The additional coverage applies to the following "eligible individuals":

- A child younger than 18 years old;
- A dependent child;
- An individual 26 years of age or younger who remains covered under a parent's health insurance policy; or
- An individual with a developmental disability.

The bill authorizes the Agency for Health Care Administration (AHCA) to provide Medicaid coverage payment for certain orthotics and prosthetics, all materials and components necessary to use them, instructions on their use, and any necessary repairs or replacements. AHCA is required to seek federal approval and amend contracts as necessary to implement the change made to Medicaid coverage in the bill.

Further, the bill mandates coverage of certain orthotics and prosthetics for insured eligible individuals if certain conditions are met for the following types of insurance coverage beginning on or after July 1, 2026:

- An individual accident and health insurance policy ("individual insurance policy"),
- A group, blanket, and franchise health insurance ("group insurance policy"), and
- A health maintenance organization (HMO) contract.

The bill provides that an insurer or HMO may require supporting documentation from an insured's provider to confirm the need for a replacement that is less than 3 years old. An insurer or HMO may not deny a claim that is medically necessary to restore a physical function for an insured with a disability which would be covered by a nondisabled person. The bill requires

insurers and HMOs to submit an annual report to the Office of Insurance Regulation (OIR) with specified information.

See Section IV. For Fiscal Impact.

The bill is effective July 1, 2026.

II. Present Situation:

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[1] As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.[2] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[3] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[4] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[5]

The Agency for Health Care Administration (AHCA) regulates the quality of care by health maintenance organizations (HMO) under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[6] As part of the certificate process used by the agency, an HMO must provide information to demonstrate that the HMO can provide quality of care consistent with the prevailing standards of care.[7]

Florida's Medicaid Program[8]

Administration of the Program

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act (SSA). This authority includes establishing and maintaining a Medicaid state plan approved by the federal Centers for Medicare and Medicaid Services and maintaining any

[1] Section 20.121(3)(a), F.S. The Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as agency head of the Office of Insurance Regulation for purposes of rulemaking. Further, the Financial Services Commission appoints the commissioner of the Office of Insurance Regulation.
[2] Section 624.418, F.S.
[3] Section 624.316(1)(a), F.S.
[4] Section 624.318(2), F.S.
[5] Section 624.3161, F.S.
[6] Section 641.21(1), F.S.
[7] Section 641.495, F.S.
[8] Agency for Healthcare Administration, *2026 Agency Legislative Bill Analysis Agency for Healthcare Administration for SB 1110*, 8, Jan. 8, 2026 (on file with Senate Committee on Banking and Insurance) (hereinafter cited as "2026 AHCA Agency Analysis for SB 1110).

Medicaid waivers needed to operate the Florida Medicaid program as directed by the Florida Legislature.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs; it establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. State Medicaid programs may request a formal waiver of the requirements codified in the SSA. Federal waivers give states flexibility not afforded through their Medicaid state plan.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirement. The federal government sets the minimum mandatory populations and minimum mandatory benefits to be covered in every state Medicaid program. States can add optional benefits, with federal approval. Florida has added many optional benefits including prescription drugs, ambulatory surgical center services, and dialysis. Florida does not cover all low-income Floridians.

Medicaid services can be delivered both fee-for-services (FFS) or through a managed care delivery model. In FFS, providers contract directly with the AHCA to provide services, and bill and get reimbursed directly by the AHCA. In a managed care delivery model, managed care plans contract with the AHCA and are paid a per member per month capitated payment for providing all of an enrollee's medical, dental, or home and community-based care, depending on the type of managed care plan.

In Florida, most Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and Dental. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S. The SMMC benefits are a robust health care package covering acute, preventive, behavioral health, prescribed drugs, LTC services and dental services.

Mandatory Medicaid Coverage

Section 409.905, F.S., relating to mandatory Medicaid services, provides that the AHCA may make payments for delineated services, which are required of the state. Medicaid providers provide services to recipients who are determined to be eligible on the dates the services were provided. Currently, the Florida Medicaid program covers several mandatory services, such as:

- Advanced practice registered nurse services.[9]
- Home health care services.[10]
- Covered hospital inpatient services.[11]

[9] Section 409.905(1), F.S.
[10] Section 409.905(4), F.S.
[11] Section 409.905(5), F.S.

- Hospital outpatient services.[12]
- Independent Laboratory Services.[13]
- Early and periodic screening, diagnosis, and treatment services for children under 21, including durable medical equipment determined to be medically necessary for the treatment, correction, or amelioration the problem.[14]

Optional Services

Florida law authorizes AHCA to make payments for services which are optional to the state and are provided by Medicaid providers to recipients who are determined to be eligible on the dates the services were provided.[15] Some of the optional services covered include:

- Adult dental care.[16]
- Chiropractic services.[17]
- Community mental health services.[18]
- Durable medical equipment.[19]

Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage[20]

AHCA's Durable Medical Equipment and Medical Supply Services are available through both the SMMC program and FFS delivery system. Florida provides several durable medical equipment, such as:

- Custom and specialized equipment when a less costly alternative is not available to fulfill the recipient's need.
- Recipients under the age of 21 years residing in a skilled nursing facility may receive customized orthotic and prosthetic devices.
- Dynamic splinting.
- Orthopedic footwear.
- Orthotic and prosthetic devices which cover splints and passive motion devices, including sheepskin pads.
- Orthotic and prosthetic equipment.
- Maintenance and repair of orthotic and prosthetic durable medical equipment that meets certain criteria.
- Certain early, periodic, screening, diagnostic, and treatment services that are medically necessary.
- Certain physical therapy and occupational therapy services.

[12] Section 409.905(6), F.S.
[13] Section 409.905(7), F.S.
[14] Section 409.905(2), F.S.
[15] Section 409.906, F.S.
[16] Section 409.906(1), F.S.
[17] Section 409.906(7), F.S.
[18] Section 409.906(8), F.S.
[19] Section 409.906(10), F.S. (providing the AHCA may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary).
[20] 2026 AHCA Agency Analysis for SB 1110 at 4-5.

Patient Protection and Affordable Care Act

Essential Benefits

Under the Patient Protection and Affordable Care Act (PPACA),[21] all non-grandfathered health plans in the non-group and small-group private health insurance markets must offer a core package of health care services known as the essential health benefits (EHBs). While the PPACA does not specify the benefits within the EHB, it provides 10 categories of benefits and services that must be covered and it requires the Secretary of Health and Human Services to further define the EHB.[22]

The 10 EHB categories are:
- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitation and habilitation services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.[23]

The PPACA requires each state to select its own reference benchmark plan as its EHB benchmark plan that all other health plans in the state use as a model. Beginning in 2020, states could choose a new EHB plan using one of three options, including: selecting another's state benchmark plan; replacing one or more categories of EHB benefits; or selecting a set of benefits that would become the State's EHB benchmark plan.[24] Florida selected its EHB plan before 2012 and has not modified that selection.[25]

Individual Insurance Policies

Florida law requires individual insurance policies to comply with several requirements, such as required provisions,[26] limits on preexisting conditions,[27] and claims processing.[28] There are several provisions that require minimum mandatory coverage for certain services, such as

[21] Patient Protection and Affordable Care Act of 2010. Pub. L. No. 111-141, as amended.
[22] 45 CFR 156.100. et seq.
[23] 45 CFR 156.110
[24] Centers for Medicare and Medicare Services, *Marketplace – Essential Health Benefits,* available at https://www.cms.gov/marketplace/resources/data/essential-health-benefits (last reviewed Jan. 31, 2026).
[25] Centers for Medicare and Medicaid Services, *Information on Essential Health Benefits (EHB) Benchmark Plans,* Florida State Required Benefits, available at https://downloads.cms.gov/ (last viewed on Jan. 31, 2026).
[26] Section 627.605, F.S.
[27] Section 627.6046, F.S.
[28] *See* ss. 627.610 and 627.611, F.S.

mammograms,[29] diabetes treatment services,[30] and osteoporosis[31] that meet certain criteria. Any health insurance policy that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy.[32]

Group Insurance Policies

Group health insurance is health insurance covering groups of persons under a master group health insurance policy issued to specified groups, such as employee groups.[33] Group coverage does not apply to certain types of policies, such as auto medical payments and workers compensation.[34] Similar to individual insurance policies, there are several provisions that require minimum mandatory coverage for certain services, such as mammograms,[35] diabetes treatment services,[36] and osteoporosis[37] that meet certain criteria. Any health insurance policy that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy.[38]

HMO Contracts

"Health maintenance contract" means any contract entered into by a health maintenance organization with a subscriber or group of subscribers to provide coverage for comprehensive health care services in exchange for a prepaid per capita or prepaid aggregated fixed sum.[39] An health maintenance organization[40] (HMO) that issues a health insurance contract must renew or continue in force such coverage at the option of the contract holder. There are provisions that require minimum mandatory coverage for certain services, such as mammograms[41] and certain

[29] Section 627.6418, F.S.
[30] Section 627.6408, F.S.
[31] Section 627.6409, F.S.
[32] Section 627.6417(1), F.S. (providing the coverage for prosthetic devices and breast reconstructive surgery is subject to any deductible and coinsurance conditions and all other terms and conditions applicable to other benefits).
[33] Sections 627.652 627.653, F.S.
[34] Section 627.6513, F.S.
[35] Section 627.6613, F.S.
[36] Section 627.65745, F.S.
[37] Section 627.6691, F.S.
[38] Section 627.6612(1), F.S. (providing the coverage for prosthetic devices and breast reconstructive surgery is subject to any deductible and coinsurance conditions and all other terms and conditions applicable to other benefits).
[39] Section 641.19(11), F.S.
[40] Section 641.19(12), F.S., defines "health maintenance organization" as any organization authorized under part I under ch. 641, F.S., which: (a) Provides, through arrangements with other persons, emergency care, inpatient hospital services, physician care including care provided by physicians licensed under chs. 458, 459, 460, and 461, F.S., ambulatory diagnostic treatment, and preventive health care services; (b) Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis; (c) Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract; (d) Provides physician services, by physician licensed under chs. 458, 459, 460, and 461, F.S., directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians; (e) If offering services through a managed care system, has a system in which a primary physician licensed under chs. 458, 459, 460, and 461, F.S., is designed for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary.
[41] Section 641.31095, F.S.

developmental disabilities.[42] Similar to individual and group insurance policies, a health maintenance contract that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy.[43]

Employee Health Care Access Act

The Employee Health Care Access Act is intended to promote health insurance availability for small employers[44] that employ an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year.[45] To transact business in Florida, every small employer carrier must offer and issue all small employer health benefits plans on a guaranteed-issued basis to every eligible small employer that meets certain conditions.[46] The Financial Services Commission may establish rules to ensure that small employer carrier rates are reasonable and reflect objective differences in plan design.[47]

State Employee Health Plan

For state employees who participate in the state employee benefit program, the Department of Management Services through the Division of State Group Insurance (DSGI) administers the state group health insurance program (Program).[48] The Program is a cafeteria plan managed consistent with section 125 of the Internal Revenue Service Code.[49] To administer the program, DSGI contracts with third party administrators for self-insured plans, a fully insured HMO, and a pharmacy benefits manager for the state employees' self-insured prescription drug program, pursuant to s.110.12315, F.S. For the 2025 Plan Year, which began January 1, 2026, the HMO plans under contract with DSGI are Aetna, Capital Health Plan, and United Healthcare, and the preferred provider organization (PPO) plan is Florida Blue.[50]

Study of Mandated Health Benefits

Section 624.215, F.S., directs every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, must submit to the Agency for Health Care Administration and the legislative committees having jurisdiction a report which assesses the social and financial impacts of the proposed coverage.

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[42] Section 641.31098, F.S.
[43] Section 641.31(32), F.S. (providing coverage for prosthetic devices and breast reconstructive surgery is subject to any deductible and coinsurance conditions).
[44] Section 627.6699(2), F.S.
[45] Section 627.6699(3)(v), F.S.
[46] Section 627.6699(5)(b), F.S.
[47] Section 627.6699(6)(a), F.S.
[48] Section 110.123, F.S.
[49] A section 125 cafeteria plan is a type of employer offered, flexible health insurance plan that provides employees a menu of pre-tax and taxable qualified benefits to choose from, but employees must be offered at least one taxable benefit such as cash, and one qualified benefit, such as a Health Savings Account.
[50] Department of Management Services, Division of State Group Insurance, *2024 Open Enrollment Brochure for Active State Employee Participants,* available at https://www.mybenefits.myflorida.com/beta_-_open_enrollment (last visited Jan. 31, 2026).

The requirement is designed to assist the Legislature in determining whether mandating a particular coverage or the offer of such coverage is in the public interest through a systematic evaluation of a proposed mandated benefit's beneficial social and health consequences which may be in the public interest in contrast with the potential increased cost of health insurance premiums.

The guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage, to the extent that information is available, shall include:

- To what extent is the treatment or service generally used by a significant portion of the population.
- To what extent is the insurance coverage generally available.
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- To what extent will the coverage increase or decrease the cost of the treatment or service.
- To what extent will the coverage increase the appropriate uses of the treatment or service.
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.
- The impact of this coverage on the total cost of health care.

III. Effect of Proposed Changes:

Section 1 of SB 1110 expands Medicaid coverage to allow the Agency for Health Care Administration (AHCA) to authorize and pay for the following orthotics and prosthetics services for eligible individuals:

- Orthoses[51] and prostheses.[52] Coverage must include payment for:
  - The model of an orthosis or a prosthesis which is deemed by the recipient's provider to be the most appropriate to meet the medical needs of the recipient to perform activities of daily living and essential job-related activities; and
  - When medically necessary, an orthosis or a prosthesis designed for physical or recreational activities that maximize the recipient's full body health and lower and upper limb function.
- All materials and components necessary to use the orthosis or prosthesis.
- Instruction on the use of the orthosis or prosthesis.
- Any necessary repairs or replacement of the orthosis or prosthesis.

The bill defines "eligible individual" as a Medicaid recipient who is:
- A child younger than 18 years of age;
- A dependent child as specified in s. 627.6562;
- An individual 26 years of age or younger who remains covered under a parent's health insurance policy pursuant to s. 627.6562, F.S.; or
- An individual with a developmental disability as defined in s. 393.063.

Section 2 requires AHCA to seek federal approval and amend contracts as necessary to implement the coverages provided in Section 1 of the bill.

Sections 3, 4, and 5 creates ss. 627.64085, 627.6614, and 641.31079, F.S., relating to an individual insurance policy; a group insurance policy; and a health maintenance organization contract, respectively, to revise the state's coverage mandates for orthotics and prosthetics for an eligible individual beginning on or after July 1, 2026. Insurers and HMOs must provide coverage for the following:
- An orthosis or a prosthesis that is medically necessary for the insured to perform activities of daily living, essential job-related activities, and physical recreational activities, such as running, biking, swimming, strength training, and other activities that maximize the insured's or subscriber's full body health and lower and upper limb function.
- Any replacement of the orthosis or prosthesis, or part thereof, without regard to continuous use or useful lifetime restrictions, if the insured's or subscriber's provider determines that it is medically necessary due to one of the following:

[51] Section 468.80(6), F.S., defines "orthosis" as any medical device used to provide support, correction, or alleviation of neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity but does not include the following assistive technology devices: upper extremity adaptive equipment used to facilitate the activities of daily living, including specialized utensils, combs, and brushes; finger splints; wheelchair seating and equipment that is an integral part of the wheelchair and not worn by the patient; elastic abdominal supports that do not have metal or plastic reinforcing stays; nontherapeutic arch supports; nontherapeutic accommodative inlays and nontherapeutic accommodative footwear, regardless of method of manufacture; unmodified, over-the-counter nontherapeutic shoes; prefabricated nontherapeutic foot care products; durable medical equipment such as canes, crutches, or walkers; dental appliances; or devices implanted into the body by a physician. The term "accommodative" means designed with the primary goal of conforming to the individual's anatomy. The term "inlay" means any removable material upon which the foot directly rests inside the shoe and which may be an integral design component of the shoe. The term "musculoskeletal" and "neuromuscular" mean the systems of the body providing support and movement and include the skeletal, muscular, circulatory, nervous, and integumentary systems.

[52] Section 468.80(14), F.S., defines "prosthesis" as a medical device used to replace a missing appendage or other external body part, including an artificial limb, hand, or foot. It does not include surgically implanted devices or artificial eyes; dental appliances; ostomy products; or cosmetic devices such as breast protheses, eyelashes, or wigs.

- A change in the physiological condition of the insured or subscriber.
- An irreparable change in the condition of the orthosis or prosthesis, or any part of the condition.
- A change in the condition of the orthosis or prosthesis, or any part of the condition, requires repairs that would cost more than 60 percent of the cost of a replacement orthosis or prosthesis or of the part requiring replacement.

Each section applies the mandated coverage to eligible individuals, who are defined in the same way as in Section 1 of the bill, except that reference is made to being an insured or subscriber rather than a Medicaid recipient.

An insurer or HMO may require supporting documentation from an insured's or subscriber's provider to confirm the need for a replacement for an orthosis or a prosthesis that is less than 3 years old.

An insurer or HMO may not deny a claim as a medically necessary intervention to restore physical function for an insured or subscriber with a disability which would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same type of physical function affected.

Each insurer and HMO is required to submit an annual report beginning July 1, 2027, to the OIR detailing the total number of claims submitted for orthotics and prosthetics services in the previous plan year and the total number of such claims that were paid, including the amount paid.

Sections 1, 3, 4, and 5 provide that the bill may not be construed to require coverage of orthotics or prosthetics services for an insured who is not an eligible individual.

Section 6 provides the bill is effective July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The fiscal impact on the private sector is indeterminate but, based on the additional coverage provided under the bill, a negative fiscal may impact the private sector if premiums are raised.

Insurers may incur indeterminate administrative costs for implementing provisions of the bill. Any increased costs which the insurers may incur due to the enhanced coverage requirement within the bill would likely be passed on to insureds.

C. Government Sector Impact:

The Division of State Group Insurance may incur an indeterminate negative fiscal impact to cover state employees for the additional coverage required in the bill.

The Agency for Healthcare Administration (AHCA) would need to amend its rules and managed care contracts to include the expanded coverage. The agency would need to determine whether additional treatment code would be required and, if so, then AHCA would need to update billing systems and set rates for the additional therapy treatment codes. These actions are part of AHCA's routine business practices and can be accomplished using existing resources.[53]

The AHCA would also be required to submit a state plan amendment to seek federal approval for the expanded access to services. This is part of AHCA's routine business practice and can be accomplished using existing resources.[54]

The AHCA reports that the bill will have a fiscal impact on the Medicaid program since it expands access to all orthotic and prosthetic devices for recipients of all ages and therapy treatment to adults that are currently ineligible for such devices. If additional therapy treatment codes are required for implementation, the addition of codes to the therapy fee schedule also will result in a fiscal impact.[55]

The AHCA reports in SFY 2024-25 there was $31,171,568 ($9,339,765 related to children and $21,835,680 related to adults) spent on services related to orthotic and

[53] 2026 AHCA Agency Analysis for SB 1110 at 7-8.
[54] *Id.* at 8.
[55] *Id.*

prosthetic services related to the population below. It is estimated that a 1% increase in services cost would be $311,716. [56]

Estimated Impact for Children[57]		
% Increase to Service Cost	**Total Cost for Increase in Children**	**Impact to General Revenue**
Estimated Increase of 1% to Service Cost	$93,397.65	$41,209.38
Estimated Increase of 5% to Service Cost	$466,988.25	206,046.89
Estimated Increase of 10% to Service Cost	$933,976.51	$412,093.78
Estimated Increase of 25% to Service Cost	$2,334,941.26	$1,030,234.46

Estimated Impact for Adults[58]		
% Increase to Service Cost	**Total Cost for Increase in Adults**	**Impact to General Revenue**
Estimated Increase of 1% to Service Cost	$218,356.80	$96,344.48
Estimated Increase of 5% to Service Cost	$1,091,784.01	$481,722.40
Estimated Increase of 10% to Service Cost	$2,183,568.03	$963,444.80
Estimated Increase of 25% to Service Cost	$5,458,920.07	$2,408,612.01

The current unduplicated population potentially impacted by the proposal, based on diagnosis codes reported on claim submission, is 238,762 individuals, including 173,728 adults and 65,034 children.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Health coverage plan years generally correspond to the calendar year, thus revising the bill's effective date to January 1, 2027, would coincide with the beginning of a new plan year for most insureds and subscribers.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.906
This bill creates the following sections of the Florida Statutes: 627.64085, 627.6614, and 641.31079

[56] *Id.* at 10.
[57] *Id.*
[58] *Id.*

IX. Additional Information:

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

CS by Banking and Insurance Committee on February 11, 2026:
The committee substitute specifies that the orthotics and prosthetics coverage provided in the bill applies only to eligible individuals. Each section that provides for orthotics and prosthetics coverage defines the term "eligible individual" and provides statutory construction to clarify that coverage is not required for an insured who is not an eligible individual.

B. Amendments:

None.